Filing at a Glance

Company:	BCBSVT
Product Name:	BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
State:	VermontGMCB
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001C Any Size Group - Other
Filing Type:	GMCB Rate
Date Submitted:	05/11/2016
SERFF Tr Num:	BCVT-130567350
SERFF Status:	Pending State Action
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Pam Young, Jude Daye, Martine Brisson-Lemieux, Andrew Proulx
Reviewer(s):	Thomas Crompton (primary), David Dillon, Judith Henkin, Jacqueline Lee, Marisa Melamed, Noel Hudson
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: *BCBSVT 2017 Vermont Qualified Health Plans 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: 07/05/2016
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 Vermont Health Connect or directly to consumers effective 01/01/2017.

Filing Description:
May 11, 2016

Noel Hudson
Director of Health Policy
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Subject: Blue Cross and Blue Shield of Vermont - NAIC # 53295
2017 Vermont Qualified Health Plans Rate Filing

Dear Mr. Hudson:

Attached for the Green Mountain Care Board's review and approval is Blue Cross and Blue Shield of Vermont's 2017 Vermont Qualified Health Plans Rate Filing.

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

Sincerely,

Ruth Greene

cc: Tom Crompton/GMCB
Paul Schultz/BCBSVT
Martine Lemieux/BCBSVT

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *BCBSVT 2017 Vermont Qualified Health Plans 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?	Yes
Fee Amount:	$150.00
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: *BCBSVT 2017 Vermont Qualified Health Plans 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	07/01/2016	07/01/2016
Pending Response	Jacqueline Lee	06/21/2016	06/21/2016
Pending Response	Jacqueline Lee	06/21/2016	06/21/2016
Pending Response	Jacqueline Lee	06/09/2016	06/09/2016
Pending Response	Jacqueline Lee	05/23/2016	05/23/2016

Response Letters

Responded By	Created On	Date Submitted
Martine Brisson-Lemieux	07/05/2016	07/05/2016
Jude Daye	06/22/2016	06/22/2016
Jude Daye	06/24/2016	06/24/2016
Martine Brisson-Lemieux	06/13/2016	06/13/2016
Martine Brisson-Lemieux	05/31/2016	05/31/2016

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Attachments A & B	Martine Brisson-Lemieux	05/31/2016	05/31/2016

State:	*VermontGMCB*	**Filing Company:**	*BCBSVT*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*BCBSVT 2017 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	07/01/2016
Submitted Date	07/01/2016
Respond By Date	07/06/2016

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on July 6th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
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Bonnie S. Albritton, F.S.A.
Jacqueline B. Lee, F.S.A.
Wesley R. Campbell, F.C.A.S., F.S.A.
Xiaoxiao (Lisa) Jiang, F.S.A.
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Christopher J. Merkel, F.S.A.
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London/Kansas City
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Scott E. Morrow, F.S.A., F.I.A.

Denver
Mark P. Stukowski, F.S.A.
William J. Gorski, F.S.A.

Indianapolis
Kathryn R. Koch, A.C.A.S.

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

July 1, 2016

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
BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
SERFF Tracking #: BCVT-130567350

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2016. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. We note that House Bill 873 allocates the expenses incurred by the Office of the Health Care Advocate for services related to the Green Mountain Care Board's and Department of Financial Regulation's regulatory and supervisory duties. Was the allocation of these expenses accounted for in the proposed rates?
2. Per page 19 of the 2017 URRT Instructions, "Utilization Trend also includes any effects of selection since this cannot be reflected in the relative cost of the various products and plans offered." Please justify including the impact of selection (line C6 in Exhibit 5) in the other factor in the URRT or modify the URRT to comply. We note that this will not have an impact on the rates.

3. Please provide additional detailed descriptions for the calculations of the values in rows 19 and 20 in Exhibit 2F.
4. Please confirm that cells O6 and AK6 should be labeled as GMCB in the confidential response provide on May 31, 2016.
5. Please provide additional detail for the "potential up-take in 2015" on the top of page 16 in the Actuarial Memorandum.
6. Does BCBSVT have any concerns with the proposed rates in light of the updated 2015 risk adjustment information released on June 30th by CMS?

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 6, 2016. 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:	*BCBSVT 2017 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/21/2016
Submitted Date	06/21/2016
Respond By Date	06/22/2016

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 22nd.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
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Indianapolis
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Baltimore
David A. Palmer, C.F.E.

June 21, 2016

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
BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
SERFF Tracking #: BCVT-130567350

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2016. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. We note that all issuers in Vermont submitted at least 3 quarters of data to CCIIO in order for the Interim Summary Report on Risk Adjustment for 2015 to be issued for Vermont. However, it is not clear from the report whether each carrier submitted 3 or 4 quarters of data. Does the Interim Summary Report on Risk Adjustment reflect 3 or 4 quarters of BCBSVT data?

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 22, 2016. 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:	*BCBSVT 2017 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/21/2016
Submitted Date	06/21/2016
Respond By Date	06/24/2016

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 24th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
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Indianapolis
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Baltimore
David A. Palmer, C.F.E.

June 21, 2016

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
BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
SERFF Tracking #: BCVT-130567350

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2016. The following additional information is being requested on behalf of the Office of the Health Care Advocate.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. Please list and quantify the services included in the projected "Other Medical" benefit category on the URRT.

2. Was the experience period adjusted for an unusually high amount of large claims? If it was, please explain the adjustment.

3. The product of all Population Risk Morbidity Adjustments in Exhibit 5 equal an adjustment of 1.004. Please explain why this is different than the 0.995 included on the URRT.

4. Regarding the "Other" Adjustments in Exhibit 5 and the URRT, please reconcile the Other Adjustments in Exhibit 5 to the URRT.

5. Please explain why the Taxes and Fees PMPM in the MLR calculation (Exhibit 8) only amount to $1.08 PMPM as opposed to the $4.61 in Exhibit 7C and the URRT.

6. Please provide the Part II justification for all plans with more than a 10% rate increase.

7. Section 3.4.3 of the Actuarial Memorandum at page 10 discusses changes in the morbidity of the population insured. It describes upward pressure attributable to those members migrating from Medicaid and downward pressure resulting from adverse experience for voluntary cancellations. It does not discuss new enrollees that were previously uninsured. Do you have any estimates regarding the morbidity of this group?

8. Please provide the calculation of the Risk Adjustment amount of $1.36 using the federal formula.

9. On page 13 of the Actuarial Memorandum, you explain that VHC agreed to pay you for 2014 claims for which members had been retroactively cancelled. What settlement amount was received for 2014? What settlement amount is anticipated for 2015? What is the timing of any payments or expected payments?

10. On page 17 of the Actuarial Memorandum you describe the Pharmacy Trend Development. You indicated: "In this filing, we removed the contract adjustment from the cost trend calculation and added a factor to the overall trend calculation to account for the contracting changes. Accordingly, we based our cost trend calculation on Average Wholesale Price (AWP), which does not reflect contracted discounts, instead of contract-adjusted allowed charges as in previous filings." How were contracted discounts and rebates considered in the trend calculation?

11. At the end of page 19 and continuing onto page 20 of the Actuarial Memorandum, you discuss how you have incorporated the impact of Viekira. At the top of page 20 you state: "There is no discount reflected in the claim, however we do receive large rebates from ESI for Viekira claims. As drug rebates are credited to groups in a separate part of the renewal formula, we used the claim cost of $30,000 per month in the trend development." Since there are no renewals formula that apply to small groups in this pool, please explain why rebates for all the specialty drugs that you have singled out in this section should not be incorporated into the cost estimates?

12. On Page 24 of your Actuarial Memorandum you report that you completed an extensive cost accounting study. Please quantify the impact of any changes to your cost accounting on the administrative costs of the Qualified Health Plans. What other insurance lines were adjusted to offset any changes to the allocated administrative costs for the Qualified Health Plans?

13. In 2016, how many small businesses with 51-100 employees purchased plans from you on the Exchange and how many were self-funded? How did the number of small groups and morbidity of these small groups compare to the estimates you made in your 2016 Vermont Health Connect filing? How many additional small groups do you expect to enroll in 2017?

14. Please explain your provider contracting timeline. When do you establish the rates you will pay different providers and how often are they renegotiated?

15. Please explain any assumptions you made in your filing based on current Health Care reform initiatives in Vermont.

16. Your predicted federal risk adjustment payment is one third of the amount MVP predicts it will pay. Can you explain this discrepancy?

17. Please indicate whether you believe that it is necessary to make any adjustments to this filing as the result of legislative changes in Vermont during the 2016 session or to federal changes that were not included in your original filing and that will affect rates. Please provide details about each such necessary adjustment.

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 24, 2016. 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:	*BCBSVT 2017 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/09/2016
Submitted Date	06/09/2016
Respond By Date	06/13/2016

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 13th.

Conclusion:

Sincerely,
Jacqueline Lee

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

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

June 9, 2016

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
BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
SERFF Tracking #: BCVT-130567350

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2016. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. We note that Viekira is the only hepatitis C drug on ESI's formulary for 2017. Please describe the expected impact, if any, of the FDA approval of Zepatier for claims in 2017 and for future years.
2. How long are the increased costs of the multi-year project to migrate to a new operating platform and the significant upgrades to cybersecurity protocols expected to remain at elevated levels?
3. Please reconcile the 6.4% increase in administrative costs due to the comprehensive cost accounting study with the response to question #12 dated March 14, 2016 in the 3Q 2016 Large Group filing.

4. Please confirm that the labels in column B for rows 7 and 8 should be switched in the response to question #7 dated March 31, 2016.
5. Please provide the preliminary risk adjustment information received from CCIIO that is BCBSVT specific.
6. Please provide quantitative support for the 0.25% risk margin for bad debt.
7. Please provide the number of inforce members by plan that is consistent with the number of inforce contracts provided in Exhibit 9.

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 13, 2016. 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:	*BCBSVT 2017 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	05/23/2016
Submitted Date	05/23/2016
Respond By Date	05/31/2016

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on May 31st.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
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Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.
Kimberly S. Shores, F.S.A.
Michael A. Brown, F.S.A.
Naomi J. Kloeppersmith, F.S.A
Stephanie T. Crownhart, F.S.A
Mark W. Birdsall, F.S.A.

London/Kansas City
Timothy A. DeMars, F.S.A., F.I.A.
Scott E. Morrow, F.S.A., F.I.A.

Denver
Mark P. Stukowski, F.S.A.
William J. Gorski, F.S.A.

Indianapolis
Kathryn R. Koch, A.C.A.S.

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

May 23, 2016

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
BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
SERFF Tracking #: BCVT-130567350

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2016. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. Please provide quantitative support for the unit cost trends for:
   a. Vermont facilities and providers impacted by the hospital budget review process of the GMCB;
   b. other providers within the BCBSVT service area; and
   c. providers outside the BCBSVT service area.

   Source: Actuarial Memorandum page 17
2. Please quantify the impact of the lower charges from the Rutland Regional Medical Center. Are any additional changes anticipated for other hospitals?
   Source: Actuarial Memorandum page 16

3. Provide quantitative support for the considerably unfavorable paid claims experience. *Source: Actuarial Memorandum page 4*
4. Please provide an actual to expected comparison of the contributions to reserves for the most recent 5 years based on the final premiums after amendments made by regulators.
5. Please provide quantitative support for the increase in the experience period administrative costs from $28.40 in the prior filing to $32.93 in the current filing. *Source: Actuarial Memorandum page 24 and 2016 Actuarial Memorandum page 28*
6. Confirm that the projected period membership in the exhibit on the top of page 25 in the Actuarial Memorandum is correctly allocated between "Enrolled through VHC" and "Directly Enrolled with BCBSVT."
7. What percentage of groups with 51 – 100 employees that were expected in the prior filing to offer a QHP, have offered or have informed you that they intend to offer a QHP? *Source: Actuarial Memorandum page 9*
8. Please reconcile Exhibit 2B with the table in section 3.4.1 of the Actuarial Memorandum.
9. Please provide the projected number of contracts by plan by tier.

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 May 31, 2016. 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: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/05/2016
Submitted Date	07/05/2016

Dear Thomas Crompton,

Introduction:

Response 1

Comments:

Please find attached BCBSVT's responses to the 2017 QHP filing inquiries dated July 1, 2016.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5.pdf Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5 -excel.pdf Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5.xlsx

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: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/22/2016
Submitted Date	06/22/2016

Dear Thomas Crompton,

Introduction:

Attached please find the response from BCBSVT on the "Objection" to the BCBSVT 2017 QHP Filing Inquiry Letter 4.

Response 1

Comments:

Requested documentation for objection.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 4
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 4.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Jude Daye

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/24/2016
Submitted Date	06/24/2016

Dear Thomas Crompton,

Introduction:

Attached please find the response from BCBSVT on the "Objection" to the BCBSVT 2017 QHP Filing Inquiry Letter 3.

Response 1

Comments:

Requested documentation for objection.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to BCBSVT 2017 QHP Filing Inquiry Letter 3
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries Letter 3.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Jude Daye

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/13/2016
Submitted Date	06/13/2016

Dear Thomas Crompton,

Introduction:

Response 1

Comments:

Please find attached BCBSVT's responses to the 2017 QHP filing inquiries dated June 9, 2016.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016 - Excel.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016.xlsx

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: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/31/2016
Submitted Date	05/31/2016

Dear Thomas Crompton,

Introduction:

Response 1

Comments:

Please find attached BCBSVT's responses to the 2017 QHP filing inquiries dated May 23, 2016.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016 - EXCEL.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016.xlsx

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: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Amendment Letter

Submitted Date: 05/31/2016

Comments:

BCBSVT has revised its nonstandard 73 percent Cost Sharing Reduction (CSR) plan to comply with 45 CFR 156.420(f). This rule requires at least a two percent difference from the base silver plan and the 73 percent CSR silver plan. The original benefit submitted by BCBSVT for the 73 percent CSR plan variation of the nonstandard silver plan was 1.8 percent richer than the base silver plan. To meet this standard, we decreased the deductible for the silver 73 percent CSR plan by $100. This change was filed with Department of Financial Regulation in a revised BCBSVT actuarial certification. This change does not affect the rate calculations in the qualified health plan rate filing. We are informing you of this change because the original actuarial certification was an attachment to the qualified health plan rate filing in this docket. A copy of the revised certification is attached with the changes highlighted on pages 13 and 17.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes	
Satisfied - Item:	Attachments A & B
Comments:	
Attachment(s):	Attachment A - Standard Plans AV Certification - 2017.pdf Attachment B - Blue Rewards AV Certification 2017 - Revised.pdf ltr GMCB re 73 CSR plan actuarial cert 05312016.pdf
Previous Version	
Satisfied - Item:	*Attachments A & B*
Comments:	
Attachment(s):	*Attachment A - Standard Plans AV Certification - 2017.pdf* *Attachment B - Blue Rewards (Non-Standard) Plans AV Certification - 2017.pdf*

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: BCBSVT 2017 Vermont Qualified Health Plans 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: 5.900%
Effective Date of Last Rate Revision: 01/01/2016
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	8.169%	8.169%	$31,726,984	42,527	$388,384,890	10.924%	5.222%

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 (Individual)	13627VT034		16934
BCBSVT EPO (Small Group)	13627VT032		23344
BCBSVT EPO Blue Rewards (Individual)	13627VT038		4361
BCBSVT EPO Blue Rewards (Small Group)	13627VT036		2377
BCBSVT EPO Blue Rewards CDHP (Individual)	13627VT039		2375
BCBSVT EPO Blue Rewards CDHP (Small Group)	13627VT037		8390
BCBSVT EPO CDHP (Individual)	13627VT035		5038
BCBSVT EPO CDHP (Small Group)	13627VT033		7604

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: 816,633
Benefit Change: Increase
Percent Change Requested: Min: 5.222 Max: 10.924 Avg: 8.169

PRIOR RATE:

Total Earned Premium: 388,384,890.00
Total Incurred Claims: 299,338,107.00
Annual $: Min: 205.73 Max: 588.85 Avg: 459.59

REQUESTED RATE:

Projected Earned Premium: 459,647,930.00
Projected Incurred Claims: 417,240,152.00
Annual $: Min: 217.33 Max: 623.68 Avg: 497.13

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	BCBSVT 2017 QHP Filing - Actuarial Memorandum.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	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 2017 QHP 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: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	Unified_Rate_Review_Template_2017_BCBSVT_13627.xlsm Unified_Rate_Review_Template_2017_BCBSVT_13627.pdf UnifiedRateReviewSubmission2017_BCBSVT_13627_20160510105821.xml
Item Status:	
Status Date:	

Satisfied - Item:	Exhibits
Comments:	
Attachment(s):	BCBSVT 2017 QHP Filing - Exhibits.pdf BCBSVT 2017 QHP Filing - Exhibits.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Attachments A & B
Comments:	
Attachment(s):	Attachment A - Standard Plans AV Certification - 2017.pdf Attachment B - Blue Rewards AV Certification 2017 - Revised.pdf ltr GMCB re 73 CSR plan actuarial cert 05312016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Data Template
Comments:	
Attachment(s):	RatesTablesTemplate2017_BCBSVT_13627.pdf RatesTablesTemplate_BCBSVT_13627.xls RatesTablesTemplate2017_BCBSVT_13627.xml
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Data Set
Comments:	
Attachment(s):	Actuarial Memo Dataset (2017 issues) - BCBSVT - 2017.pdf Actuarial Memo Dataset (2017 issues) - BCBSVT - 2017.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: BCBSVT 2017 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016 - EXCEL.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016 - Excel.pdf Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 4
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 4.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response to BCBSVT 2017 QHP Filing Inquiry Letter 3
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiries Letter 3.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5
Comments:	
Attachment(s):	Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5.pdf Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5 -excel.pdf Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5.xlsx
Item Status:	
Status Date:	

Attachment Unified_Rate_Review_Template_2017_BCBSVT_13627.xlsm is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission2017_BCBSVT_13627_20160510105821.xml is not a PDF document and cannot be reproduced here.

Attachment BCBSVT 2017 QHP Filing - Exhibits.xlsx is not a PDF document and cannot be reproduced here.

Attachment RatesTablesTemplate_BCBSVT_13627.xls is not a PDF document and cannot be reproduced here.

Attachment RatesTablesTemplate2017_BCBSVT_13627.xml is not a PDF document and cannot be reproduced here.

Attachment Actuarial Memo Dataset (2017 issues) - BCBSVT - 2017.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2017 QHP Filing Inquiries - 05.23.2016.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2017 QHP Filing Inquiries - 06.09.2016.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2017 QHP Filing Inquiry Letter 5.xlsx is not a PDF document and cannot be reproduced here.

BLUE CROSS BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
ACTUARIAL MEMORANDUM

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BLUE CROSS BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
ACTUARIAL MEMORANDUM

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, 2017

1.2. Company Contact Information

Primary Contact Name: Paul A. 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 Qualified Health Plans (QHPs) that Blue Cross and Blue Shield of Vermont (BCBSVT) proposes to offer for the 2017 benefit year.

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 147
- 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 8.2 percent.

1.5. Reason for Rate Increase(s)

The starting point of any renewal rate analysis is an assessment of actual to expected experience results. The basis for this rate filing is calendar year 2015 experience. That experience was much worse than expected in the 2016 rate filing, driving a 6.3 percent increase in 2017 rates:

- Allowed QHP claims were higher than expected, driving a rate increase of 1.5 percent.

- Benefit plans proved to be richer than expected, as measured by the ratio of paid claims to allowed claims. Reflecting this in our modeling of 2017 benefits had a 3.8 percent impact on 2017 rates. Paid claims are the product of allowed claims and paid-to-allowed ratio. Considerably unfavorable paid claims experience therefore increases rates by 5.4 percent.

- Vermont law defines groups of 51 to 100 as small groups starting in 2016. Such groups that have either already joined a QHP or are expected to do so had significantly worse than expected claims experience during 2015. Revising our assumptions to match current observations of the number and cost profile of these groups joining QHPs during 2016 pressures rates by an additional 0.9 percent.

In the absence of mandated changes associated with the Affordable Care Act, a 9.1 percent increase would have been requested. In addition to the experience impact, various assumptions drive the balance of the increase:

- An estimate of increases in the amounts providers are paid was included in 2016 QHP rates. Increases that have already occurred in 2016, or that are projected to occur before the end of 2016, drive a premium decrease of 0.4 percent by virtue of being lower than those assumed in the 2016 filing.

- Amounts that providers are paid are expected to increase in 2017, with a premium impact of 4.0 percent. This includes a 1.6 percent premium increase due to increases in the wholesale price of prescription drugs and a 2.4 percent premium increase due to payments to providers of medical services.

- The new pharmacy contract BCBSVT has negotiated with its Pharmacy Benefit Manager reduces the premium by 0.9 percent.

- BCBSVT assumes that members who have or will enroll in our QHPs in 2017 will prove to be healthier on average than those insured during calendar 2015, either in QHPs or individual and small group products. This assumption creates a premium decrease of 1.6 percent.

- During 2015, BCBSVT completed an extensive cost accounting study. The administrative expense projection reflects this new allocation. After offsets for continued membership growth, the exclusion of one-time charges and an expected decrease in administrative costs due to expanded opportunities for members to enroll directly with BCBSVT, the increase in administrative costs per member per month increased premium by 0.9 percent. BCBSVT administrative expenditures for members included in this filing remain below seven percent of premium.

- A contribution to reserves (CTR) is required in order to maintain an adequate level of surplus. Surplus is a critical consumer protection required by financial regulation to assure health care system stability for QHP members. A long-term CTR of two percent represents an adequate, yet not excessive, contribution to reserves. CTR at this level allows BCBSVT to manage short-term fluctuations in order to maintain Risk-Based Capital (RBC) levels that are within our established, modest target range. While a contribution to reserves of 3.8 percent would be required to maintain RBC in light of 2017 premium and membership increases, BCBSVT believes that CTR should be managed to an adequate long-term level rather than fluctuating significantly from year to year with changes in membership and health care cost trend. For this reason, we have continued to file a CTR of 2.0 percent for 2017. As this is greater than the CTR approved by the Green Mountain Care Board for 2016 QHP rates, this has the effect of increasing premiums by 1.0 percent.

- Other adjustments to the assumptions used in the 2017 rate development cumulatively have the effect of reducing the required rate increase by 0.3 percent.

Mandated changes associated with the Affordable Care Act combine for a net decrease to premium of 0.8 percent:

- The federal government assessed a charge on all health plans to subsidize QHP coverage for the three year-period between 2014 and 2016, through its Transitional Reinsurance Program. The subsidy will be eliminated in 2017, requiring groups and members to pay 2.3 percent more for their coverage. This is more than offset by a temporary suspension of the Federal Insurer Fee for 2017, resulting in a combined premium reduction of 0.4 percent.

- Some deductibles, out-of-pocket maximums and co-pays in QHPs remain unchanged from 2016 to 2017. As overall costs increase and the amounts that members pay in cost-sharing contributions stay the same, more of the total cost is transferred to premiums. This has an impact of 1.6 percent on premium, offset by a 2.0 percent decrease due to plan changes implemented by BCBSVT and the State of Vermont for a net premium decrease of 0.4 percent.

2. PROPOSED BENEFITS

2.1. Description of Benefits

BCBSVT will be offering two types (Standard and Non-Standard) of QHPs in 2017. These plans include coverage for all Essential Health Benefits (EHBs). All QHPs are on the Exclusive Provider Organization (EPO) network and offer members access to a nationwide network of providers, including 92 percent the of providers in Vermont.

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 1A – "State of Vermont Standard Plan Designs." The Form filings for these products can be found under BCVT-130476826 for Non-CDHP plans and BCVT-130476866 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 Blue Rewards CDHP. Please see Exhibit 1B – "BCBSVT Blue Rewards (Non-Standard) Plan Designs" for details on the benefit structure. The Form filings for these products can be found under BCVT-130476860 for Non-CDHP plans and BCVT-130476879 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 or having a routine eye or dental exam. BCBSVT is introducing a new Blue Rewards Silver CDHP plan effective January 1, 2017.

Uniform Compliance
All of the renewing benefits are in compliance with 45 C.F.R 147.106. Specifically, all renewing benefits continue to be offered on BCBSVT's Exclusive Provider Organization (EPO) network and continue to cover the same service area. Some cost sharing levels were modified to maintain the same metal tier levels. Each product covers the same benefits except for the addition of Non-EHB benefits (described in section 3.8.3) which impacts each plan by 0.02 percent.

2.2. AV Metal Values

Standard plans are designed by the State of Vermont and offered by all issuers of QHPs. Please see *Attachment A – Standard Plans AV Certification - 2017* for the certification provided by the State.

Blue Rewards (Non-Standard) plans are designed by BCBSVT. The metal values included in the Unified Rate Review Template (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 - 2017*, 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 2015 experience of Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group QHP products. This population will be the Single Risk Pool.

We used claims incurred January 1, 2015 through December 31, 2015 and paid through February 29, 2016. 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. We also included an estimate of IBNR for the outstanding Pharmacy Rebates.

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 I of Worksheet 1) for the Experience Period.

	Incurred Claims	Allowed Claims
Claims incurred and paid through December 31, 2015	$293,712,993	$386,004,072
Estimate of IBNR as of February 29, 2016 for Claims	$1,399,309	$1,417,075
Estimate of IBNR as of February 29, 2016 for Pharmacy Rebates	($2,786,937)	($2,786,937)
Total Claims	$292,325,366	$384,634,210
Member Months	766,083	766,083
Total Per Member Per Month (PMPM)	$381.58	$502.08

The experience period total allowed charges PMPM are $502.08.

In the experience period, the earned premium was $334,972,631. BCBSVT will not be required to pay MLR rebates for the 2015 calendar year.

3.2. Benefit Categories

Medical claims are initially categorized into two 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 of the URRT 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 "Benefit Period" 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. As shown in section 3.1, the experience index rate is $502.08.

To calculate the Projected Period Index Rate, we first excluded pharmacy rebates, BlueCard 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 Period Index Rate (as described in section 3.4.6.).

BCBSVT has access to the detailed claims information underlying capitated claims and since capitated payments are routinely adjusted to target 100 percent of FFS claims, using the FFS equivalent represents the expected payment better than the capitation.
Dental and vision claims were removed in this step both because the projection factors described below do not apply to these benefits. See Section 3.4.4 for more details.

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	$384,634,210	$502.08
Remove BlueCard Fees	($1,305,040)	($1.70)
Remove Pharmacy Rebates	$5,483,704	$7.16
Remove Payments to Blueprint Program	($1,748,767)	($2.28)
Replace Capitation with FFS equivalent	$352,623	$0.46
Remove Dental and Vision Claims	($1,333,382)	($1.74)
Line A of Exhibit 5	**$386,083,348**	**$503.97**

3.4. Projection Factors

3.4.1. Change in the Definition of Small Group

As of the first renewal date on or after January 1, 2016, the Vermont definition of Small Group changes to include groups with 51-100 employees. These groups can either offer QHPs or move to a self-funded alternative. To calculate this factor, we included groups that had already joined the QHP line of business and groups that had already informed us that they intended to offer a QHP upon their 2016 renewal. For groups with non-calendar plan years that have neither joined QHP nor informed us of their intentions, we assumed that only groups that would realize lower premiums by choosing QHPs would join the risk pool. We included these claims and member months in all of the factors described below.

	Single Risk Pool	Groups with 51-100 employees offering QHP in 2016	Groups with 51-100 employees expected to offer QHP in 2017	Total
Experience Period Allowed Claims	$386,083,348	$25,727,986	$4,425,372	$416,236,706
Experience Period Member Months	766,083	43,108	7,442	816,633
PMPM	$503.97	$596.83	$594.65	$509.70

The factor ($1+b_1$ on Exhibit 5) to adjust for the change in the definition of Small Group is $509.70/$503.97 = 1.0114.

3.4.2. Membership Projections

As of March 2015, BCBSVT had 70,423 members enrolled in a QHP product, either individually through Vermont Health Connect or directly as individual or small group employees.

We used this information to project the 2017 QHP enrollment and the distribution by plan. As described in the previous section, BCBSVT expects that a portion of its current enrollment in groups with 51-100 employees will purchase QHPs. We projected their choice of product to be that most similar to their current product offering.

The Vermont Department of Health Access (DHVA) is in the process of requalifying all Medicaid enrollment. Any Vermonter who loses their Medicaid coverage would be eligible for a special enrollment period and allowed to join a QHP. Based on preliminary results from DHVA, approximately 18 percent of the 81,300 adults currently enrolled in Medicaid would no longer be eligible. We estimate that 50 percent of these members will enroll in a QHP, in the same proportion as current QHP enrollment by issuer. Since BCBSVT currently has 90 percent of the QHP market, we estimate that 6,500 members previously in Medicaid will join by January 2017.

This membership assumption has impacts on many other assumptions. Throughout the balance of the Actuarial Memorandum, the projection factors other adjustments will include the effects of this increase in membership. We will include the impact on projected claims in $1+b_3$ on Exhibit 5. Since we are assuming that all of these new members will continue to be subsidized and enroll

in a Silver plan, the impact of the change in distribution by plan will be reflected in $1+b_6$ and $1+c_1$ of Exhibit 5. The increase in membership with projected claims higher than the average will also impact the projected risk adjustment transfer payment. Finally, the administrative charges will reflect the projected increase in membership and its impact on fixed costs. It should be noted that the overall rate impact of adding these members, based on the assumptions in this filing, is expected to be less than 0.1 percent, and that this rate impact is not sensitive to the total number of additional members who enroll after losing Medicaid eligibility.

The total member months expected to be covered by this filing is 930,456.

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 by plan and market are on Exhibit 2A.

3.4.3. Changes in the Morbidity of the Population Insured

Our experience period is based on calendar year 2015. It includes members that enrolled in a QHP with BCBSVT during 2015, are expected to enroll in a QHP with BCBSVT upon the renewal date of their group plan, or canceled. Canceled members can be divided into two categories, voluntary cancelation and cancelation due to death. Voluntary cancelations can be further broken down by aging out, cancellations from normal group turnover, and individual cancellations. Individuals aging out are captured in our demographic adjustment (see section 3.4.5), while we assume that group turnover leads to the hiring of similarly-situated individuals; therefore, we only adjust for the impact of individual cancellations.

We split the experience claims costs based on these categories in order to compare the different populations. We used the allowed charges from the experience and adjusted for the change in network (see section 3.4.6 for details on this adjustment) and the change in the definition of Small Group previously described in section 3.4.1. We adjusted the experience period claims cost to reflect the average claims cost of members who did not voluntarily terminate prior to 2015.

	Voluntary Cancelation in the Individual Market	All Other Members	Total
Experience Period Allowed	$24,969,529	$390,735,060	$415,704,589
Member Months	40,990	775,643	816,633
PMPM	$609.16	$503.76	$509.05

The factor ($1+b_9$ on Exhibit 5) to adjust for the change in pool morbidity is $503.76/$509.05 = 0.9896.

We also adjusted the projected allowed charges ($1+b_3$ on Exhibit 5) for the impact of members previously enrolled in Medicaid joining QHP. We assumed that these members would have claims levels similar to members enrolled in a subsidized QHP in 2015. See Exhibit 2B for details.

3.4.4. 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 (PA) ratio for the benefits in the experience period and the paid to allowed ratio for the benefits in the projection period. We then apply an induced utilization factor to each PA ratio and weight it on membership. The induced utilization (IU) factor is calculated by using the HHS formula where IU = $(PA)^2$— (PA) + 1.24.

Calculation of the Impact of the change in benefits	
Experience Period Average Utilization Factor	1.0918
Projected Period Average Utilization Factor	1.0763
Benefit Adjustment ($1+c_1$ on Exhibit 5) = 1.0763/1.0918	0.9859

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.

For the Pediatric Vision benefit, the experience allowed claims cost was $0.50 PMPM. We do not expect this cost to be different in the projection period. This cost is included in the buildup of the Projected Index Rate (Exhibit 5, line e_6). We assumed that vision benefits would have the same paid to allowed ratio as the base benefit.

For the Pediatric Dental benefit, the experience allowed claims was $1.62 PMPM, which was 8.3 percent higher than the 2014 experience period. In previous filings, Milliman performed the calculation of the expected claims by trending claims experience by 5 percent. We selected a trend assumption that was the midpoint of our experienced trend and this national benchmark. Using a 6.7 percent annual trend, we calculate the overall expected allowed charges at $1.84 PMPM. For benefits inforce in the experience period, we are using the actual paid to allowed ratio to estimate the paid claims. For new benefits or benefits without experience, we are using the relationship between the overall medical and pharmacy paid to allowed ratio and the dental paid to allowed ratio to derive the estimated paid claims. This cost is included in the built up of the Projected Index rate (Exhibit 5, line e_7). See Exhibit 2C for details.

3.4.5. 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 (2014) age-gender factors. We applied these factors to both the experience membership and the projected membership, excluding members previously on Medicaid, and compared the average factors. See details of the experience and projected population on Exhibit 2D.

Calculation of the Demographic Adjustment	
Experience Period Average Age-Sex Factor	1.2206
Projected Period Average Age-Sex Factor	1.2277
Demographic Adjustment ($1+c_3$ on Exhibit 5) = 1.2277 / 1.2209	1.0058

3.4.6. Other Adjustments

The buildup of the Projected Index Rate also includes a factor for the change in provider networks, a factor to reflect new pharmacy contracts, a factor to reflect the impact of selection on allowed costs, a factor to reflect the impact of the expected settlement with VHC, 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 2017 QHPs are offered on our EPO Network. All of the QHP experience used was on the EPO Network but some of the groups with 51-100 employees that are expected to be in a QHP in 2017 had claims that came from one of three different networks: BCBSVT's Non-Managed network (PPO/Indemnity), BCBSVT's Managed network (VHP/EPO) and The Vermont Health Plan's (TVHP) network. All three 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 2017. See details on Exhibit 2E.

BCBSVT entered into a new contract with its pharmacy benefit manager, ESI, on July 1, 2015. In the previous filing, the impact of the change in contract between the experience period and the projected period was embedded in the pharmacy cost trend. For this filing, we have removed the contract adjustment from the trend assumption and included a separate factor in the build-up of the projected index rate. To calculate this factor, we applied the contracted discounts and dispensing fees for each type of drug (Generic, Brand and Specialty) to calendar year 2015 claims for both the experience period and the projected period contract provisions. The contract adjustment factor for each type of drug, calculated by taking the ratio of the projected pharmacy claims under each contract, was applied to the projected pharmacy claims (see Exhibit 3H for details). The adjusted projected pharmacy claims were then added to the projected medical claims to calculate the overall impact of the contract changes, as shown on Exhibit 3I and on line $1+c_5$ of Exhibit 5.

Subscribers will make financial decisions that are right for them. Typically, this manifests itself in healthier subscribers selecting low-cost plans while less healthy subscribers select richer benefits. While we do not reflect selection in the plan-level adjustments, as per the instructions, it can be demonstrated that total premium will be understated without adjusting the index rate to spread the impact of selection across all plans (see Exhibit 2F). This is due to the plan share of allowed costs being greater for richer plan designs, which demonstrably experience antiselection in excess of benefit richness adjustments. The top section of Exhibit 2F

[1] Non-system claims are payments that are not processed through the claims adjudication system.

shows the build-up of paid claims from allowed charges using actual plan-level adjustments described in Section 3.8 of this Memorandum. The bottom section of the same exhibit demonstrates the impact on total paid claims of using benefit richness adjustments that instead reflect actual 2015 QHP experience. The ratio of weighted average projected paid claims calculated via each of these two approaches produces a factor that must be included in the index rate so that application of the various plan-level adjustments results in the correct total paid claims across all plans.

In the fall of 2015, VHC agreed to pay BCBSVT for 2014 claims for which members at had been retroactively cancelled instead of negatively impacting providers through adjustments to the claims. These claims were therefore not adjusted in our core system and are included in the experience for 2014. We project that a similar agreement will take place for 2015. Based on 2014 experience, we project that 0.5 percent of total claims will be reimbursed by VHC. This reduction in experience claims is reflected on Line $1+b_8$ of Exhibit 5.

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 are estimated to be $7.25 PMPM. This number is estimated using our contractual rebate guarantee since we have not yet received the details underlying the rebate payment for part of the 2015 calendar year. Pharmacy rebates are expected to trend at the same rate as Brand Drugs. As shown on Exhibit 3H, the projected trend for Brand drugs is 8.8 percent, which brings projected pharmacy rebates to $7.89 PMPM.

- Blueprint Payments (e_2):
  BCBSVT participates in the Vermont Blueprint for Health[2] program. The Vermont Blueprint for Health Manual, effective January 1, 2016, details the funding for both portions of the program: Community Health Teams (CHT) and Patient Centered Medical Homes (PCMH). The CHT funding is $2.77 per patient per month (PPPM), where patients are members attributed to a PCMH. The PCMH funding was increased to $3.00 PPPM with a maximum of $0.50 of additional incentives for quality and performance on January 1, 2016. Based on Medicaid's projection for their population, we assumed that the average payment for PCMH would be $3.25 PPPM.

  The expected 2017 Blueprint payment (CHT+PCMH) is $6.02 PPPM. Based on membership figures through March 2016, BCBSVT projects that 60.3 percent of the QHP membership will be attributed to a PCMH. The projected Blueprint payment is therefore $3.63 PMPM.

- 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 annual utilization trend is 1.0 percent and therefore these fees are expected to increase at the

[2] http://blueprintforhealth.vermont.gov/

same rate. The experience period fees ($1.80 PMPM) are projected to grow to $1.84 PMPM in 2017.

- 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 assessment is now based on a PMPM charge, which is a change from the previous year when it was based on claims. We applied the 2016 rates of $10.73 per child and $0.58 per adult to the experience period membership. The average PMPM for the experience period, $1.88, 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 ($1.32) was calculated in BCBSVT Large Group Rating Program Filing (BCVT-130453174).

3.4.7. Trend Factors (cost/utilization):

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, 2013 and December 31, 2015, completed through February 29, 2016, were used in the analysis. Completion factors are applied to estimate the ultimate incurred claims for each period shown in the exhibits.

The data includes claims from the single risk pool and groups with 51-100 employees that either joined the single risk pool in 2016 or are expected to purchase QHPs in 2017 (as described in section 3.4.1). The data excludes members in the Individual Market who voluntarily cancelled (as described in section 3.4.3)

Medical Trend Development

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.

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.

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

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 combinations of CPT and CPT modifier 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 about 82 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 2015 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

Claims were normalized to the December 2015 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 2015. The derived trend for other claims was assumed to be continuous. Please see Exhibit 3A for an illustration of this approach.

Shown on Exhibit 3B is the resulting array of allowed PMPM claims costs, before and after normalization for contract changes for the continuing members. We performed regressions on a number of periods. Results vary from -1.0 percent (most recent 36 months through December 2015) to +3.5 percent (most recent 24 months through December 2015). With the difficult start to the Exchange and the option to delay enrollment into a QHP until April 2014, the claims utilization in the last few months of 2013 were much higher than expected and the early months of 2014 were much lower than expected. This is skewing both the 24-month and the 36-month regressions, which is why we have decided to use the 18-month regression as a starting point.

Utilization is influenced by the richness of a product and, as shown on Exhibit 3C, when benefits get richer over time, the utilization will increase. To adjust for this phenomenon, we calculated the average induced utilization factor, based on the actuarial values of the plans in the experience and adjusted each month to reflect the benefits in place in December 2015. Utilization is also influenced by age. We adjusted the result for aging using the Milliman Health Cost Guidelines by calculating the average age-gender factors for each year included in the regression.

Calendar Year	Member Months	Average Age-Gender Factor	Aging Adjustment
2014	741,844	1.2165	
2015	803,735	1.2175	1.001

The utilization trend is 1.7 percent, calculated as follows:

Utilization Trend from Unadjusted Data	2.5%
Adjustment for Benefits (= 1.018/1.025)	0.993
Adjustment for Aging (= 1/1.001)	0.999
Adjusted Utilization Trend (= 1.025 x 0.993 x 0.990)	1.7%

Although we adjusted the regression to account for unexpected seasonal patterns in 2014, we believe that our utilization trend is still skewed upward by these patterns and potential up-take in 2015. We therefore selected 1.0 percent for the projected utilization tend.

Unit Cost

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

During calendar year 2015, about 53 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, 2016 and October 1, 2017 that support identical commercial increases as that approved for October 1, 2015. Based upon that assumption, the provider contracting and actuarial departments worked together to assess the impact such an increase would have on contract negotiations specific to the EPO network used for Qualified Health Plans. In addition to those increases, we made an adjustment to reflect the lower charges from Rutland Regional Medical Center starting on May 1, 2016[4].

Similarly, we assumed for other providers within the BCBSVT service area that overall 2016 and 2017 budget increases would be identical to those implemented during calendar 2015. Again, the provider contracting and actuarial departments 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 2015 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

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

[4] http://gmcboard.vermont.gov/sites/gmcboard/files/Meetings/Rutland_3_31_16_FY15_MidYearCheckIn.pdf

Annual Reimbursement Changes due to Budget Increases and Contracting Season

	Percent of Total Allowed Claims	FY 2016 Unit Cost Increases	Assumption to 2017	Total Annual Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	53.0%	4.2%	2.9%	3.5%
Other facilities and providers	47.0%	3.0%	3.2%	3.1%
Total	100.0%	3.6%	3.1%	3.3%

Overall Medical Trend
Our selected trend assumptions are 1.0 percent for utilization (including intensity) and 3.3 percent for unit cost increases, resulting in an overall medical trend assumption of 4.3 percent.

Pharmacy Trend Development

ESI has been the pharmacy benefits manager for BCBSVT since July 2009. The initial ESI contract was for a period of 3 years; a new contract became effective July 2012 and July 2015. As mentioned in section 3.4.6, in previous filings, we included the impact of contracting changes in the cost trend assumption. In this filing, we removed the contract adjustment from the cost trend calculation and added a factor to the overall trend calculation to account for the contracting changes. Accordingly, we based our cost trend calculation on Average Wholesale Price (AWP), which does not reflect contracted discounts, instead of contract-adjusted allowed charges as in previous filings.

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.

Non-Specialty Drugs
Exhibit 3D 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. We selected the regressions for the period ending December 2015 for both Generic and Brand cost trend. For the utilization trend, we selected the 18 months regression for the period ending December 2015. As previously described for the medical utilization, with the difficult start to the Exchange and the option to delay enrollment into a QHP until April 2014, the claims utilization in the last few months of 2013 were much higher than expected and the early months of 2014 were much lower than expected. This is skewing the 24 months regression, which is why we have decided to use the 18 months regression as a starting point.

As described above, utilization trends should be adjusted for changes in benefits and aging. To calculate the impact of the change in benefit, we compared the utilization regression with and without the benefit adjustment for the period ending December 2015, as shown on Exhibit 3E. We then adjusted the utilization trend for aging.

The utilization trend is 1.4 percent, calculated as follows:

Utilization Trend from Unadjusted Data	3.5%
Adjustment for Benefits (= 1.015/1.035)	0.981
Adjustment for Aging (= 1/1.001)	0.999
Adjusted Utilization Trend (= 1.035 x 0.981 x 0.999)	1.4%

Although we adjusted the regression to account for unexpected seasonal patterns in 2014, we believe that our utilization trend is still skewed upward by these patterns and potential up-take in 2015. We therefore selected 0.5 percent for the projected utilization tend.

Based on our current distribution of days supply, for all members, 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 88.9 percent in the projected period, as shown on Exhibit 3F. It is important to note that care must be taken in projecting the GDR to avoid the simplistic 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.

Utilization for brand drugs losing or expected to lose their patent protection from calendar year 2015 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”), monthly utilization for the year ending December 2015 is projected through six months following each generic launch date (i.e. we assume the same days of supply in December 2016 as we had in December 2015, and so on). After that time, all utilization is expected to shift to generic. We

assume drugs with no generic exclusivity period will switch to generic immediately after the patent expires.

Specialty Drugs

The introduction of new specialty drugs for the treatment of hepatitis C in January 2014 required an adjustment to the trend calculation for specialty drugs. The high cost of the drugs skews the specialty trend, making it higher than we believe is warranted. Other high-cost or high-utilization drugs have also entered the market recently, such as Orkambi, a treatment for cystic fibrosis with an annual cost of almost $250,000, and PCSK9 inhibitors like Repatha, used to treat high cholesterol in patients with the genetic disease familial hypercholesterolemia (FH). To accurately capture the effect of these new drugs on specialty trend, we removed their claims from the experience to calculate a trend rate to apply to these non-excluded claims. We trended those claims forward at the calculated rate for 27 months, then added back in our projections of claims for the new treatments (hepatitis C drugs, Orkambi, and PCSK9 inhibitors). We used the total restated projected claims to calculate a restated specialty trend.

Exhibit 3G, Page 1 shows the calculation of specialty trend both for all specialty drugs and for specialty drugs excluding the new treatments described above. For our regressions, we chose 24 points of 12-month rolling data to 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. The total specialty trend is 25.0 percent. Removing the large cost increases associated with the new treatments results in a 13.3 percent trend for the remaining specialty drugs.

For the same reasons stated above, we then adjust the results for aging. Using the Milliman Health Guideline factors, we calculated the average age-gender factors for the continuing population.

Calendar Year	Member Months	Average Age-Gender Factor	Aging Adjustment
2013	770,784	1.2019	
2014	741,464	1.2164	
2015	803,735	1.2175	$= (1.2175/1.2019)^{0.5}$

To project the expected cost of hepatitis C treatment in the rating period, we began by looking at actual hepatitis C claimants in 2014 and 2015. Based on the actual claimants and estimates provided by ESI, we project 40 hepatitis C claimants in 2017

There are several different drugs available for the treatment of hepatitis C (Sovaldi, Viekira Pak, Harvoni, and Olysio are in our experience), but the only drug that will be on ESI's formulary in 2017 is Viekira. Viekira is available in 3- and 6-month treatments. In our experience, roughly 2/3s of claimants receive the 3-month treatment and 1/3 receive the 6-month treatment, so the average claimant receives four months of the drug.

In our previous filing, we had estimated the cost of four months of Viekira at $72,000. This price was based on an expected discount due to the exclusivity arrangement between ESI and the manufacturer of Viekira. Viekira claims are now part of our experience with a monthly cost of

almost $30,000. There is no discount reflected in the claim, however we do receive large rebates from ESI for Viekira claims. As drug rebates are credited to groups in a separate part of the renewal formula, we used the claim cost of $30,000 per month in the trend development. At this cost, 40 claimants with an average treatment of four months have a projected 2017 cost of $4.6 million.

PCSK9 inhibitors such as Repatha are used to treat high cholesterol. BCBSVT's current policy is to approve PCSK9 inhibitors for the treatment of familial hypercholesterolemia (FH), a genetic disease characterized by very high levels of cholesterols in the blood. Current incidence studies suggest that 200 persons per 100,000 lives are diagnosed with FH. Another indication for these drugs is for patients who have had a heart attack and then failed two different high-dose statins for 60 days. Based on current membership, we project 152 members will use a PCSK9 inhibitor in 2017. With an annual cost of about $13,750, the projected total is $2.1 million.

Orkambi is a drug used in the treatment of cystic fibrosis. In particular, it is used to treat a specific mutation of the disease that is found in roughly 50 percent of cystic fibrosis patients. Orkambi is prescribed to patients age 12 and older. We assumed that 50 percent of our members diagnosed with cystic fibrosis who are at least age 12 will take Orkambi. Orkambi has an annual cost of $247,000 and we project 8 members will use it. The projected cost for those members is $2.0 million.

One final adjustment to the projected specialty claims deals with a class of drugs called biosimilars. Biosimilars are functionally equivalent to biologic drugs, which are produced in a lab using recombinant DNA technology. Biosimilars have a lower cost than their equivalent biologic drugs. Humira, a biologic, was our highest cost drug in 2014. The FDA has recently approved a biosimilar for Humira that will be available sometime in the fall of 2016. For the 2017 projection period, we anticipate the cost of the biosimilar will be 10 percent less than the cost of Humira, which current cost $4,200 per month. We will not be requiring existing Humira patient to switch to biosimilars but intend to direct new patients to the biosimilars. Based on recent data, the number of patients on this drugs has been fairly stable, which on average three patients no longer needing the drugs each month and three new patients each months. In December 2015, we had 81 members who filed a script for Humira. Assuming that we will start to direct new patients to biosimilars in September 2017, we expect 378 of the 972 projected Humira scripts to instead be biosimilar, which will result in a $158,200 reduction in claims.

To calculate the effective trend, we started with the pharmacy claims from the calendar year 2015 removed the claims for hepatitis C drugs, PCSK9 inhibitors, and Orkambi. We then trended the remaining claims at a 12.6 percent rate for 24 months and added the incremental cost of hepatitis C treatments, PCSK9 inhibitors, and Orkambi for a total restated projected claims. Using this method, the restated effective specialty drug trend is 17.7 percent. See Exhibit 3G, Page 2 for details.

Overall Pharmacy Trend

For this filing, we have removed the contract adjustment factor from the cost trend assumption and included it as a separate factor in the index rate calculation (see section 3.4.6).

Exhibit 3H summarizes the trends calculates our total allowed pharmacy trend as 10.2 percent.

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 impact of the change in the Small Group definition, 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 3I.

3.5. Credibility of Experience

BCBSVT's experience period had 766,083 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.

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 $559.11. This is calculated by adjusting the Projected Index Rate (line F of Exhibit 5, $560.66) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustments PMPM:

BCBSVT received a risk adjustment transfer for the combined market and paid out a risk adjustment transfer for the catastrophic market for the 2014 calendar year[5]. On March 18, 2016, CMS published an Interim Summary Report on Risk Adjustment for the 2015 benefit year[6]. Since Vermont was deemed Eligible for the interim report, we received preliminary information on the state averages and BCBSVT detailed information. Using those two sources of data, BCBSVT estimated the 2015 transfer payment. From the interim information, we noticed that our plan average liability risk score (PLRS) was lower than in 2014 in relationship to the average for the combined market. This is due to the PLRS for the other carrier in the market increasing at a more rapid rate than BCBSVT's PLRS. To project the 2017 transfer payments, we assumed that BCBSVT would continue experience lower PLRS due to the assumption that the other carrier is engaging in coding growth initiative. The projected overall risk adjustment receivable for 2017 is $1,268,182, or $1.36 PMPM.

Since the Market Adjusted Index Rate is on an allowed claims basis, we adjusted the net projected risk adjustment payment by the average paid to allowed ratio (from Exhibit 6C).

[5] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf
[6] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2015_5CR_031816.pdf

As described in the Final Notice of Benefits and Payment Parameters for 2017 rule (81 F.R. 12204), the per capita risk adjustment user fee, used to fund the HHS-risk adjustment program, is $1.56 per enrollee per year.

The overall market-wide adjustment (line g_1 of Exhibit 5) for the risk adjustment program is ($1.55) as shown on Exhibit 4.

3.7.2. Exchange User Fees

BCBSVT does not expect Vermont Health Connect to charge a user fee for 2017.

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 two factors:

- Benefit Richness Adjustment
- Paid to Allowed Ratio

The experience used to calculate the benefit richness adjustment and the paid to allowed ratio is our calendar year 2015 data, adjusted by the network, changes in Small Group definitions and trend factors ($1+c_2$, $1+b_1$, $1+c_2$, $1+d_1$, $1+d_2$ of Exhibit 5). To better model family benefits, we only included members who maintained their tier type (Single versus Family) throughout the year. This adjusted experience was then used to model each plan. The model re-adjudicates claims by starting with the allowed charges and applying appropriate cost sharing for each service. The model generates the projected average paid claims for each benefit, which is used to calculate a paid to allowed ratio.

3.8.1.1. 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. To calculate this adjustment, we first calculated a base paid to allowed ratio, to which the HHS formula for induced utilization was applied.

For this factor, we summarized the data described above by subscriber and re-adjudicated the claims for each plan to calculate a subscriber level paid to allowed ratio. We then applied the HHS Induced Utilization formula ($IU=AV^2-AV+1.24$) to the base paid to allowed ratio.

These factors were normalized using the projected membership to ensure that the total adjustment was 1.000. The plan level adjustment for benefit richness calculated by applying the benefit richness adjustment to vary by base benefit and 1.000 for non-system claims, pediatric dental claims, pediatric vision claims and market-wide adjustment. See Exhibit 6B for details.

3.8.1.2. Paid to Allowed Ratio

To calculate the paid to allowed ratio, we adjusted the starting allowed charges described in the previous section by the benefit richness adjustment and re-adjudicated the benefits. The paid to allowed ratio in previous filing represented a single member benefit applied to all members and was then adjusted by a family tiering factor to reflect the impact of family deductibles and out-of-pocket. In this filing, the paid to allowed ratio includes both components. We then added the additional EHB paid and allowed, and the non-system claims and market-wide adjustment amounts in both paid and allowed. Finally, we calculated the overall expected paid to allowed ratio. Please see details in Exhibit 6C.

Late in the day on May 9, 2016, we received an updated benefit design for the Standard Bronze CDHP plan. We estimate that this change would increase the paid-to-allowed ratio by 0.07 percent. Because of the timing of the announcement, we were not able to make changes with adequate peer review prior to filing (note that we have updated Exhibit 1A to reflect the final plan design). We consider this change to be de minimis, and therefore believe that the rates in this filing are adequate.

In the URRT, the Paid to Allowed Average Factor is the weighted average expected claims cost, including non-EHB benefit and excluding market-wide adjustments ($446.42) divided by projected allowed charges ($560.76). As shown in Section 3 of Worksheet 1 of the URRT, the paid to allowed average factor is 79.6 percent.

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

3.8.3. Adjustment for benefits in addition to the EHBs:

BCBSVT is removing an exclusion for routine circumcision. Based on recent information from the American Academy of Pediatrics, there is new evidence that "the health benefits of newborn male circumcision outweigh the risks but the benefits are not great enough to recommend universal newborn circumcision."[7] On the basis of this evidence, our Medical Directors have recommended that we add coverage for this procedure. Based on historical data from groups that had already removed the exclusion, we estimate the additional cost to be $0.10 PMPM of allowed charges. Applying the same paid to allowed ratio to this benefit as to the EHB benefit, we calculate an adjustment of 1.0002, as shown on Exhibit 6A.

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. We used our current enrollment in the Catastrophic plan as a proxy for eligibility and adjusted the projected members that would qualify under the hardship rule to account for the increase

[7] https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/newborn-male-circumcision.aspx

premiums. We project that 94.4 percent of the population eligible for this product will be under age 30.

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 0.5717 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 0.8798.

These factors were applied to the EHB portion of the Projected Period Index Rate. Because this adjustment doesn't impact the Non-System claims and Market Wide Adjustment, we calculated the Expected Claims cost and backed into the plan level adjustment for the impact of eligibility.

The total adjustment for the specific eligibility categories for the catastrophic plan is 0.5042. See Exhibit 6D 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 calendar year 2015 data from both individual and small group members enrolled in a QHP. During 2015, BCBSVT completed an extensive cost accounting study. The base administrative expenses reflect this new allocation and is reflecting the operating cost relating to membership in this filing. The starting PMPM for the base administrative charges is $32.93 PMPM.

  The QHP population is comprised of Individuals who have to enroll through the Vermont Health Connect (VHC) website and Small Groups who can enroll directly with BCBSVT. The experience period base administrative for Individual was $37.97 PMPM compared to $28.99 PMPM for members in Small Groups.

  Starting in 2016, individuals who are not receiving subsidies can enroll directly with BCBSVT, either by phone, by mail or online. We project that for 2017, 7,500 members will elect to enroll directly with BCBSVT.

  Since the projected mix between directly enrolled members and VHC enrolled members differs from that in the experience period, we have reduced the base administrative charges by 2.2 percent to reflect the different membership mix.

	Enrolled through VHC	Directly Enrolled with BCBSVT	Total
Experience Member Months	336,288	429,765	766,083
Experience PMPM	$37.97	$28.99	$32.93
Projected Period Membership	49,830	27,708	77,538
Projected PMPM			$32.20
Impact			= $32.20/$32.93 = 0.9778

We have removed one-time expenses related to the resource augmentation of certain enrollment functions during calendar 2015, as we do not expect these expenses to recur in future years. This reduced base period expenses by $0.33 PMPM.

The remaining charges ($31.87 PMPM) are projected to 2017 using a 2.4 percent annual trend. This projection factor is intended to make reasonable but modest provision for increases in overall operating costs PMPM. We assume that personnel costs (wages and benefits) will increase by 3 percent annually, the budgeted wage increase for 2016, over the projection period. Other operating costs are assumed to remain flat. We have calculated that 78.4 percent of our administrative costs are for salaries and benefits. We are therefore increasing our projected administrative expenses by the weighted average of 2.4 percent per annum.

		BCBSVT Totals	Percent of Total
Employee costs:	$A = a_1 + a_2$	$41,155,334	56.1%
Salaries and taxes	a_1	$30,898,129	
Benefits	a_2	$10,257,205	
Purchased services	B	$20,832,680	28.4%
Other operating costs	C	$11,363,516	15.5%
Total Administrative Expenses	A + B + C	$73,351,530	100.0%
BCBSVT Personnel Cost	A /(A + C)		78.4%

An examination of historical administrative charges will show a decreasing trend in recent years, driven primarily by membership increases and non-recurring incremental cost and savings initiatives.

2017, we project an increase in total membership, mostly due to the new enrollment from Vermonters previously covered by Medicaid. We calculated enterprise-wide PMPM administrative charges with both experience period enrollment and projected 2017 enrollment, and found that charges decreased by 1.7 percent with the increase in projected enrollment. We assumed that variable costs represent half of the increase, and therefore applied a decrease of 0.8 percent to the base PMPM charges to account for the increase in membership.

Summary of Base Administrative Charges Calculation

Experience Base Administrative Charges	A	$32.93
Adjustment for Membership Mix	B	0.9778
Adjusted Administrative Charges	C = A x B	$32.20
Exclusion of non-recurring expenses	D	($0.33)
Adjustment for Projected Membership Increase	E	0.9915
Trend Projection (2 years)	F	1.0476
Projected Base Administrative Charges	G = (C-D) x E x F	$33.10

- Charges for Outside Vendors
  - 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 QHP population split between adult and child, was applied to get the per member per month charge.
  - Health Equity
    All QHP 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 2016.
  - Blue Rewards 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

    Based on participation projection from the Marketing and Product department, we estimate that the cost of this program to be $2.32 PMPM for Blue Rewards plans only.

The total of these charges adds up to 6.9 percent of premium. The details of the administrative charges are on Exhibit 7A.

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

- Contribution to Reserves

The filed rates include a two percent contribution to reserves (CTR). A contribution to reserves is required in order to maintain an adequate level of surplus. Surplus is a critical consumer protection that allows subscribers to receive needed care and providers to continue to receive payments in the event of unforeseen adverse events that may otherwise impact BCBSVT's ability to pay claims. We believe that a long-term CTR of two percent represents an adequate, yet not excessive, contribution to reserves. CTR at this level allow us to manage short-term fluctuations in order to maintain Risk-Based Capital (RBC) levels that are within our established, modest target range.

As demonstrated in section 1 of Exhibit 7B, a contribution to reserves of 3.8 percent would be required to maintain RBC levels in light of increases in total claims costs in QHP products during 2017. While increases due to per member per month claims costs alone would require a lower CTR (approximately 1.7 percent for this filing), anticipated membership increases resulting from the State's Medicaid eligibility reverification yield a substantially higher total premium estimate, and therefore a higher CTR requirement.

BCBSVT believes that CTR should be managed to an adequate long-term level, rather than fluctuating significantly from year to year with changes in membership and health care cost trend. For this reason, we have continued to file a CTR of 2.0 percent for 2017. It is our expectation that our future filings will also include a 2.0 percent contribution to reserves. While this amount may exceed or fall below that required to maintain RBC in any given future year, maintaining an adequate long-term assumption will allow us to avoid rate shocks in years of expected high growth in membership, such as 2017.

Furthermore, an adequate long-term contribution to reserves should exceed the minimum required to keep pace with increases in total claims costs. While best estimate assumptions are by definition expected to lead to equal likelihood of gains and losses, unexpected events or periods of sustained losses may lead to financial deterioration of sufficient magnitude to render a company insolvent. This is the basic tenet of classical ruin theory.

There are many examples of risk to surplus. The rating cycle is 24 months in duration, meaning that rate deficiencies may persist for an extended period in an increasing trend environment. Regulatory action can have a meaningful impact on surplus when required rate increases are not approved. Membership growth creates a need for additional RBC, much in the same way as trend. Finally, unusual events such as a flu epidemic or new technology may create a one-time shock to capital. A relevant example of the latter is the ongoing development of very expensive but clinically effective specialty pharmaceuticals. Should such a medication become widely prescribed, the cost could immediately bring us below our target RBC range. While we choose not to recognize the non-zero probability of such events directly in our pricing, it is necessary to include a sufficient margin for contingent events in CTR such that RBC can be maintained within the target range established in conjunction with state regulators.

Maintaining an adequate RBC level is critical for any insurer. Consequences of low RBC include reduced flexibility in responding to customer needs, a need for higher margins in rates in order to avoid further deterioration, and a reduced ability to attract or retain business or to handle

membership growth. Stability is particularly important in times of unprecedented change, such as the continuing evolution of Vermont Health Connect and the health care reform environment.

BCBSVT must remain financially strong in order to continue to provide Vermonters with outstanding member experiences, responsible cost management and access to high value care. We are therefore filing for a 2.0 percent contribution to reserve, which represents the long-term level necessary to maintain Risk-Based Capital (RBC) levels that are within our established, modest target range in the face of short-term membership and/or health care cost trend fluctuations.

- Other Risk Margin:

Under the ACA, enrollees who are receiving APTC have a three month grace period to pay premiums, and enrollees who are not receiving APTC have a one month grace period. For both these populations, the State requires the insurer to pay for claims incurred in the first month of the grace period even if premium is never collected. This uncollected premium is considered bad debt. To ensure that BCBSVT collects enough premium on the total pool to cover the 30-day grace periods, we need to include a risk margin for bad debt of 0.25 percent.

Details of Contribution to Reserve and Risk Margin for Bad Debt by product are on section 2 of Exhibit 7B.

3.8.5.3. Taxes and Fees:

The proposed rates include on average 0.9 percent in Taxes and Fees. These taxes and fees are both from the State Government and the Federal Government.

The Health Care Claims Tax (HCCT) levied by the State of Vermont totals 0.999 percent of claims.

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 $2.35 per member per year, or $0.20 per member per month.

The Federal Insurer Fee is intended to help pay for some provisions in the Affordable Care Act. The Consolidated Appropriation Act of 2016 temporarily suspended this fee for 2017 only.

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

3.8.6. AV Pricing Values

As described in the 2017 Unified Rate Review Instructions, 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 by product.

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

Per CMS instructions dated January 30, 2015, the MLR calculation will be performed 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 90.9 percent. 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 tier factors. 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 1.1107.

Rate Structure	Single	Couple	Adult + child(ren)	Family	Average
Vermont Tier Factors	1.000	2.000	1.930	2.810	1.4733
Tier weights	63.3%	19.7%	3.6%	13.4%	100.0%

Average Members per Subscriber	1.6364
Contract Conversion Factor	= 1.6364/1.4733 = 1.1107

The Consumer Adjusted Premium Rates are shown on Exhibit 9.

3.10. Small Group Plan Premium Rates

All Small Groups must renew on 1/1/2017 according to the combined market rules. BCBSVT will not file small group rates for Q2-Q4 2017.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

BCBSVT will not be terminating any product prior to 01/01/2017.

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

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)

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the Qualified Health Plans that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to offer in 2017. 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 2017, 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.

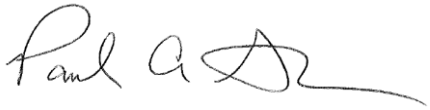
In my opinion, the projected Index Rate is in compliance with all applicable State and Federal Statutes and Regulations (including 45 CFR 156.80 and 147.102), has been developed in compliance with the applicable Actuarial Standards of Practice, is reasonable in relation to the benefits provided and the population anticipated to be covered, and is 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.

Data used in this filing were reviewed for reasonableness, but no audit was performed.

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 A. Schultz, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont
May 11, 2016

BLUE CROSS BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS 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 Qualified Health Plans (QHPs) that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to offer effective January 1, 2017.

There are 42,527contracts (70,423 members) currently enrolled in a BCBSVT QHP.

BCBSVT is proposing an average rate increase of 8.2 percent across all QHPs. Increases for specific QHPs range from 5.2 percent to 10.9 percent.

The starting point of any renewal rate analysis is an assessment of actual to expected claims cost experience results. The basis for this rate filing is calendar year 2015 experience. That experience was much higher than expected in the 2016 rate filing, driving a 6.3 percent increase in 2017 rates.

In the absence of mandated changes associated with the Affordable Care Act, a 9.1 percent increase would have been requested. In addition to the experience impact, various assumptions drive the balance of the increase:

- Amounts that providers are paid are expected to increase for the balance of 2016 and into 2017, generating a premium impact of 3.7 percent.

- The new pharmacy contract BCBSVT has negotiated with its Pharmacy Benefit Manager reduces the premium by 0.9 percent.

- An increase in administrative costs per member per month, driven largely by ongoing challenges coordinating with Vermont Health Connect, increased premium by 0.9 percent. BCBSVT administrative expenditures for members included in this filing remain below seven percent of premium.

- A contribution to reserves (CTR) is required in order to maintain an adequate level of surplus. BCBSVT believes that CTR should be based on an adequate long-term required level rather than fluctuating significantly from year to year with changes in total premiums. For this reason, we have continued to file a CTR of 2.0 percent for 2017, which

is significantly lower than the amount required to maintain our current capital position relative to total QHP premium. Nonetheless, as this is greater than the CTR approved by the Green Mountain Care Board for 2016 QHP rates, this has the effect of increasing premiums by 1.0 percent.

- Other adjustments to the assumptions used in the 2017 rate development, including an assumption that that members who will enroll in our qualified health plans in 2017 will prove to be significantly healthier on average than those insured during calendar 2015, cumulatively have the effect of reducing the required rate increase by 1.9 percent.

Mandated changes associated with the Affordable Care Act combined for a net decrease to premium of 0.8 percent:

- The federal government assesses a charge on all health plans to subsidize QHP coverage for the three year-period between 2014 and 2016, through its Transitional Reinsurance Program. The subsidy will be eliminated in 2017, requiring groups and members to pay 2.3 percent more for their coverage. This is more than offset by a temporary suspension of the Federal Insurer Fee for 2017, resulting in a combined premium reduction of 0.4 percent.

- Some deductibles, out-of-pocket maximums and co-pays in QHPs remain unchanged from 2016 to 2017. As overall costs increase and the amounts that members pay in cost-sharing contributions stay the same, more of the total cost is transferred to premiums. This impact of 1.6 percent on premium was offset by a 2.0 percent decrease due to plan changes implemented by BCBSVT and the State of Vermont, for a net premium decrease of 0.4 percent.

BCBSVT started selling QHPs in January 2014. In its first two years, this line of business represented $580 million of earned premium. Due to higher-than-expected actual claims and administrative charges, the line of business has incurred a cumulative loss of 0.6 percent. BCBSVT has not included any additional contribution to member reserves to offset this loss.

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 driven by the cost and utilization of health care 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

Ruth Greene

Ruth Greene
Vice President, Treasurer & Chief Financial Officer

5-11-16

Date

Unified Rate Review v3.3

Company Legal Name: **Blue Cross and Blue Shield of V** State: **VT**
HIOS Issuer ID: **13627** Market: **Combined**
Effective Date of Rate Change(s): **1/1/2017**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2015 to 12/31/2015

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$332,392,760	$433.89	100.00%
Incurred Claims in Experience Period	$292,325,366	381.58	87.95%
Allowed Claims:	$384,634,210	502.08	115.72%
Index Rate of Experience Period		$502.00	
Experience Period Member Months	766,083		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2017 to 12/31/2017 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	51.42	$20,428.97	$87.54	0.995	1.003	1.033	1.010	52.20	$21,874.23	$95.15	0.00	$0.00	$0.00
Outpatient Hospital	Services	2,342.67	995.99	194.44	0.995	1.004	1.033	1.010	2,378.21	1,066.64	211.39	0.00	0.00	0.00
Professional	Visits	7,756.87	173.82	112.36	0.995	1.001	1.033	1.010	7,874.55	185.65	121.83	0.00	0.00	0.00
Other Medical	Visits	1,454.54	175.42	21.26	0.995	0.920	1.033	1.010	1,476.61	172.23	21.19	0.00	0.00	0.00
Capitation	Benefit Period	16,131.00	4.67	6.28	0.995	0.715	1.033	1.010	16,375.72	3.56	4.86	0.00	0.00	0.00
Prescription Drug	Prescriptions	14,046.28	68.52	80.20	0.995	1.097	1.097	1.005	14,118.54	90.38	106.34	0.00	0.00	0.00
Total				$502.08							$560.76			$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%	$560.76	$521,764,754
Paid to Allowed Average Factor in Projection Period			0.796	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$446.37	$415,324,744
Projected Risk Adjustments PMPM			1.23	1,144,461
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$445.14	$414,180,284
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$445.14	$414,180,284
Administrative Expense Load		6.91%	34.22	31,841,570
Profit & Risk Load		2.25%	11.14	10,365,165
Taxes & Fees		0.93%	4.61	4,286,992
Single Risk Pool Gross Premium Avg. Rate, PMPM			$495.11	$460,674,011
Index Rate for Projection Period			$560.66	
% increase over Experience Period			14.11%	
% Increase, annualized:			6.82%	
Projected Member Months				930,456

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):	**1/1/2017**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	BCBSVT EPO (Small Group)				BCBSVT EPO CDHP (Small Group)		BCBSVT EPO (Individual)					BCBSVT EPO CDHP (Individual)	
Product ID:	13627VT032				13627VT033		13627VT034					13627VT035	
Metal:	Platinum	Gold	Silver	Bronze	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze
AV Metal Value	0.891	0.820	0.715	0.613	0.700	0.609	0.620	0.891	0.820	0.715	0.613	0.700	0.609
AV Pricing Value	1.115	0.980	0.846	0.716	0.838	0.719	0.389	1.115	0.980	0.846	0.716	0.838	0.719
Plan Category	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing	Renewing
Plan Type:	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	BCBSVT Platinum Plan	BCBSVT Gold Plan	BCBSVT Silver Plan	BCBSVT Bronze Plan	BCBSVT Silver CDHP Plan	BCBSVT Bronze CDHP Plan	BCBSVT Blue Rewards Catastrophic Plan	BCBSVT Platinum Plan	BCBSVT Gold Plan	BCBSVT Silver Plan	BCBSVT Bronze Plan	BCBSVT Silver CDHP Plan	BCBSVT Bronze CDHP Plan
Plan ID (Standard Component ID):	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002
Exchange Plan?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	0.00%				0.00%		0.00%					0.00%	
Historical Rate Increase - Calendar Year - 1	8.37%				5.77%		8.91%					5.75%	
Historical Rate Increase - Calendar Year 0	4.91%				6.96%		4.52%					7.08%	
Effective Date of Proposed Rates	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017
Rate Change % (over prior filing)	5.49%	6.12%	8.42%	8.61%	10.92%	9.76%	5.22%	5.49%	6.12%	8.42%	8.61%	10.92%	9.76%
Cum'tive Rate Change % (over 12 mos prior)	5.49%	6.12%	8.42%	8.61%	10.92%	9.76%	5.22%	5.49%	6.12%	8.42%	8.61%	10.92%	9.76%
Proj'd Per Rate Change % (over Exper. Period)	12.37%	13.71%	14.22%	13.69%	20.73%	17.74%	7.08%	12.37%	13.71%	14.22%	13.69%	20.73%	17.74%
Product Rate Increase %	6.50%				10.62%		7.45%					10.71%	

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

Plan ID (Standard Component ID):	Total	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002
Inpatient	$4.64	$4.30	$3.93	$4.53	$3.51	$6.04	$4.19	-$0.80	$4.30	$3.93	$4.53	$3.51	$6.04	$4.19
Outpatient	$10.31	$9.56	$8.73	$10.07	$7.80	$13.42	$9.32	-$1.78	$9.56	$8.73	$10.07	$7.80	$13.42	$9.32
Professional	$5.94	$5.51	$5.03	$5.80	$4.49	$7.74	$5.37	-$1.02	$5.51	$5.03	$5.80	$4.49	$7.74	$5.37
Prescription Drug	$5.19	$4.81	$4.39	$5.07	$3.92	$6.75	$4.69	-$0.89	$4.81	$4.39	$5.07	$3.92	$6.75	$4.69
Other	$1.03	$0.96	$0.88	$1.01	$0.78	$1.35	$0.93	-$0.18	$0.96	$0.88	$1.01	$0.78	$1.35	$0.93
Capitation	$0.24	$0.22	$0.20	$0.23	$0.18	$0.31	$0.21	-$0.04	$0.22	$0.20	$0.23	$0.18	$0.31	$0.21
Administration	$4.16	$3.77	$3.77	$3.78	$3.80	$3.74	$3.63	$6.10	$3.77	$3.77	$3.78	$3.80	$3.74	$3.63
Taxes & Fees	$0.90	-$2.44	-$0.49	$1.65	$3.37	$2.11	$3.47	$7.38	-$2.44	-$0.49	$1.65	$3.37	$2.11	$3.47
Risk & Profit Charge	$6.67	$8.14	$7.18	$6.30	$5.33	$6.33	$5.40	$2.83	$8.14	$7.18	$6.30	$5.33	$6.33	$5.40
Total Rate Increase	$39.08	$34.84	$33.63	$38.44	$33.19	$47.79	$37.21	$11.60	$34.84	$33.63	$38.44	$33.19	$47.79	$37.21
Member Cost Share Increase	-$5.12	-$2.81	$1.08	$5.69	$2.79	$0.10	$3.80	-$13.27	-$0.95	-$4.17	-$8.00	-$6.46	-$20.93	-$11.18
Average Current Rate PMPM	$435.58	$588.85	$514.17	$434.48	$366.93	$420.49	$364.84	$205.73	$588.85	$514.17	$434.48	$366.93	$420.49	$364.84
Projected Member Months	930,456	113,256	58,632	76,596	20,448	58,860	23,424	2,028	42,684	28,956	153,180	14,940	60,780	14,976

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002
OK	$ 433.89	Premium Information	Plan Adjusted Index Rate	$433.49	$555.04	$481.74	$414.04	$351.94	$387.88	$341.48	$202.96	$555.04	$481.74	$414.04	$351.94	$387.88	$341.48
OK	766,083		Member Months	766,083	117,166	59,842	72,227	17,713	70,050	37,449	1,075	44,826	31,006	104,993	15,058	46,722	16,928
OK	$332,392,760		Total Premium (TP)	$332,093,116	$65,031,533	$28,828,404	$29,904,665	$6,233,905	$27,170,900	$12,788,050	$218,180	$24,880,115	$14,936,892	$43,471,008	$5,299,505	$18,122,467	$5,780,558
			EHB Percent of TP, [see instructions]	99.99%	100.00%	99.99%	99.99%	99.99%	99.99%	100.00%	99.60%	100.00%	99.99%	99.99%	99.97%	99.99%	99.98%
			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%
			Other benefits portion of TP	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.40%	0.00%	0.01%	0.01%	0.03%	0.01%	0.02%
OK	$384,634,210	Claims Information	Total Allowed Claims (TAC)	$384,634,210	$74,972,154	$28,631,032	$27,805,247	$6,406,120	$27,103,183	$12,012,034	$128,105	$51,675,716	$18,827,698	$57,229,287	$3,587,074	$24,725,588	$5,317,886
			EHB Percent of TAC, [see instructions]	99.99%	100.00%	99.99%	99.99%	99.99%	99.99%	100.00%	99.60%	100.00%	99.99%	99.99%	99.97%	99.99%	99.98%
			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%
			Other benefits portion of TAC	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.40%	0.00%	0.01%	0.01%	0.03%	0.01%	0.02%
			Allowed Claims which are not the issuer's obligation:	$92,308,844	$5,967,309	$4,589,230	$6,997,224	$2,063,373	$7,328,302	$4,330,733	$75,201	$10,055,919	$4,520,216	$18,509,533	$1,717,483	$8,396,927	$2,227,587
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$7,086,197	$0	$0	$2,213	$4,091,413	$0	$0	$0	$0	$0	$0	$0	$1,485,587	$0
			Portion of above payable by HHS on behalf of insured person, as %	7.68%	0.00%	0.00%	0.03%	198.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.69%	0.00%
OK	$292,325,366		Total Incurred claims, payable with issuer funds	$292,325,366	$69,004,845	$24,041,802	$20,808,023	$4,342,747	$19,774,881	$7,681,301	$52,903	$41,619,797	$14,307,482	$38,719,755	$1,869,592	$16,328,660	$3,090,299
			Net Amt of Rein	$16,110,085.16	-$429,999.22	-$219,620.14	-$265,073.09	-$65,006.71	-$257,083.50	-$137,437.83	-$3,945.25	$6,798,975.09	$1,380,285.74	$4,596,845.48	$151,304.71	$2,492,800.14	$392,834.87
			Net Amt of Risk Adj	$2,518,584.35	$5,681,394.08	-$1,209,334.27	-$4,113,275.75	-$903,459.89	-$4,089,895.10	-$2,577,031.36	-$20,860.47	$17,233,987.04	$2,035,115.47	$2,601,465.37	-$1,706,137.38	-$21,162.78	-$1,108,669.92
OK	$ 381.58		Incurred Claims PMPM	$381.58	$588.95	$401.75	$288.09	$245.17	$282.30	$205.11	$49.21	$928.47	$461.44	$368.78	$124.16	$349.49	$182.56
OK	$ 502.08		Allowed Claims PMPM	$502.08	$639.88	$478.44	$384.97	$361.66	$386.91	$320.76	$119.17	$1,152.81	$607.23	$545.08	$238.22	$529.21	$314.15
			EHB portion of Allowed Claims, PMPM	$502.04	$639.86	$478.40	$384.93	$361.63	$386.87	$320.76	$118.68	$1,152.77	$607.18	$545.04	$238.14	$529.17	$314.08

			Product		BCBSVT EPO (Small Group)				BCBSVT EPO CDHP (Small Group)		BCBSVT EPO (Individual)					BCBSVT EPO CDHP (Individual)	
			Product ID:		13627VT032				13627VT033		13627VT034					13627VT035	
			Metal:		Platinum	Gold	Silver	Bronze	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002
OK	$ 495.11	Premium Information	Plan Adjusted Index Rate	$495.07	$623.68	$547.80	$472.92	$400.12	$468.28	$402.05	$217.33	$623.68	$547.80	$472.92	$400.12	$468.28	$402.05
OK	930,456		Member Months	930,456	113,256	58,632	76,596	20,448	58,860	23,424	2,028	42,684	28,956	153,180	14,940	60,780	14,976
OK	$460,674,011		Total Premium (TP)	$460,640,739	$70,635,502	$32,118,610	$36,223,780	$8,181,654	$27,562,961	$9,417,619	$440,745	$26,621,157	$15,862,097	$72,441,886	$5,977,793	$28,462,058	$6,021,101
			EHB Percent of TP, [see instructions]	99.98%	99.98%	99.98%	99.98%	99.97%	99.98%	99.97%	99.95%	99.98%	99.98%	99.98%	99.97%	99.98%	99.97%
			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%
			Other benefits portion of TP	0.02%	0.02%	0.02%	0.02%	0.03%	0.02%	0.03%	0.05%	0.02%	0.02%	0.02%	0.03%	0.02%	0.03%
OK	521,764,754	Claims Information	Total Allowed Claims (TAC)	$521,765,102	$63,509,751	$32,878,644	$42,952,187	$11,466,478	$33,006,498	$13,135,308	$1,137,227	$23,935,599	$16,237,447	$85,897,644	$8,377,796	$34,083,162	$8,397,984
			EHB Percent of TAC, [see instructions]	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%
			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%
			Other benefits portion of TAC	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%
			Allowed Claims which are not the issuer's obligation	$106,907,032	$14,480,394	$3,102,274	$3,773,727	$2,432,744	$1,842,949	-$1,126,108	$276,129	$23,318,175	$4,325,527	$23,459,616	-$359,075	$9,994,046	$430,367
			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%
OK	414,180,284		Total Incurred claims, payable with issuer funds	$414,858,070	$49,029,357	$29,776,369	$39,178,460	$9,033,733	$31,163,549	$14,261,416	$861,097	$617,424	$11,911,921	$62,438,028	$8,736,871	$24,089,116	$7,967,617
#DIV/0!	-		Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Net Amt of Risk Adj	$1,147,222	$9,653,944	-$1,644,084	-$5,801,175	-$1,084,041	-$5,648,230	-$5,118,274	$97,650	$21,499,179	$1,981,490	$4,311,312	-$2,928,557	$2,258,506	-$2,122,001
OK	$ 445.14		Incurred Claims PMPM	$445.87	$432.91	$507.85	$511.49	$441.79	$529.45	$608.84	$424.60	$14.46	$411.38	$407.61	$584.80	$396.33	$532.03
OK	$ 560.76		Allowed Claims PMPM	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76
			EHB portion of Allowed Claims, PMPM	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63

Product-Plan Data Collection

Company Legal Name:
HIOS Issuer ID:
Effective Date of Rate Change(s):

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	BCBSVT EPO Blue Rewards (Small Group)		BCBSVT EPO CDHP Blue Rewards (Small Group)			BCBSVT EPO Blue Rewards (Individual)		BCBSVT EPO CDHP Blue Rewards (Individiual)		
Product ID:	13627VT036		13627VT037			13627VT038		13627VT039		
Metal:	Gold	Silver	Gold	Silver	Bronze	Gold	Silver	Gold	Silver	Bronze
AV Metal Value	0.810	0.716	0.788	0.690	0.616	0.810	0.716	0.788	0.690	0.616
AV Pricing Value	0.946	0.823	0.898	0.775	0.711	0.946	0.823	0.898	0.775	0.711
Plan Category	Renewing	Renewing	Renewing	New	Renewing	Renewing	Renewing	Renewing	New	Renewing
Plan Type:	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	BCBSVT Blue Rewards Gold Plan	BCBSVT Blue Rewards Silver Plan	BCBSVT Blue Rewards Gold CDHP Plan	BCBSVT Blue Rewards Silver CDHP Plan	BCBSVT Blue Rewards Bronze CDHP Plan	BCBSVT Blue Rewards Gold Plan	BCBSVT Blue Rewards Silver Plan	BCBSVT Blue Rewards Gold CDHP Plan	BCBSVT Blue Rewards Silver CDHP Plan	BCBSVT Blue Rewards Bronze CDHP Plan
Plan ID (Standard Component ID):	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
Exchange Plan?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	0.00%		0.00%			0.00%		0.00%		
Historical Rate Increase - Calendar Year - 1	7.61%		5.67%			8.15%		5.67%		
Historical Rate Increase - Calendar Year 0	7.93%		11.49%			8.48%		11.49%		
Effective Date of Proposed Rates	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017	1/1/2017
Rate Change % (over prior filing)	10.52%	9.90%	10.16%	0.00%	9.90%	10.52%	9.90%	10.16%	0.00%	9.90%
Cum'tive Rate Change % (over 12 mos prior)	10.52%	9.90%	10.16%	0.00%	9.90%	10.52%	9.90%	10.16%	0.00%	9.90%
Proj'd Per Rate Change % (over Exper. Period)	20.39%	20.89%	#DIV/0!	#DIV/0!	24.06%	20.39%	20.89%	#DIV/0!	#DIV/0!	24.06%
Product Rate Increase %	10.25%		10.10%			9.96%		9.96%		

Section II: Components of Premium Increase (PMPM Dollar Amount abo

Plan ID (Standard Component ID):	Total	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
Inpatient	$4.64	$6.52	$4.88	$5.72	$0.00	$3.77	$6.52	$4.88	$5.72	$0.00	$3.77
Outpatient	$10.31	$14.48	$10.84	$12.71	$0.00	$8.37	$14.48	$10.84	$12.71	$0.00	$8.37
Professional	$5.94	$8.35	$6.24	$7.32	$0.00	$4.82	$8.35	$6.24	$7.32	$0.00	$4.82
Prescription Drug	$5.19	$7.29	$5.45	$6.39	$0.00	$4.21	$7.29	$5.45	$6.39	$0.00	$4.21
Other	$1.03	$1.45	$1.09	$1.27	$0.00	$0.84	$1.45	$1.09	$1.27	$0.00	$0.84
Capitation	$0.24	$0.33	$0.25	$0.29	$0.00	$0.19	$0.33	$0.25	$0.29	$0.00	$0.19
Administration	$4.16	$6.01	$6.07	$6.46	$0.00	$6.15	$6.01	$6.07	$6.46	$0.00	$6.15
Taxes & Fees	$0.90	$0.66	$2.13	$1.20	$0.00	$3.56	$0.66	$2.13	$1.20	$0.00	$3.56
Risk & Profit Charge	$6.67	$7.13	$6.18	$6.76	$0.00	$5.34	$7.13	$6.18	$6.76	$0.00	$5.34
Total Rate Increase	$39.08	$52.22	$43.13	$48.12	$0.00	$37.25	$52.22	$43.13	$48.12	$0.00	$37.25
Member Cost Share Increase	-$5.12	-$21.76	-$15.81	-$16.67	$0.00	-$8.46	-$21.76	-$15.81	-$16.67	$0.00	-$8.46

Average Current Rate PMPM	$435.58	$476.48	$417.13	$454.05	$0.00	$360.43	$476.48	$417.13	$454.05	$0.00	$360.43
Projected Member Months	930,456	12,708	10,740	70,296	36,816	26,184	6,348	60,516	5,976	9,900	22,212

Section III: Experience Period Information

Warning Alert	Wsht 1 Total
OK	$ 433.89
OK	766,083
OK	$332,392,760
OK	$384,634,210
OK	$292,325,366
OK	$ 381.58
OK	$ 502.08

	Plan ID (Standard Component ID):	Total	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
Premium Information	Plan Adjusted Index Rate	$433.49	$439.16	$380.72	$0.00	$0.00	$320.56	$439.16	$380.72	$0.00	$0.00	$320.56
	Member Months	766,083	25,111	12,052	0	0	18,185	8,451	45,200	0	0	22,029
	Total Premium (TP)	$332,093,116	$11,027,858	$4,588,405	$0	$0	$5,829,325	$3,711,378	$17,208,423	$0	$0	$7,061,545
	EHB Percent of TP, [see instructions]	99.99%	99.99%	100.00%	100.00%	100.00%	99.99%	99.99%	99.96%	100.00%	100.00%	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%
	Other benefits portion of TP	0.01%	0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.04%	0.00%	0.00%	0.01%
Claims Information	Total Allowed Claims (TAC)	$384,634,210	$9,795,718	$3,884,103	$0	$0	$6,339,605	$4,715,731	$16,069,844	$0	$0	$5,408,084
	EHB Percent of TAC, [see instructions]	99.99%	99.99%	100.00%	100.00%	100.00%	99.99%	99.99%	99.96%	100.00%	100.00%	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%
	Other benefits portion of TAC	0.01%	0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.04%	0.00%	0.00%	0.01%
	Allowed Claims which are not the issuer's obligation:	$92,308,844	$2,088,931	$1,100,960	$0	$0	$2,450,974	$1,236,403	$6,036,790	$0	$0	$2,615,749
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$7,086,197	$0	$0	$0	$0	$0	$0	$1,495,316	$0	$0	$11,670
	Portion of above payable by HHS on behalf of insured person, as %	7.68%	0.00%	0.00%	#DIV/0!	#DIV/0!	0.00%	0.00%	24.77%	#DIV/0!	#DIV/0!	0.45%
	Total Incurred claims, payable with issuer funds	$292,325,366	$7,706,787	$2,783,143	$0	$0	$3,888,630	$3,479,328	$10,033,054	$0	$0	$2,792,335
	Net Amt of Rein	$16,110,085.16	-$92,157.37	-$44,230.84	$0.00	$0.00	-$66,738.95	$332,758.83	$1,089,544.31	$0.00	$0.00	$456,028.89
	Net Amt of Risk Adj	$2,518,584.35	-$923,453.71	-$1,009,085.18	$0.00	$0.00	-$1,480,822.43	$203,604.10	-$3,808,584.38	$0.00	$0.00	-$2,265,209.09
	Incurred Claims PMPM	$381.58	$306.91	$230.93	#DIV/0!	#DIV/0!	$213.84	$411.71	$221.97	#DIV/0!	#DIV/0!	$126.76
	Allowed Claims PMPM	$502.08	$390.10	$322.28	#DIV/0!	#DIV/0!	$348.62	$558.01	$355.53	#DIV/0!	#DIV/0!	$245.50
	EHB portion of Allowed Claims, PMPM	$502.04	$390.08	$322.28	#DIV/0!	#DIV/0!	$348.59	$557.95	$355.39	#DIV/0!	#DIV/0!	$245.48

		Product		BCBSVT EPO Blue Rewards (Small Group)		BCBSVT EPO CDHP Blue Rewards (Small Group)			BCBSVT EPO Blue Rewards (Individual)		BCBSVT EPO CDHP Blue Rewards (Individiual)		
		Product ID:		13627VT036		13627VT037			13627VT038		13627VT039		
		Metal:		Gold	Silver	Gold	Silver	Bronze	Gold	Silver	Gold	Silver	Bronze

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
OK	$ 495.11	Premium Information	Plan Adjusted Index Rate	$495.07	$528.70	$460.26	$502.18	$433.56	$397.68	$528.70	$460.26	$502.18	$433.56	$397.68
OK	930,456		Member Months	930,456	12,708	10,740	70,296	36,816	26,184	6,348	60,516	5,976	9,900	22,212
OK	$460,674,011		Total Premium (TP)	$460,640,739	$6,718,720	$4,943,192	$35,301,245	$15,961,945	$10,412,853	$3,356,188	$27,853,094	$3,001,028	$4,292,244	$8,833,268
			EHB Percent of TP, [see instructions]	99.98%	99.98%	99.98%	99.98%	99.97%	99.97%	99.98%	99.98%	99.98%	99.97%	99.97%
			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%
			Other benefits portion of TP	0.02%	0.02%	0.02%	0.02%	0.03%	0.03%	0.02%	0.02%	0.02%	0.03%	0.03%
OK	521,764,754	Claims Information	Total Allowed Claims (TAC)	$521,765,102	$7,126,174	$6,022,592	$39,419,381	$20,645,043	$14,683,013	$3,559,722	$33,935,121	$3,351,118	$5,551,552	$12,455,663
			EHB Percent of TAC, [see instructions]	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%	99.98%
			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%
			Other benefits portion of TAC	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%
			Allowed Claims which are not the issuer's obligation	$106,907,032	$673,765	$1,079,070	$4,837,723	$4,347,073	$3,091,387	$890,050	$4,189,120	$932,315	$859,586	$56,179
			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%
OK	414,180,284		Total Incurred claims, payable with issuer funds	$414,858,070	$6,452,409	$4,943,522	$34,581,658	$16,297,970	$11,591,625	$2,669,672	$29,746,001	$2,418,803	$4,691,966	$12,399,484
#DIV/0!	-		Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Net Amt of Risk Adj	$1,147,222	-$517,107	-$359,384	-$2,860,449	-$1,231,945	-$1,509,340	$295,176	-$3,916,050	$277,879	-$640,639	-$3,846,638
OK	$ 445.14		Incurred Claims PMPM	$445.87	$507.74	$460.29	$491.94	$442.69	$442.70	$420.55	$491.54	$404.75	$473.94	$558.23
OK	$ 560.76		Allowed Claims PMPM	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76	$560.76
			EHB portion of Allowed Claims, PMPM	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63	$560.63

Exhibit 1A

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS 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	$250	$850	$2,150	$1,550	$4,600	$5,050
Rx Ded	$0	$100	$150	Combined	$700	Combined
Integrated Ded	No	No	No	Yes	No	Yes
Medical OOPM	$1,300	$4,500	$6,000	$6,400	$7,150	$6,550
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	No	No	Yes	Yes	Yes	Yes
Family Deductible / OOP	Stacked	Stacked	Stacked	Aggregate, Embedded Individual OOPM of $7,150	Stacked	Aggregate, Embedded Individual OOPM of $7,150
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	$30	$30	$65	25%	$90	50%
Urgent Care	$40	$45	$60	25%	$100	50%
Ambulance	$50	$50	$100	25%	$100	50%
DME	10%	20%	40%	25%	50%	50%
ER	$100	$150	$250	25%	50%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	25%	50%	50%
Outpatient	10%	20%	40%	25%	50%	50%
Inpatient	10%	20%	40%	25%	50%	50%
Rx Generic	$5	$5	$15	$10	$20	$12
Rx Preferred Brand	$50	$50	$60	$40	$85	40%
Rx Non-Preferred Brand	50%	50%	50%	50%	60%	60%
Pediatric Vision (Exam and Materials)	$30	$30	$65	25%	$90	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%

Exhibit 1B

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

BLUE REWARDS (NON-STANDARD) PLAN DESIGNS

	GOLD	GOLD	SILVER	SILVER	BRONZE	CATASTROPHIC
	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards
Deductible/OOP Max	**Deductible**	**CDHP**	**Deductible**	**CDHP**	**CDHP**	**Deductible**
Medical Ded	$1,250	$2,500	$2,300	$4,500	$7,150	$7,150
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$2,500	$7,150	$4,500	$7,150	$7,150
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, Embedded Individual OOPM of $7,150	Aggregate	Aggregate, Embedded Individual OOPM of $7,150	Aggregate, Embedded Individual OOPM of $7,150	Aggregate, Embedded Individual OOPM of $7,150	Aggregate, Embedded Individual OOPM of $7,150
Medical Deductible waived for:	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care	Preventive Care	Preventive Care, 3 PCP/MH Office Visits
Drug Deductible waived for:	N/A	Wellness Scripts	N/A	Wellness Scripts	Wellness Scripts	N/A
Service Category						
Preventive	$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	0%	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	0%	0%	3 visits per member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit		0%		0%	0%	
Specialist Office Visit	$30	0%	$50	0%	0%	0%
Urgent Care	$30	0%	$50	0%	0%	0%
Ambulance	$30	0%	$50	0%	0%	0%
DME	$30	0%	$50	0%	0%	0%
ER	$250	0%	$400	0%	0%	0%
Radiology (MRI, CT, PET)	$500	0%	$1,500	0%	0%	0%
Outpatient	$500	0%	$1,500	0%	0%	0%
Inpatient	$500	0%	$1,500	0%	0%	0%
Rx Generic	$5	$5	$5	$15	$25	0%
Rx Preferred Brand	40%	40%	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	0%
Pediatric Vision (Exam and Materials)	$30	0%	$50	0%	0%	0%
Pediatric Dental Class I	0%	0%	0%	0%	0%	0%
Pediatric Dental Class II	30%	0%	30%	0%	0%	0%
Pediatric Dental Class III	50%	0%	50%	0%	0%	0%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 2A

PROJECTED MEMBERSHIP BY PLAN AND MARKET

Product	Individual Market	Small Group Market	TOTAL
Blue Rewards Gold	529	1,059	1,588
Blue Rewards Gold CDHP	498	5,858	6,356
Blue Rewards Silver	5,043	895	5,938
Blue Rewards Silver CDHP	825	3,068	3,893
Blue Rewards Bronze CDHP	1,851	2,182	4,033
Standard Platinum	3,557	9,438	12,995
Standard Gold	2,413	4,886	7,299
Standard Silver	12,765	6,383	19,148
Standard Silver CDHP	5,065	4,905	9,970
Standard Bronze	1,245	1,704	2,949
Standard Bronze CDHP	1,248	1,952	3,200
Catastrophic	169	0	169
Total	**35,208**	**42,330**	**77,538**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 2B

ADJUSTMENT FOR IMPACT OF THE HEALTH STATUS OF NEWLY INSURED

Coverage Category in the Experience	**Projected Membership**	**CY 2015 Allowed PMPM Adjuted for Network**
Individual Non-Subsidized QHP	10,872	$561.82
Individual Subsidized QHP	17,836	$561.46
Small Group QHP	37,286	$458.88
Groups with 51-100 employees known to have joined QHP	4,429	$585.54
Groups with 51-100 employees expected to join QHP	615	$588.52
Weighted Average before adjustment for new membership	**71,038**	**$509.41**
Membership previously enrolled in Medicaid	**6,500**	**$561.46**
Total Weighted Average	**77,538**	**$513.77**
Impact of Newly Insured (Line 1+b3 on Exhibit 5) = $513.77 / $509.41		**1.0086**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

PEDIATRIC DENTAL

Actuals Pediatric Dental Experience PMPM	$1.62	
Trend	6.7%	
Trended Pediatric Dental PMPM	$1.84	(line e_7 of Exhibit 5)

Product	Projected Membership	Projected Allowed Charges PMPM	Projected Dental paid to allowed ratio	Projected Paid Claims PMPM
Blue Rewards Gold	1,588	$1.84	65.8%	$1.21
Blue Rewards Gold CDHP	6,356	$1.84	51.7%	$0.95
Blue Rewards Silver	5,938	$1.84	65.7%	$1.21
Blue Rewards Silver CDHP	3,893	$1.84	39.9%	$0.74
Blue Rewards Bronze CDHP	4,033	$1.84	24.7%	$0.45
Standard Platinum	12,995	$1.84	80.0%	$1.47
Standard Gold	7,299	$1.84	73.7%	$1.36
Standard Silver	19,148	$1.84	65.2%	$1.20
Standard Silver CDHP	9,970	$1.84	44.9%	$0.83
Standard Bronze	2,949	$1.84	45.0%	$0.83
Standard Bronze CDHP	3,200	$1.84	36.2%	$0.67
Catastrophic	169	$1.84	49.8%	$0.92
Total	**77,538**	**$1.84**	**59.4%**	**$1.10**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

DEMOGRAPHIC ADJUSTMENT

Experience Period			
Coverage Category in the Experience	**CY 2015 Member Months**	**Average Age**	**Age/Gender Factor**
Individual Non-Subsidized QHP	124,629	45.1	
Individual Subsidized QHP	211,659	45.2	
Small Group QHP	429,795	38.8	
Groups with 51-100 employees known to have joined QHP	43,108	37.7	
Groups with 51-100 employees expected to join QHP	7,442	40.5	
Weighted Average	**816,633**		**1.2206**

Projected Period			
Coverage Category in the Projected Period	**Projected Members**	**Average Age**	**Age/Gender Factor**
Individual Non-Subsidized QHP	10,872	45.3	
Individual Subsidized QHP	17,836	45.5	
Small Group QHP	37,286	38.9	
Groups with 51-100 employees known to have joined QHP	4,429	38.3	
Groups with 51-100 employees expected to join QHP	615	40.5	
Weighted Average	**71,038**		**1.2277**

Demographic Adjustment (Line 1+c3 on Exhibit 5) = 1.2277 / 1.2206 **1.0058**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

IMPACT OF THE CHANGE IN PROVIDER NETWORK

MEDICAL CLAIMS

Coverage Category in the Experience	CY 2015 Allowed Claims	Experience Membership	CY 2015 Allowed PMPM	Network Adjustment	CY 2015 Allowed PMPM Adjuted for Network
Individual Non-Subsidized QHP	$56,878,050	124,629	$456.38	1.0000	$456.38
Individual Subsidized QHP	$98,709,198	211,659	$466.36	1.0000	$466.36
Small Group QHP	$163,573,231	429,795	$380.58	1.0000	$380.58
Groups with 51-100 employees known to have joined QHP	$21,573,885	43,108	$500.46	0.9774	$489.18
Groups with 51-100 employees expected to join QHP	$3,672,136	7,442	$493.43	0.9876	$487.30
Weighted Average PMPM			$421.74	0.9985	$421.09

PHARMACY CLAIMS

Coverage Category in the Experience	CY 2015 Allowed Claims	Experience Membership	CY 2015 Allowed PMPM	Network Adjustment	CY 2015 Allowed PMPM Adjuted for Network
Individual Non-Subsidized QHP	$13,141,293	124,629	$105.44	1.0000	$105.44
Individual Subsidized QHP	$20,129,649	211,659	$95.10	1.0000	$95.10
Small Group QHP	$33,651,928	429,795	$78.30	1.0000	$78.30
Groups with 51-100 employees known to have joined QHP	$4,154,101	43,108	$96.36	1.0000	$96.36
Groups with 51-100 employees expected to join QHP	$753,236	7,442	$101.21	1.0000	$101.21
Weighted Average PMPM			$87.96	1.0000	$87.96
Total Average PMPM			**$509.70**		**$509.05**
Impact of Change in Provider Network (Line 1+c2 on Exhibit 5) = $509.05 / $509.7					**0.9987**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 2F

IMPACT OF SELECTION

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Projected Paid Claims													
Using HHS Induced Utilization Factors													
Projected FFS Allowed Charges - Without Selection	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	
Benefit Richness Adjustment	1.0184	1.0003	0.9721	0.9568	0.9383	1.0959	1.0331	0.9822	0.9781	0.9401	0.9407	0.9314	
Pricing Actuarial Value	83.59%	80.51%	75.40%	71.79%	66.67%	93.06%	86.01%	77.28%	76.84%	67.38%	67.72%	66.59%	
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	0.5030	
Projected Paid Claims	$469.68	$444.32	$404.41	$379.01	$345.12	$562.72	$490.29	$418.80	$414.67	$349.48	$351.48	$172.10	$439.37
Projected Paid Claims													
Using BCBSVT Actual Utilization Factors													
Projected FFS Allowed Charges - Without Selection	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	$551.75	
Benefit Richness Adjustment	1.0088	1.0088	0.9037	0.9037	0.6160	1.5891	1.0088	0.9037	0.9037	0.6160	0.6160	0.3750	
Pricing Actuarial Value	82.58%	79.43%	73.74%	69.97%	64.10%	93.54%	84.93%	75.92%	75.06%	64.79%	65.00%	61.16%	
Projected Paid Claims	$459.59	$442.09	$367.67	$348.89	$217.85	$820.15	$472.69	$378.55	$374.25	$220.20	$220.90	$126.55	$443.98
Selection Impact												line 1+c6 on Exhibit 5	**1.0105**
Projected Membership	1,588	6,356	5,938	3,893	4,033	12,995	7,299	19,148	9,970	2,949	3,200	169	77,538

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 3A

MEDICAL TREND DEVELOPMENT
ILLUSTRATION OF CONTRACT NORMALIZATION

Month	Contract Increase	Normalization Factor	Experience Claims	Normalized Claims
Jan-12		1.1699	$1,000,000	$1,169,859
Feb-12		1.1699	$1,000,000	$1,169,859
Mar-12		1.1699	$1,000,000	$1,169,859
Apr-12		1.1699	$1,000,000	$1,169,859
May-12		1.1699	$1,000,000	$1,169,859
Jun-12		1.1699	$1,000,000	$1,169,859
Jul-12		1.1699	$1,000,000	$1,169,859
Aug-12		1.1699	$1,000,000	$1,169,859
Sep-12		1.1699	$1,000,000	$1,169,859
Oct-12	1.0400	1.1249	$1,000,000	$1,124,864
Nov-12		1.1249	$1,000,000	$1,124,864
Dec-12		1.1249	$1,000,000	$1,124,864
Jan-13		1.1249	$1,000,000	$1,124,864
Feb-13		1.1249	$1,000,000	$1,124,864
Mar-13		1.1249	$1,000,000	$1,124,864
Apr-13		1.1249	$1,000,000	$1,124,864
May-13		1.1249	$1,000,000	$1,124,864
Jun-13		1.1249	$1,000,000	$1,124,864
Jul-13		1.1249	$1,000,000	$1,124,864
Aug-13		1.1249	$1,000,000	$1,124,864
Sep-13		1.1249	$1,000,000	$1,124,864
Oct-13	1.0400	1.0816	$1,000,000	$1,081,600
Nov-13		1.0816	$1,000,000	$1,081,600
Dec-13		1.0816	$1,000,000	$1,081,600
Jan-14		1.0816	$1,000,000	$1,081,600
Feb-14		1.0816	$1,000,000	$1,081,600
Mar-14		1.0816	$1,000,000	$1,081,600
Apr-14		1.0816	$1,000,000	$1,081,600
May-14		1.0816	$1,000,000	$1,081,600
Jun-14		1.0816	$1,000,000	$1,081,600
Jul-14		1.0816	$1,000,000	$1,081,600
Aug-14		1.0816	$1,000,000	$1,081,600
Sep-14		1.0816	$1,000,000	$1,081,600
Oct-14	1.0400	1.0400	$1,000,000	$1,040,000
Nov-14		1.0400	$1,000,000	$1,040,000
Dec-14		1.0400	$1,000,000	$1,040,000
Jan-15		1.0400	$1,000,000	$1,040,000
Feb-15		1.0400	$1,000,000	$1,040,000
Mar-15		1.0400	$1,000,000	$1,040,000
Apr-15		1.0400	$1,000,000	$1,040,000
May-15		1.0400	$1,000,000	$1,040,000
Jun-15		1.0400	$1,000,000	$1,040,000
Jul-15		1.0400	$1,000,000	$1,040,000
Aug-15		1.0400	$1,000,000	$1,040,000
Sep-15		1.0400	$1,000,000	$1,040,000
Oct-15	1.0400	1.0000	$1,000,000	$1,000,000
Nov-15		1.0000	$1,000,000	$1,000,000
Dec-15		1.0000	$1,000,000	$1,000,000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS 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	Regression on Adjusted PMPM - 24 Months	Regression on Adjusted PMPM - 18 Months
Jan-12	63,943	$23,537,833	$368.11	$27,236,461	$425.95	$435.10	$375.85	$389.73
Feb-12	63,962	$24,508,218	$383.17	$28,382,610	$443.74	$434.73	$376.96	$390.54
Mar-12	64,241	$25,421,709	$395.72	$29,263,617	$455.53	$434.38	$378.01	$391.29
Apr-12	64,460	$24,185,205	$375.20	$27,908,661	$432.96	$434.01	$379.13	$392.10
May-12	64,384	$26,635,892	$413.70	$30,839,141	$478.99	$433.66	$380.21	$392.88
Jun-12	64,332	$22,683,317	$352.60	$25,901,821	$402.63	$433.29	$381.34	$393.69
Jul-12	64,273	$22,527,870	$350.50	$25,721,574	$400.19	$432.93	$382.43	$394.48
Aug-12	64,244	$23,994,721	$373.49	$27,365,280	$425.96	$432.56	$383.56	$395.29
Sep-12	64,436	$20,341,515	$315.69	$23,074,554	$358.10	$432.19	$384.70	$396.10
Oct-12	64,466	$26,647,040	$413.35	$30,081,336	$466.62	$431.83	$385.80	$396.90
Nov-12	64,602	$25,445,583	$393.88	$28,725,316	$444.65	$431.47	$386.94	$397.71
Dec-12	64,710	$25,561,795	$395.02	$27,783,648	$429.36	$431.11	$388.05	$398.51
Jan-13	64,537	$26,103,277	$404.47	$28,327,415	$438.93	$430.74	$389.20	$399.33
Feb-13	64,270	$23,297,876	$362.50	$25,449,074	$395.97	$430.38	$390.35	$400.15
Mar-13	64,320	$25,484,770	$396.22	$27,741,073	$431.30	$430.04	$391.39	$400.90
Apr-13	64,235	$26,646,635	$414.83	$28,900,972	$449.93	$429.68	$392.55	$401.72
May-13	64,091	$27,075,121	$422.45	$29,314,855	$457.39	$429.32	$393.67	$402.53
Jun-13	64,386	$24,448,960	$379.72	$26,393,178	$409.92	$428.96	$394.84	$403.36
Jul-13	64,839	$25,429,940	$392.20	$27,442,045	$423.23	$428.60	$395.97	$404.16
Aug-13	65,000	$25,236,313	$388.25	$27,218,217	$418.74	$428.24	$397.14	$404.99
Sep-13	64,831	$25,757,207	$397.30	$27,651,813	$426.52	$427.87	$398.31	$405.83
Oct-13	64,548	$30,148,171	$467.07	$32,352,445	$501.22	$427.52	$399.46	$406.64
Nov-13	64,535	$27,949,650	$433.09	$29,800,867	$461.78	$427.16	$400.64	$407.48
Dec-13	63,944	$28,945,719	$452.67	$31,032,940	$485.31	$426.80	$401.78	$408.29
Jan-14	61,873	$24,491,845	$395.84	$26,039,531	$420.85	$426.44	$402.97	$409.13
Feb-14	61,373	$22,464,982	$366.04	$23,862,475	$388.81	$426.08	$404.17	$409.98
Mar-14	61,052	$23,018,600	$377.03	$24,376,033	$399.27	$425.75	$405.25	$410.74
Apr-14	59,871	$22,806,124	$380.92	$24,113,526	$402.76	$425.39	$406.45	$411.59
May-14	61,698	$23,703,764	$384.19	$25,040,913	$405.86	$425.03	$407.61	$412.41
Jun-14	61,865	$23,477,607	$379.50	$24,774,909	$400.47	$424.67	$408.82	$413.26
Jul-14	62,451	$23,396,726	$374.64	$24,467,760	$391.79	$424.32	$409.99	$414.08
Aug-14	62,672	$23,335,173	$372.34	$24,494,226	$390.83	$423.96	$411.20	$414.94
Sep-14	62,499	$24,886,801	$398.20	$26,129,096	$418.07	$423.60	$412.42	$415.79
Oct-14	62,342	$27,910,549	$447.70	$29,050,660	$465.99	$423.25	$413.60	$416.62
Nov-14	62,228	$24,605,030	$395.40	$25,601,012	$411.41	$422.89	$414.82	$417.48
Dec-14	61,920	$28,378,532	$458.31	$29,624,814	$478.44	$422.54	$416.01	$418.31
Jan-15	66,417	$27,921,980	$420.40	$28,349,293	$426.84	$422.18	$417.24	$419.18
Feb-15	66,798	$24,247,827	$363.00	$24,593,770	$368.18	$421.82	$418.47	$420.04
Mar-15	68,006	$28,691,346	$421.89	$29,102,556	$427.94	$421.50	$419.59	$420.82
Apr-15	68,158	$28,617,573	$419.87	$28,990,586	$425.34	$421.14	$420.83	$421.69
May-15	67,577	$27,033,678	$400.04	$27,340,463	$404.58	$420.79	$422.04	$422.53
Jun-15	67,630	$29,393,433	$434.62	$29,694,473	$439.07	$420.43	$423.29	$423.40
Jul-15	67,279	$28,871,855	$429.14	$29,098,570	$432.51	$420.08	$424.50	$424.25
Aug-15	66,786	$26,103,661	$390.86	$26,297,394	$393.76	$419.73	$425.76	$425.12
Sep-15	66,509	$28,314,453	$425.72	$28,479,599	$428.21	$419.37	$427.02	$426.00
Oct-15	66,490	$28,710,257	$431.80	$28,769,828	$432.69	$419.02	$428.24	$426.85
Nov-15	66,086	$27,573,375	$417.23	$27,601,768	$417.66	$418.66	$429.51	$427.73
Dec-15	65,999	$29,318,318	$444.22	$29,318,318	$444.22	$418.32	$430.74	$428.58
				Annual Increase		-1.0%	3.5%	2.5%

Regressions

Regression on Adjusted PMPM - 36 Months		Regression on Adjusted PMPM - 24 Months		Regression on Adjusted PMPM - 18 Months	
1.000	1340.540	1.000	7.614	1.000	25.718
0.000	1.495	0.000	2.323	0.000	4.068
0.017	0.068	0.119	0.057	0.029	0.065
0.592	34.000	2.968	22.000	0.472	16.000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

MEDICAL TREND DEVELOPMENT
UTILIZATION TREND CALCULATION

Month	Membership	Adjusted Claims - Normalized for Contract Changes	Adjusted PMPM	Regression on Adjusted PMPM - 18 Months	Average Induced Utilization Factor	Normalization Factor for Induced Utilization	Adjusted Claims - Normalized for Contract Changes and Induced Utilization Factor	Adjusted PMPM	Regression on Adjusted PMPM - 24 Months
Jul-14	62,451	$24,467,760	$391.79	$414.08	0.9019	1.0075	$24,650,303	$394.71	$416.68
Aug-14	62,672	$24,494,226	$390.83	$414.94	0.9022	1.0071	$24,668,441	$393.61	$417.32
Sep-14	62,499	$26,129,096	$418.07	$415.79	0.9024	1.0069	$26,309,102	$420.95	$417.95
Oct-14	62,342	$29,050,660	$465.99	$416.62	0.9027	1.0065	$29,240,089	$469.03	$418.56
Nov-14	62,228	$25,601,012	$411.41	$417.48	0.9026	1.0066	$25,770,250	$414.13	$419.20
Dec-14	61,920	$29,624,814	$478.44	$418.31	0.9032	1.0060	$29,803,235	$481.32	$419.81
Jan-15	66,417	$28,349,293	$426.84	$419.18	0.9103	0.9981	$28,295,211	$426.02	$420.45
Feb-15	66,798	$24,593,770	$368.18	$420.04	0.9101	0.9983	$24,552,853	$367.57	$421.09
Mar-15	68,006	$29,102,556	$427.94	$420.82	0.9094	0.9991	$29,077,257	$427.57	$421.66
Apr-15	68,158	$28,990,586	$425.34	$421.69	0.9093	0.9993	$28,969,810	$425.04	$422.30
May-15	67,577	$27,340,463	$404.58	$422.53	0.9092	0.9994	$27,322,894	$404.32	$422.92
Jun-15	67,630	$29,694,473	$439.07	$423.40	0.9092	0.9993	$29,674,029	$438.77	$423.56
Jul-15	67,279	$29,098,570	$432.51	$424.25	0.9094	0.9991	$29,073,190	$432.13	$424.19
Aug-15	66,786	$26,297,394	$393.76	$425.12	0.9094	0.9991	$26,274,901	$393.42	$424.83
Sep-15	66,509	$28,479,599	$428.21	$426.00	0.9092	0.9993	$28,459,889	$427.91	$425.47
Oct-15	66,490	$28,769,828	$432.69	$426.85	0.9090	0.9996	$28,758,296	$432.52	$426.10
Nov-15	66,086	$27,601,768	$417.66	$427.73	0.9089	0.9996	$27,591,649	$417.51	$426.74
Dec-15	65,999	$29,318,318	$444.22	$428.58	0.9086	1.0000	$29,318,318	$444.22	$427.37
		Annual Increase		2.5%					1.8%

Regressions

	Regression on Adjusted PMPM - 18 Months		Regression on Adjusted PMPM - 24 Months
1.00007	25.7183	1.00005	53.9337
0.00010	4.0679	0.00010	4.1222
2.87%	0.0647	1.53%	0.0656
0.47247	16	0.24906	16

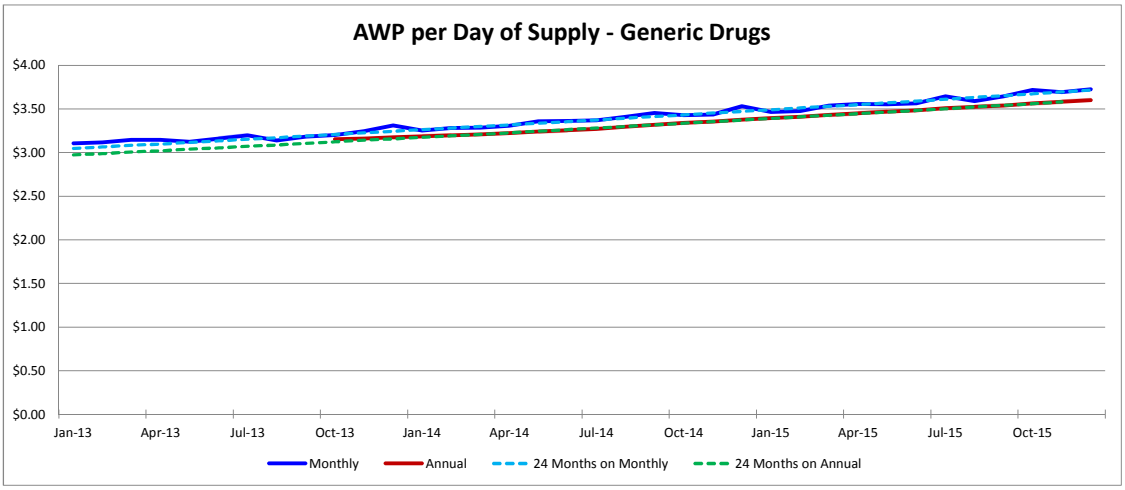
Impact of Benefit Changes **-0.6%**

PHARMACY TREND DEVELOPMENT

GENERIC DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Total AWP	Cost/ Supply	Monthly Cost Trend	Supply	Total AWP	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Jan-13	1,680,026	$5,216,012	$3.10						$3.05	$2.97
Feb-13	1,518,988	$4,736,780	$3.12						$3.07	$2.99
Mar-13	1,655,267	$5,205,996	$3.15						$3.08	$3.01
Apr-13	1,699,025	$5,348,025	$3.15						$3.10	$3.02
May-13	1,706,817	$5,333,696	$3.12						$3.12	$3.04
Jun-13	1,612,741	$5,095,368	$3.16						$3.14	$3.06
Jul-13	1,734,041	$5,545,438	$3.20						$3.15	$3.07
Aug-13	1,748,046	$5,484,689	$3.14						$3.17	$3.09
Sep-13	1,679,318	$5,346,739	$3.18						$3.19	$3.11
Oct-13	1,799,865	$5,760,616	$3.20		16,834,133	$53,073,359	$3.15		$3.21	$3.12
Nov-13	1,688,493	$5,481,275	$3.25		18,522,626	$58,554,634	$3.16		$3.23	$3.14
Dec-13	1,930,250	$6,394,871	$3.31		20,452,876	$64,949,505	$3.18		$3.25	$3.16
Jan-14	1,462,756	$4,756,445	$3.25	4.7%	20,235,606	$64,489,938	$3.19		$3.26	$3.18
Feb-14	1,412,432	$4,633,296	$3.28	5.2%	20,129,050	$64,386,454	$3.20		$3.28	$3.19
Mar-14	1,602,565	$5,266,248	$3.29	4.5%	20,076,348	$64,446,705	$3.21		$3.30	$3.21
Apr-14	1,410,737	$4,665,312	$3.31	5.1%	19,788,060	$63,763,993	$3.22		$3.32	$3.23
May-14	1,499,142	$5,036,638	$3.36	7.5%	19,580,385	$63,466,935	$3.24		$3.34	$3.25
Jun-14	1,527,303	$5,138,321	$3.36	6.5%	19,494,948	$63,509,888	$3.26		$3.36	$3.26
Jul-14	1,585,451	$5,340,238	$3.37	5.3%	19,346,358	$63,304,689	$3.27		$3.38	$3.28
Aug-14	1,566,112	$5,338,722	$3.41	8.6%	19,164,425	$63,158,722	$3.30		$3.40	$3.30
Sep-14	1,590,690	$5,495,953	$3.46	8.5%	19,075,797	$63,307,936	$3.32		$3.41	$3.32
Oct-14	1,636,480	$5,610,859	$3.43	7.1%	18,912,411	$63,158,179	$3.34		$3.43	$3.34
Nov-14	1,505,938	$5,176,728	$3.44	5.9%	18,729,856	$62,853,633	$3.36	6.2%	$3.45	$3.35
Dec-14	1,743,375	$6,159,213	$3.53	6.6%	18,542,981	$62,617,974	$3.38	6.3%	$3.47	$3.37
Jan-15	1,625,518	$5,635,064	$3.47	6.6%	18,705,744	$63,496,593	$3.39	6.5%	$3.49	$3.39
Feb-15	1,559,886	$5,425,193	$3.48	6.0%	18,853,198	$64,288,490	$3.41	6.6%	$3.51	$3.41
Mar-15	1,774,970	$6,278,356	$3.54	7.6%	19,025,603	$65,300,599	$3.43	6.9%	$3.53	$3.43
Apr-15	1,682,504	$5,985,325	$3.56	7.6%	19,297,369	$66,620,612	$3.45	7.1%	$3.55	$3.45
May-15	1,709,693	$6,072,684	$3.55	5.7%	19,507,921	$67,656,658	$3.47	7.0%	$3.57	$3.47
Jun-15	1,739,121	$6,195,766	$3.56	5.9%	19,719,739	$68,714,102	$3.48	7.0%	$3.59	$3.49
Jul-15	1,702,506	$6,208,155	$3.65	8.3%	19,836,793	$69,582,019	$3.51	7.2%	$3.61	$3.50
Aug-15	1,709,852	$6,139,328	$3.59	5.3%	19,980,533	$70,382,625	$3.52	6.9%	$3.63	$3.52
Sep-15	1,712,997	$6,241,177	$3.64	5.5%	20,102,840	$71,127,849	$3.54	6.6%	$3.65	$3.54
Oct-15	1,739,229	$6,467,796	$3.72	8.5%	20,205,589	$71,984,786	$3.56	6.7%	$3.68	$3.56
Nov-15	1,704,719	$6,295,240	$3.69	7.4%	20,404,370	$73,103,297	$3.58	6.8%	$3.70	$3.58
Dec-15	1,891,659	$7,045,674	$3.72	5.4%	20,552,654	$73,989,758	$3.60	6.6%	$3.72	$3.60

Exponential Trend:	7.0%	6.8%



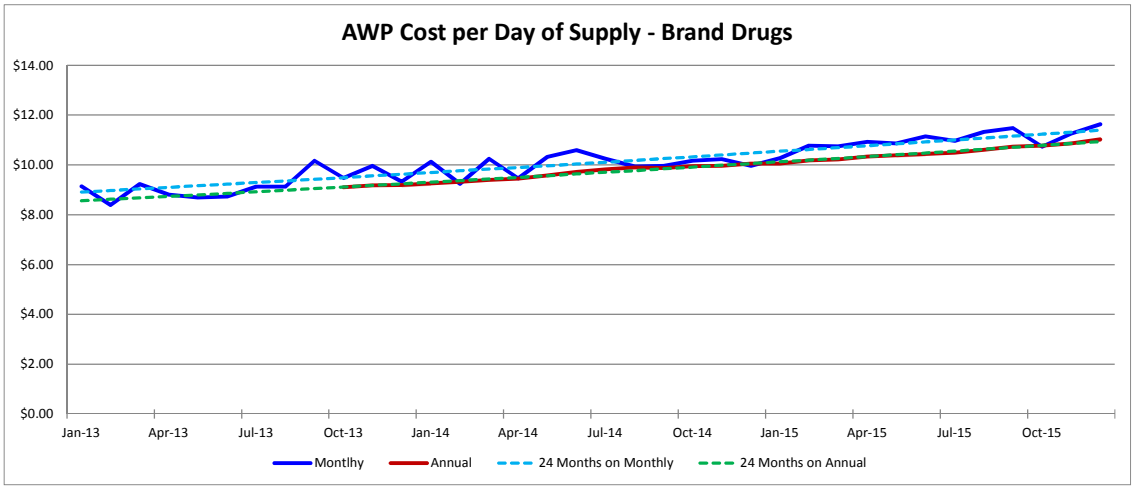
Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.001	1.000	0.002
	0.000	0.303	0.000	0.056
	0.968	0.007	0.999	0.001
	664.300	22.000	17996.291	22.000

PHARMACY TREND DEVELOPMENT

BRAND DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Total AWP	Cost/ Supply	Monthly Cost Trend	Supply	Total AWP	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Jan-13	303,526	$2,773,211	$9.14						$8.91	$8.56
Feb-13	269,628	$2,263,231	$8.39						$8.98	$8.62
Mar-13	296,212	$2,734,408	$9.23						$9.03	$8.68
Apr-13	300,744	$2,647,266	$8.80						$9.10	$8.74
May-13	307,481	$2,672,825	$8.69						$9.16	$8.80
Jun-13	287,261	$2,506,713	$8.73						$9.23	$8.86
Jul-13	307,658	$2,808,413	$9.13						$9.29	$8.92
Aug-13	318,891	$2,911,037	$9.13						$9.36	$8.99
Sep-13	308,757	$3,141,480	$10.17						$9.43	$9.05
Oct-13	338,175	$3,205,965	$9.48		3,038,333	$27,664,548	$9.11		$9.49	$9.12
Nov-13	308,740	$3,076,952	$9.97		3,347,073	$30,741,500	$9.18		$9.56	$9.18
Dec-13	363,252	$3,388,567	$9.33		3,710,325	$34,130,066	$9.20		$9.63	$9.24
Jan-14	227,213	$2,302,401	$10.13	10.9%	3,634,012	$33,659,257	$9.26		$9.70	$9.31
Feb-14	225,100	$2,081,211	$9.25	10.1%	3,589,484	$33,477,236	$9.33		$9.77	$9.38
Mar-14	249,289	$2,554,671	$10.25	11.0%	3,542,561	$33,297,500	$9.40		$9.83	$9.44
Apr-14	206,097	$1,950,751	$9.47	7.5%	3,447,913	$32,600,985	$9.46		$9.90	$9.50
May-14	220,706	$2,278,030	$10.32	18.7%	3,361,138	$32,206,191	$9.58		$9.97	$9.57
Jun-14	222,487	$2,356,037	$10.59	21.4%	3,296,364	$32,055,515	$9.72		$10.04	$9.64
Jul-14	226,227	$2,316,808	$10.24	12.2%	3,214,934	$31,563,910	$9.82		$10.11	$9.71
Aug-14	220,318	$2,189,959	$9.94	8.9%	3,116,361	$30,842,832	$9.90		$10.18	$9.78
Sep-14	236,823	$2,360,771	$9.97	-2.0%	3,044,427	$30,062,123	$9.87		$10.26	$9.85
Oct-14	257,026	$2,613,443	$10.17	7.3%	2,963,278	$29,469,601	$9.94		$10.33	$9.91
Nov-14	224,999	$2,302,140	$10.23	2.7%	2,879,537	$28,694,789	$9.97	8.5%	$10.40	$9.98
Dec-14	279,708	$2,785,251	$9.96	6.7%	2,795,992	$28,091,474	$10.05	9.2%	$10.47	$10.05
Jan-15	225,275	$2,314,918	$10.28	1.4%	2,794,054	$28,103,991	$10.06	8.6%	$10.55	$10.13
Feb-15	214,499	$2,311,954	$10.78	16.6%	2,783,453	$28,334,734	$10.18	9.1%	$10.62	$10.20
Mar-15	245,986	$2,642,353	$10.74	4.8%	2,780,150	$28,422,416	$10.22	8.8%	$10.69	$10.26
Apr-15	241,871	$2,644,219	$10.93	15.5%	2,815,925	$29,115,883	$10.34	9.4%	$10.77	$10.34
May-15	230,239	$2,500,622	$10.86	5.2%	2,825,457	$29,338,475	$10.38	8.4%	$10.85	$10.41
Jun-15	241,504	$2,691,884	$11.15	5.3%	2,844,474	$29,674,323	$10.43	7.3%	$10.92	$10.48
Jul-15	241,817	$2,651,154	$10.96	7.1%	2,860,064	$30,008,669	$10.49	6.9%	$11.00	$10.56
Aug-15	232,532	$2,633,952	$11.33	14.0%	2,872,278	$30,452,661	$10.60	7.1%	$11.08	$10.63
Sep-15	239,903	$2,754,847	$11.48	15.2%	2,875,357	$30,846,737	$10.73	8.6%	$11.16	$10.71
Oct-15	268,175	$2,880,165	$10.74	5.6%	2,886,506	$31,113,458	$10.78	8.4%	$11.24	$10.78
Nov-15	245,977	$2,770,151	$11.26	10.1%	2,907,485	$31,581,469	$10.86	9.0%	$11.32	$10.86
Dec-15	296,251	$3,446,310	$11.63	16.8%	2,924,028	$32,242,528	$11.03	9.8%	$11.40	$10.93

Exponential Trend:	8.8%	8.8%



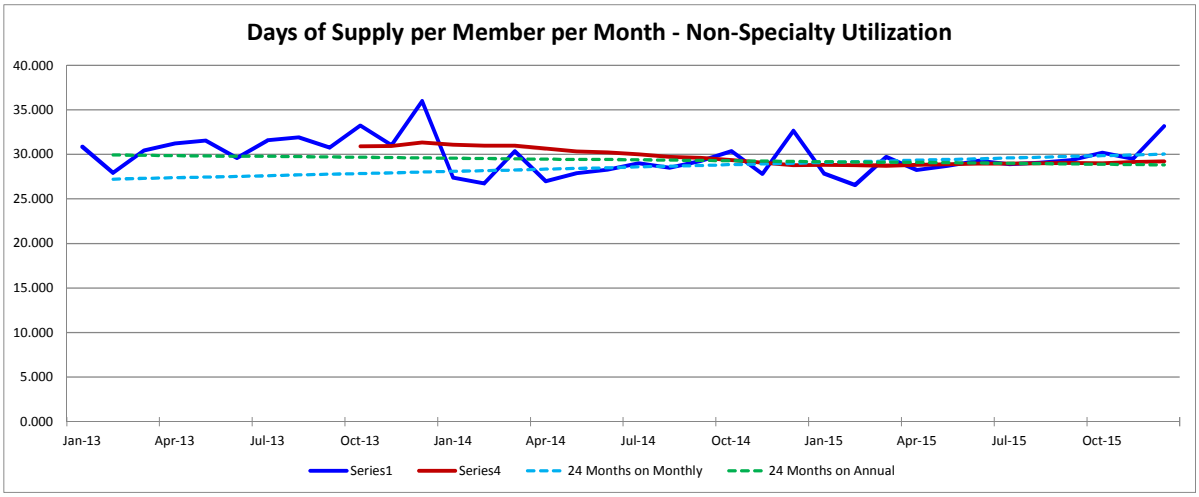
Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.001	1.000	0.001
	0.000	1.308	0.000	0.229
	0.714	0.032	0.988	0.006
	55.007	22.000	1774.453	22.000

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
Jan-13	64,294	1,983,552	30.851							
Feb-13	64,033	1,788,616	27.933						27.226	29.938
Mar-13	64,088	1,951,479	30.450						27.299	29.907
Apr-13	64,004	1,999,769	31.244						27.379	29.873
May-13	63,860	2,014,298	31.542						27.458	29.841
Jun-13	64,157	1,900,002	29.615						27.539	29.807
Jul-13	64,613	2,041,699	31.599						27.617	29.775
Aug-13	64,772	2,066,936	31.911						27.699	29.741
Sep-13	64,603	1,988,075	30.774						27.780	29.708
Oct-13	64,323	2,138,041	33.239		642,747	19,872,467	30.918		27.860	29.676
Nov-13	64,312	1,997,233	31.055		707,059	21,869,699	30.931		27.942	29.642
Dec-13	63,725	2,293,502	35.991		770,784	24,163,201	31.349		28.022	29.610
Jan-14	61,721	1,689,968	27.381	-11.2%	768,211	23,869,618	31.072		28.104	29.577
Feb-14	61,246	1,637,532	26.737	-4.3%	765,424	23,718,534	30.987		28.187	29.543
Mar-14	60,951	1,851,854	30.383	-0.2%	762,287	23,618,909	30.984		28.262	29.513
Apr-14	59,871	1,616,834	27.005	-13.6%	758,154	23,235,973	30.648		28.346	29.480
May-14	61,698	1,719,848	27.875	-11.6%	755,992	22,941,523	30.346		28.427	29.448
Jun-14	61,865	1,749,791	28.284	-4.5%	753,700	22,791,312	30.239		28.511	29.415
Jul-14	62,451	1,811,678	29.010	-8.2%	751,538	22,561,292	30.020		28.592	29.383
Aug-14	62,672	1,786,430	28.504	-10.7%	749,438	22,280,786	29.730		28.676	29.350
Sep-14	62,499	1,827,513	29.241	-5.0%	747,334	22,120,224	29.599		28.761	29.317
Oct-14	62,342	1,893,506	30.373	-8.6%	745,353	21,875,689	29.349		28.843	29.285
Nov-14	62,228	1,730,937	27.816	-10.4%	743,269	21,609,393	29.073	-6.0%	28.928	29.252
Dec-14	61,920	2,023,083	32.673	-9.2%	741,464	21,338,974	28.780	-8.2%	29.011	29.220
Jan-15	66,417	1,850,793	27.866	1.8%	746,160	21,499,798	28.814	-7.3%	29.096	29.187
Feb-15	66,798	1,774,385	26.563	-0.6%	751,712	21,636,651	28.783	-7.1%	29.182	29.154
Mar-15	68,006	2,020,956	29.717	-2.2%	758,767	21,805,753	28.738	-7.2%	29.260	29.125
Apr-15	68,158	1,924,375	28.234	4.5%	767,054	22,113,294	28.829	-5.9%	29.346	29.092
May-15	67,577	1,939,933	28.707	3.0%	772,933	22,333,379	28.894	-4.8%	29.430	29.060
Jun-15	67,630	1,980,625	29.286	3.5%	778,698	22,564,213	28.977	-4.2%	29.517	29.028
Jul-15	67,279	1,944,322	28.899	-0.4%	783,526	22,696,857	28.968	-3.5%	29.601	28.996
Aug-15	66,786	1,942,384	29.084	2.0%	787,640	22,852,810	29.014	-2.4%	29.688	28.963
Sep-15	66,509	1,952,900	29.363	0.4%	791,650	22,978,197	29.026	-1.9%	29.776	28.931
Oct-15	66,490	2,007,404	30.191	-0.6%	795,798	23,092,095	29.018	-1.1%	29.861	28.899
Nov-15	66,086	1,950,696	29.518	6.1%	799,656	23,311,855	29.152	0.3%	29.949	28.867
Dec-15	65,999	2,187,910	33.151	1.5%	803,735	23,476,682	29.209	1.5%	30.035	28.835

Exponential Trend:	3.5%	-1.3%



Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.537	1.000	134.145
	0.000	3.268	0.000	0.687
	0.086	0.052	0.236	0.011
	1.498	16.000	4.946	16.000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 3E

PHARMACY TREND DEVELOPMENT
NON-SPECIALTY UTILIZATION TREND CALCULATION

Month	Membership	Total Days Supply	Days Supply PMPM	Regression on Adjusted PMPM - 18 Months	Average Induced Utilization Factor	Normalization Factor for Induced Utilization	Adjusted Days Supply - Normalized for Induced Utilization Factor	Adjusted PMPM	Regression on Adjusted PMPM - 18 Months
Jul-14	62,451	1,811,678	29.01	28.59	0.8975	1.0233	1,853,907	29.69	29.20
Aug-14	62,672	1,786,430	28.50	28.68	0.8979	1.0228	1,827,140	29.15	29.24
Sep-14	62,499	1,827,513	29.24	28.76	0.8985	1.0221	1,867,907	29.89	29.27
Oct-14	62,342	1,893,506	30.37	28.84	0.8989	1.0216	1,934,473	31.03	29.31
Nov-14	62,228	1,730,937	27.82	28.93	0.8991	1.0214	1,767,960	28.41	29.35
Dec-14	61,920	2,023,083	32.67	29.01	0.9005	1.0198	2,063,237	33.32	29.38
Jan-15	66,417	1,850,793	27.87	29.10	0.9188	0.9995	1,849,877	27.85	29.42
Feb-15	66,798	1,774,385	26.56	29.18	0.9188	0.9995	1,773,574	26.55	29.46
Mar-15	68,006	2,020,956	29.72	29.26	0.9184	0.9999	2,020,830	29.72	29.49
Apr-15	68,158	1,924,375	28.23	29.35	0.9183	1.0000	1,924,435	28.23	29.53
May-15	67,577	1,939,933	28.71	29.43	0.9183	1.0001	1,940,058	28.71	29.57
Jun-15	67,630	1,980,625	29.29	29.52	0.9184	0.9999	1,980,523	29.28	29.61
Jul-15	67,279	1,944,322	28.90	29.60	0.9185	0.9999	1,944,116	28.90	29.64
Aug-15	66,786	1,942,384	29.08	29.69	0.9185	0.9998	1,942,093	29.08	29.68
Sep-15	66,509	1,952,900	29.36	29.78	0.9184	0.9999	1,952,742	29.36	29.72
Oct-15	66,490	2,007,404	30.19	29.86	0.9185	0.9999	2,007,158	30.19	29.76
Nov-15	66,086	1,950,696	29.52	29.95	0.9185	0.9999	1,950,464	29.51	29.80
Dec-15	65,999	2,187,910	33.15	30.03	0.9184	1.0000	2,187,910	33.15	29.83
		Annual Increase		3.5%					1.5%

Regressions

	Regression on Adjusted PMPM - 18 Months
1.00010	0.5374
0.00008	3.2675
8.56%	0.0520
1.49769	16

	Regression on Adjusted PMPM - 18 Months
1.00004	5.1609
0.00008	3.5253
1.51%	0.0561
0.24467	16

Impact of Benefit Changes **-1.9%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 3F

PHARMACY TREND DEVELOPMENT
GENERIC DISPENSING RATE

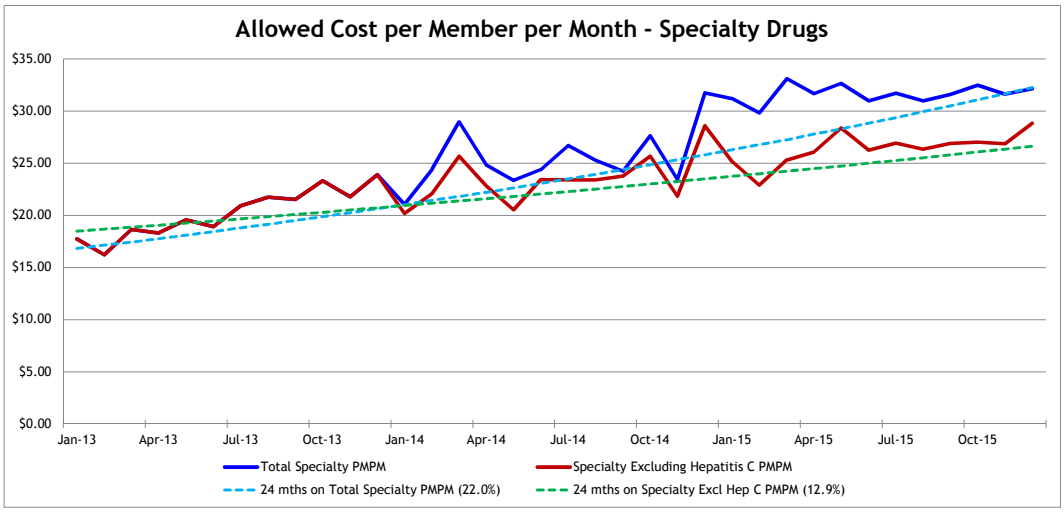
	Days Supply				Generic Dispensing Rate	
Month	Generic	Brands Losing Exclusivity	Brand	Total Non-Specialty	Monthly	Rolling 12
Jan-15	1,739,311		237,733	1,977,044	88.0%	
Feb-15	1,655,722		226,712	1,882,434	88.0%	
Mar-15	1,876,757		257,306	2,134,063	87.9%	
Apr-15	1,765,331		252,031	2,017,362	87.5%	
May-15	1,787,884		239,773	2,027,657	88.2%	
Jun-15	1,810,561		251,295	2,061,856	87.8%	
Jul-15	1,775,237		249,572	2,024,809	87.7%	
Aug-15	1,773,521		239,658	2,013,178	88.1%	
Sep-15	1,767,863		247,654	2,015,516	87.7%	
Oct-15	1,789,354		275,131	2,064,485	86.7%	
Nov-15	1,756,893		251,299	2,008,192	87.5%	
Dec-15	1,930,807		302,820	2,233,628	86.4%	87.6%
Jan-16	1,739,311	8,511	229,222	1,977,044	88.4%	87.6%
Feb-16	1,655,722	7,553	219,159	1,882,434	88.4%	87.7%
Mar-16	1,876,757	6,777	250,528	2,134,063	88.3%	87.7%
Apr-16	1,765,331	7,061	244,970	2,017,362	87.9%	87.7%
May-16	1,787,884	4,777	234,996	2,027,657	88.4%	87.8%
Jun-16	1,810,561	17,495	233,800	2,061,856	88.7%	87.8%
Jul-16	1,775,237	17,870	231,701	2,024,809	88.6%	87.9%
Aug-16	1,773,521	19,153	220,505	2,013,178	89.0%	88.0%
Sep-16	1,767,863	19,171	228,483	2,015,516	88.7%	88.1%
Oct-16	1,789,354	21,429	253,702	2,064,485	87.7%	88.1%
Nov-16	1,756,893	19,040	232,258	2,008,192	88.4%	88.2%
Dec-16	1,930,807	22,013	280,807	2,233,628	87.4%	88.3%
Jan-17	1,747,821	14,613	214,610	1,977,044	89.1%	88.4%
Feb-17	1,663,275	17,153	202,006	1,882,434	89.3%	88.4%
Mar-17	1,883,535	17,074	233,454	2,134,063	89.1%	88.5%
Apr-17	1,772,392	17,547	227,423	2,017,362	88.7%	88.6%
May-17	1,792,661	18,794	216,202	2,027,657	89.3%	88.7%
Jun-17	1,828,056	9,685	224,115	2,061,856	89.1%	88.7%
Jul-17	1,793,107	11,736	219,966	2,024,809	89.1%	88.7%
Aug-17	1,792,673	8,197	212,308	2,013,178	89.5%	88.8%
Sep-17	1,787,034	8,937	219,546	2,015,516	89.1%	88.8%
Oct-17	1,810,783	9,191	244,511	2,064,485	88.2%	88.9%
Nov-17	1,775,934	9,386	222,872	2,008,192	88.9%	88.9%
Dec-17	1,952,821	10,742	270,065	2,233,628	87.9%	88.9%

PHARMACY TREND DEVELOPMENT
SPECIALTY TREND CALCULATIONS

	MONTHLY DATA				PMPM		Rolling 12 PMPM		EXPONENTIAL FIT	
Incurred Date	Members	All Other Specialty Allowed Charges	New Treatments[1] Allowed Charges	Total Specialty Drug Allowed Charges	Total Specialty PMPM	Specialty Excluding Hepatitis C PMPM	Total Specialty PMPM	Specialty Excluding New Treatments PMPM	Total Specialty	Specialty Excluding New Treatments
Jan-13	64,294	$1,140,523	$0	$1,140,523	$17.74	$17.74			$16.82	$18.48
Feb-13	64,033	$1,038,632	$0	$1,038,632	$16.22	$16.22			$17.14	$18.68
Mar-13	64,088	$1,196,255	$0	$1,196,255	$18.67	$18.67			$17.44	$18.86
Apr-13	64,004	$1,172,192	$0	$1,172,192	$18.31	$18.31			$17.77	$19.06
May-13	63,860	$1,250,703	$0	$1,250,703	$19.59	$19.59			$18.10	$19.26
Jun-13	64,157	$1,213,840	$0	$1,213,840	$18.92	$18.92			$18.45	$19.46
Jul-13	64,613	$1,351,795	$0	$1,351,795	$20.92	$20.92			$18.79	$19.66
Aug-13	64,772	$1,408,859	$0	$1,408,859	$21.75	$21.75			$19.15	$19.87
Sep-13	64,603	$1,390,926	$0	$1,390,926	$21.53	$21.53			$19.52	$20.09
Oct-13	64,323	$1,499,750	$0	$1,499,750	$23.32	$23.32			$19.88	$20.29
Nov-13	64,312	$1,400,406	$0	$1,400,406	$21.78	$21.78			$20.26	$20.51
Dec-13	63,725	$1,522,359	$0	$1,522,359	$23.89	$23.89	$20.22	$20.22	$20.64	$20.72
Jan-14	61,721	$1,246,436	$52,034	$1,298,470	$21.04	$20.19	$20.49	$20.43	$21.03	$20.94
Feb-14	61,246	$1,353,255	$141,269	$1,494,525	$24.40	$22.10	$21.16	$20.91	$21.43	$21.17
Mar-14	60,951	$1,565,605	$200,239	$1,765,844	$28.97	$25.69	$22.00	$21.48	$21.80	$21.37
Apr-14	59,871	$1,366,885	$118,305	$1,485,190	$24.81	$22.83	$22.53	$21.86	$22.22	$21.60
May-14	61,698	$1,265,499	$175,773	$1,441,272	$23.36	$20.51	$22.85	$21.94	$22.63	$21.83
Jun-14	61,865	$1,450,019	$58,816	$1,508,834	$24.39	$23.44	$23.31	$22.32	$23.07	$22.06
Jul-14	62,451	$1,462,324	$205,519	$1,667,843	$26.71	$23.42	$23.80	$22.53	$23.49	$22.29
Aug-14	62,672	$1,466,431	$118,306	$1,584,737	$25.29	$23.40	$24.10	$22.67	$23.94	$22.53
Sep-14	62,499	$1,485,673	$29,745	$1,515,418	$24.25	$23.77	$24.33	$22.86	$24.40	$22.77
Oct-14	62,342	$1,601,710	$121,351	$1,723,062	$27.64	$25.69	$24.70	$23.06	$24.86	$23.00
Nov-14	62,228	$1,358,497	$100,390	$1,458,886	$23.44	$21.83	$24.84	$23.07	$25.33	$23.25
Dec-14	61,920	$1,770,970	$196,380	$1,967,349	$31.77	$28.60	$25.51	$23.46	$25.80	$23.49
Jan-15	66,417	$1,671,718	$400,016	$2,071,734	$31.19	$25.17	$26.38	$23.88	$26.30	$23.74
Feb-15	66,798	$1,528,436	$462,956	$1,991,391	$29.81	$22.88	$26.85	$23.94	$26.80	$23.99
Mar-15	68,006	$1,720,814	$530,906	$2,251,720	$33.11	$25.30	$27.24	$23.92	$27.26	$24.23
Apr-15	68,158	$1,777,625	$381,548	$2,159,173	$31.68	$26.08	$27.82	$24.20	$27.78	$24.49
May-15	67,577	$1,918,020	$287,426	$2,205,446	$32.64	$28.38	$28.60	$24.86	$28.30	$24.74
Jun-15	67,630	$1,776,220	$320,243	$2,096,463	$31.00	$26.26	$29.14	$25.09	$28.84	$25.00
Jul-15	67,279	$1,813,476	$320,553	$2,134,028	$31.72	$26.95	$29.56	$25.38	$29.38	$25.26
Aug-15	66,786	$1,759,629	$310,330	$2,069,960	$30.99	$26.35	$30.02	$25.62	$29.94	$25.53
Sep-15	66,509	$1,790,440	$312,619	$2,103,059	$31.62	$26.92	$30.61	$25.88	$30.51	$25.81
Oct-15	66,490	$1,798,086	$361,687	$2,159,773	$32.48	$27.04	$31.00	$25.99	$31.08	$26.07
Nov-15	66,086	$1,775,534	$315,938	$2,091,472	$31.65	$26.87	$31.64	$26.39	$31.67	$26.35
Dec-15	65,999	$1,903,574	$219,380	$2,122,955	$32.17	$28.84	$31.67	$26.42	$32.26	$26.62

1. New treatments include hepatitis C drugs, PCSK9 inhibitors, and Orkambi

Exponential Trend:	25.0%	13.3%
Aging Adjustment:	0.994	0.994
Adjusted Trend:	24.2%	12.6%



Regressions	24 Months on Monthly		24 Months on Annual	
	1.000612262	1.79503E-10	1.0003433	1.3003E-05
	1.0728E-05	0.450464867	8.874E-06	0.37260305
	99.33%	0.011066064	98.55%	0.00915332
	3255.139523	22	1496.122	22

PHARMACY TREND DEVELOPMENT
SPECIALTY TREND CALCULATIONS

Restated Specialty Drug Trend

Pharmacy Specialty Claims in the Experience (CY 2015)	A	$ 25,457,174
Claims Removed from the Experience (CY 2015)		
Hepatitis C	B1	$3,928,711
PCSK9 Inhibitors[1]	B2	$6,882
Orkambi	B3	$288,009
Total	B = B1+B2+B3	$4,223,601
Pharmacy Specialty Claims without Excluded Drugs in the Experience (CY 2015)	C = A - B	$21,233,572
Projected Specialty Claims using a 12.6% trend for 24 months	D = C x (1.126)^(24/12)	$26,929,484
Adding Incremental Cost of Excluded Treatments for the Projection Period		
Hepatitis C	E1	$4,649,067
PCSK9 Inhibitors	E2	$2,090,135
Orkambi	E3	$1,973,873
Total	E = E1+E2+E3	$8,713,075
Biosimilar Adjustment	F	($158,189)
Restated Projected Specialty Claims	G = D + E + F	$35,484,370
Restated Specialty Trend	**H = (G/A)^(12/24) -1**	**18.1%**

1. PCSK9 inhibitors in the formulary include Praluent, which was approved by the FDA on July 24, 2015, and Repatha, which was approved by the FDA on August 27, 2015.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 3H

PHARMACY TREND DEVELOPMENT
SUMMARY

		(1)	(2)	(3) = (1) + (2)	(4)	(5) = (3) + (4)	
		Generic	**Brand**	**Non-Specialty Total**	**Specialty**	**Total Pharmacy**	**PMPM**
Experience Period - Calendar Year 2015							
Member Months						816,633	
# Days Supply	a	21,429,241	3,030,982	24,460,224	144,704	24,604,928	
Allowed Charge per Supply	b	$0.83	$9.08		$183.10		
Total Allowed Charges	c=a*b	$17,821,859	$27,513,645	$45,335,503	$26,494,812	$71,830,315	$87.96
Utilization Trends							
Projected Utitlization Trend	d			**0.50%**			
Projected # Days Supply (1 yr)	$e=a*(1+d)^2$			24,705,438			
Projected Rolling-12 dispensing rate (Generic and Brand split)	f	**88.9%**	**11.1%**				
Non-Specialty Projected # Days Supply: Generic and Brand	g=f*e	21,971,221	2,734,216				
Utilization Trends: Generic and Brand	$h=(g/a)^{0.5}-1$	**1.3%**	**-5.0%**				
Cost Trends							
Calculated Annual Trend	*i*	*7.0%*	*8.8%*				
Projected Allowed Charge per Supply	$j=b*(1+i)^2$	$0.95	$10.75				
Projected Total Allowed Charges before Contract Changes	k=g*j	$20,920,302	$29,380,243	$50,300,545	$36,953,930	$87,254,475	$106.85
Annual Trend before Contract Changes	$l=(k/c)^{0.5}$	**8.3%**	**3.3%**		**18.1%**	**10.2%**	
Reduction of Projected Claims due to Contract Changes	m	0.8339	0.9962		0.9874		
Projected Total Allowed Charges after Contract Changes	n=k*m	$17,445,440	$29,268,598	*$46,714,038*	$36,488,311	$83,202,349	$101.88

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 3I

MEDICAL TREND DEVELOPMENT
PROJECTION FACTOR FOR INDEX RATE CALCULATION

TREND FACTORS			
Annual	**Cost**	**Utilization**	**Total**
Medical	3.3%	1.0%	4.3%
Pharmacy	9.7%	0.5%	10.2%

MEDICAL

Coverage Category in the Experience	Membership	CY 2015 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2017 Allowed PMPM Adjuted for Network and Small Group Definition
Individual Non-Subsidized QHP	124,629	$456.38	1.0671	$487.00	1.0201	$496.79
Individual Subsidized QHP	211,659	$466.36	1.0671	$497.65	1.0201	$507.65
Small Group QHP	429,795	$380.58	1.0671	$406.12	1.0201	$414.28
Groups with 51-100 employees known to have joined QHP	43,108	$489.18	1.0671	$521.99	1.0201	$532.49
Groups with 51-100 employees expected to join QHP	7,442	$487.30	1.0671	$520.00	1.0201	$530.45

PHARMACY

Coverage Category in the Experience	Membership	CY 2015 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2017 Allowed PMPM Adjuted for Network and Small Group Definition
Individual Non-Subsidized QHP	124,629	$105.44	1.2028	$126.82	1.0100	$128.09
Individual Subsidized QHP	211,659	$95.10	1.2028	$114.39	1.0100	$115.53
Small Group QHP	429,795	$78.30	1.2028	$94.17	1.0100	$95.12
Groups with 51-100 employees known to have joined QHP	43,108	$96.36	1.2028	$115.90	1.0100	$117.06
Groups with 51-100 employees expected to join QHP	7,442	$101.21	1.2028	$121.74	1.0100	$122.96

		Cost Trend (24mths)		Utilization Trend (24mths)		Impact of Pharmacy Contract Changes	Projected 2017 Allowed Claims
Medical	$421.09	1.0671	$449.34	1.0201	$458.37	1.0000	$458.37
Pharmacy	$87.96	1.2028	$105.79	1.0100	$106.85	0.9535	$101.88
Total	$509.05	1.0905	$555.13	1.0182	$565.22	0.9912	$560.25

Cost Trend Factor	$1+d_1$	1.0905
Utilization Trend Factor	$1+d_2$	1.0182
Impact of Pharmacy Contract Changes factor	$1+c_5$	0.9912

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 4

EXPECTED RISK ADJUSTMENT TRANSFERS

	Transfer Amounts	
	Combined Market	**Catastrophic Market**
Actual 2014	-$2,691,752	$21,502
Estimated 2015 based on Interim Report	-$1,379,536	-$84,378
Estimated 2016, includes a 7.7% average premium increase	-$1,486,071	-$90,894
Estimated 2016, includes a 7.7% average premium increase and 1.5% coding growth assuption for Other Carriers	-$1,119,916	-$90,894
Estimated 2017 before Medicaid Membership adjustment, includes a 7.7% average premium increase and 1.5% coding growth assuption for Other Carriers	-$806,858	-$97,913
Estimated 2017 after Medicaid Membership adjustment, includes a 7.7% average premium increase and 1.5% coding growth assuption for Other Carriers	-$1,170,268	-$97,913

* receivable are expressed as negative numbers

Projected Risk Adjusment Transfer	-$1,268,182
Projected Risk Adjustment Fee ($1.56 per enrollee per year)	$120,959
Net Projected Risk Adjusment	**-$1,147,222**
Member Months	930,456
Net Projected Risk Adjusment PMPM	-$1.23
Paid to Allowed Ratio (from Exh 6C)	79.32%
Market Wide Adjustment for the Risk Adjustment Program	**-$1.55**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 5

INDEX RATE CALCULATION

Index Rate : Experience Period Allowed Claims for EHB	A	$503.97
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of the Change in Small Group definition	$1+b_1$	1.0114
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	1.0086
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 VHC Settlement	$1+b_8$	0.9951
Changes in pool morbidity	$1+b_9$	0.9896
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	0.9859
Changes in provider networks	$1+c_2$	0.9987
Changes in demographics (age, gender, region, etc.)	$1+c_3$	1.0058
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in pharmacy contract	$1+c_5$	0.9912
Impact of Selection	$1+c_6$	1.0105
Adjusted Experience Period Allowed Claims for EHB		$502.12
Trend Factors		
Cost Trend	$1+d_1$	1.0905
Utilization Trend	$1+d_2$	1.0182
Projected Period Allowed Claims for Experience EHB		$557.53
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$7.89
Projected Blue Print Payments	e_2	$3.63
Projected ITS Fees	e_3	$1.84
Projected Vaccine Payments	e_4	$1.88
Projected Net cost of Reinsurance	e_5	$1.32
Additional Adjustments for Additional Benefits		
Projected Allowed Claims for Pediatric Vision	e_6	$0.50
Projected Allowed Claims for Pediatric Dental	e_7	$1.84
Projected Index Rate	$F = A\prod_{n=1}^{8}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$560.66
Market Wide Adjustments		
Risk Adjustment Payments and Fees	g_1	-$1.55
Transitional Reinsurance Payments and Recoveries	g_2	$0.00
Vermont Exchange Fees	g_3	$0.00
Market Adjusted Index Rate	$H = F + \sum_{n=1}^{3} g_n$	**$559.11**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6A

PLAN LEVEL ADJUSTMENT SUMMARY

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11
Benefit Richness Adjustment	1.0183	1.0003	0.9722	0.9569	0.9383	1.0957	1.0330	0.9823	0.9782	0.9402	0.9408	0.9315	
Paid to Allowed Ratio	83.57%	80.45%	75.39%	71.71%	66.54%	93.07%	86.01%	77.27%	76.76%	67.31%	67.63%	66.54%	
Plan Benefits in addition to EHB	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	1.0002	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5042	
Expected Claims Cost	**$475.88**	**$449.98**	**$409.87**	**$383.72**	**$349.15**	**$570.21**	**$496.86**	**$424.41**	**$419.86**	**$353.93**	**$355.80**	**$174.78**	**$445.10**
Administrative Charges Plan Level Adjustment	1.0757	1.0806	1.0873	1.0941	1.1029	1.0589	1.0674	1.0789	1.0799	1.0946	1.0941	1.2046	
Taxes and Fees Plan Level Adjustment	1.0096	1.0096	1.0095	1.0095	1.0095	1.0097	1.0097	1.0096	1.0096	1.0095	1.0095	1.0091	
Contribution to Reserve Plan Level Adjustment	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	
Plan Level Adjusted Index Rate	**$528.70**	**$502.18**	**$460.26**	**$433.56**	**$397.68**	**$623.68**	**$547.80**	**$472.92**	**$468.28**	**$400.12**	**$402.05**	**$217.33**	**$495.07**
Projected Membership	1,588	6,356	5,938	3,893	4,033	12,995	7,299	19,148	9,970	2,949	3,200	169	77,538

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6B

PLAN LEVEL ADJUSTMENT
BENEFIT RICHNESS ADJUSTMENT FACTOR

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	1,588	6,356	5,938	3,893	4,033	12,995	7,299	19,148	9,970	2,949	3,200	169	77,538
Base Paid to Allowed Ratio	82.58%	79.43%	73.74%	69.97%	64.10%	93.54%	84.93%	75.92%	75.06%	64.79%	65.00%	61.16%	
Benefit Richness Adjustment for EHB	1.0961	1.0766	1.0463	1.0299	1.0099	1.1796	1.1120	1.0572	1.0528	1.0119	1.0125	1.0025	1.0763
Normalized Benefit Richness Adjustment for EHB	1.0184	1.0003	0.9721	0.9568	0.9383	1.0959	1.0331	0.9822	0.9781	0.9401	0.9407	0.9314	
Projected Period Paid Claims for Experience EHB	$466.04	$448.87	$420.36	$400.26	$371.69	$518.85	$479.55	$430.86	$428.39	$375.64	$377.56	$371.24	
Benefit Richness Adjustment for EHB	1.0184	1.0003	0.9721	0.9568	0.9383	1.0959	1.0331	0.9822	0.9781	0.9401	0.9407	0.9314	1.0000
Additional EHB Paid Claims	$1.63	$1.36	$1.59	$1.10	$0.79	$1.94	$1.79	$1.59	$1.21	$1.16	$1.01	$1.25	
Non-System Claims	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	
Market Wide Adjustments (Paid)	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	
Total Paid Claims with Benefit Richness Adjustment	$475.80	$449.90	$409.80	$383.64	$349.08	$570.12	$496.78	$424.34	$419.78	$353.87	$355.73	$346.57	
Overall Benefit Richness Adjustment	1.0183	1.0003	0.9722	0.9569	0.9383	1.0957	1.0330	0.9823	0.9782	0.9402	0.9408	0.9315	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6C

PLAN LEVEL ADJUSTMENT
PAID TO ALLOWED RATIOS

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total
Projected Membership	1,588	6,356	5,938	3,893	4,033	12,995	7,299	19,148	9,970	2,949	3,200	169	77,538
Projected Period Allowed Claims for Experience EHB	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53	$557.53
Paid to Allowed Ratio for EHB Portion	83.59%	80.51%	75.40%	71.79%	66.67%	93.06%	86.01%	77.28%	76.84%	67.38%	67.72%	66.59%	79.32%
Projected Period Paid Claims for Experience EHB	$466.04	$448.87	$420.36	$400.26	$371.69	$518.85	$479.55	$430.86	$428.39	$375.64	$377.56	$371.24	$442.22
Additional EHB Allowed Claims	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34	$2.34
Additional EHB Paid Claims	$1.63	$1.36	$1.59	$1.10	$0.79	$1.94	$1.79	$1.59	$1.21	$1.16	$1.01	$1.25	$1.49
Non-System Claims	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79	$0.79
Market Wide Adjustments (Paid)	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23	-$1.23
Market Wide Adjustments (Allowed)	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55	-$1.55
Market Adjusted Index Rate	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11
Total Paid Claims	$467.23	$449.78	$421.51	$400.92	$372.03	$520.34	$480.89	$432.00	$429.16	$376.36	$378.12	$372.05	$443.27
Paid to Allowed Ratio	83.57%	80.45%	75.39%	71.71%	66.54%	93.07%	86.01%	77.27%	76.76%	67.31%	67.63%	66.54%	79.28%

For Section 3 of worksheet 1 of the URRT

Expected Claims Cost (from Exhibit 6A)	$445.10
Non-EHB benefit claims cost	$0.08
Market-wide adjustment	$1.23
Projected Incurred Claims, before market-wide adjustments	$446.42
Projected Index Rate	$560.66
Projected Non-EHB Claims	$0.10
Projected Allowed Experience Claims	$560.76
Paid to Allowed Ratio = $446.42/$560.76	79.6%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6D

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

	Percent of Eligible Population	Projected Allowed Charges for Experience EHB	Paid to Allowed Ratio for EHB Claims	Projected Paid Claims for EHB Claims
Average Population	100.0%	$560.25	69.5%	$389.49
Individual Ages 30 or Less	94.4%	$300.22	60.0%	$180.19
Individual Ages over 30	5.6%	$661.52	70.0%	$463.04
Weighted Average		$320.30	61.2%	$195.90
Allowed Charges Adjustment		*0.5717*		
Paid to Allowed Ratio Adjustment			*0.8798*	
Plan Level Adjustment Calculation				
Projected Period Allowed Claims for Experience EHB		$557.53		
Paid to Allowed Ratio for EHB Portion		66.6%		
Benefit Richness Adjustment for EHB		0.9314		
Adjustment for Allowed Charges and Paid to Allowed Ratio		*0.5030*		
Projected Period Paid Claims for Experience EHB		$173.91		
Additional EHB Paid Claims		$1.25		
Non-System Claims		$0.79		
Market Wide Adjustments		-$1.23		
Non-EHB Benefits		$0.07		
Expected Claims Cost		$174.78		
Market Adjusted Index Rate		$559.11		
Paid to Allowed Ratio		66.5%		
Benefit Richness Adjustment		0.9315		
Plan Benefits in addition to EHB		1.0002		
For Catastrophic Only - Impact of Eligibility		0.5042		
Expected Claims Cost		$174.78		
Total Adjustment for Catastrophic Plan			**0.5042**	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 7A

DETAILS OF ADMINISTRATIVE CHARGES

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
BCBSVT Base Administrative Charges	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10	$33.10
Administrative Charges for Outside Vendors	$0.58	$0.83	$0.35	$0.67	$0.52	$0.47	$0.38	$0.37	$0.43	$0.39	$0.39	$0.34	$0.46
Blue Rewards Program	$2.32	$2.32	$2.32	$2.32	$2.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.32	$0.66
Total Administrative Charges PMPM	**$36.00**	**$36.25**	**$35.77**	**$36.10**	**$35.94**	**$33.58**	**$33.49**	**$33.47**	**$33.53**	**$33.49**	**$33.50**	**$35.76**	**$34.22**
Administrative Charges Plan Level Adjustment	1.0757	1.0806	1.0873	1.0941	1.1029	1.0589	1.0674	1.0789	1.0799	1.0946	1.0941	1.2046	1.0769
Administrative Charges as a percent of Premium	6.81%	7.22%	7.77%	8.33%	9.04%	5.38%	6.11%	7.08%	7.16%	8.37%	8.33%	16.45%	**6.91%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 7B

DETAILS OF CONTRIBUTION TO RESERVE

Section 1

BCBSVT Totals		2016 Forecast	2017 Forecast
Premium/Premium Equivalent			
QHP	A	$395,836,846	$459,647,930
Large Group Insured	B	$88,502,778	$69,329,905
Medicare Supplement	C	$9,513,260	$9,513,260
Medicare Part D	D	$5,137,935	$5,137,935
Cost Plus	E	$349,329,922	$293,251,878
Total Premium Shares	F = (A+B+C+D) + 25% x E	$586,323,299	$616,941,999
Investment Income	G	$2,694,286	$2,694,286
Tax Rate	H	20%	20%
Investment Income Net of Taxes	J = G x (1-H)	$2,155,429	$2,155,429
QHP Share of Investment Income	K = J x A/F	$1,455,167	$1,605,886

Estimated YE 2016 Authorized Control Level (ACL)	L	$24,970,342
Estimated YE 2017 ACL	M	$27,509,271
Increase in Capital Required to Maintain Target RBC	N = 600% x (M-L)	$15,233,574
Additional Required Grossed Up for FIT	P = N/(1-H)	$19,041,968
CTR Required in 2017	Q = P-K	$17,436,082
Required Insured CTR Factor to Maintain Target RBC		**3.8%**

Section 2

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
BCBSVT Contribution to Reserve	$10.57	$10.04	$9.21	$8.67	$7.95	$12.47	$10.96	$9.46	$9.37	$8.00	$8.04	$4.35	$9.90
Risk Margin for Bad Debt	$1.32	$1.26	$1.15	$1.08	$0.99	$1.56	$1.37	$1.18	$1.17	$1.00	$1.01	$0.54	$1.24
Total Contribution to Reserve PMPM	**$11.90**	**$11.30**	**$10.36**	**$9.76**	**$8.95**	**$14.03**	**$12.33**	**$10.64**	**$10.54**	**$9.00**	**$9.05**	**$4.89**	**$11.14**
Contribution to Reserve and Risk Margin Plan Level Adjustment	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230	1.0230
Contribution to Reserve as a percent of Premium	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Risk Margin Bad Debt as a percent of Premium	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 7C

DETAILS OF TAXES AND FEES

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**Total**
State Assessment - HCCA	$3.78	$3.57	$3.25	$3.04	$2.76	$4.53	$3.94	$3.36	$3.33	$2.80	$2.82	$1.37	$3.53
State Tax - VITL	$0.94	$0.89	$0.81	$0.76	$0.69	$1.13	$0.98	$0.84	$0.83	$0.70	$0.70	$0.34	$0.88
Federal Assessment - PCORI	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20
Federal Insurer Fee	$0.00	$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 Taxes and Fees PMPM	**$4.91**	**$4.66**	**$4.26**	**$3.99**	**$3.65**	**$5.86**	**$5.12**	**$4.40**	**$4.35**	**$3.70**	**$3.72**	**$1.91**	**$4.61**
Taxes and Fees Plan Level Adjustment	1.0096	1.0096	1.0095	1.0095	1.0095	1.0097	1.0097	1.0096	1.0096	1.0095	1.0095	1.0091	1.0096
Taxes and Fees as a percent of Premium	0.93%	0.93%	0.92%	0.92%	0.92%	0.94%	0.94%	0.93%	0.93%	0.92%	0.92%	0.88%	0.93%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 7D

AV PRICING VALUE

	NON-STANDARD PLANS					STANDARD PLANS						
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Market Wide Adjusted Index Rate	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11
Plan Level Adjusted Index Rate	$528.70	$502.18	$460.26	$433.56	$397.68	$623.68	$547.80	$472.92	$468.28	$400.12	$402.05	$217.33
AV Pricing Value	94.56%	89.82%	82.32%	77.54%	71.13%	111.55%	97.98%	84.58%	83.75%	71.56%	71.91%	38.87%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 8

FEDERAL MINIMUM LOSS RATIO for COMBINED MARKET
(PROJECTION)

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
Expected Direct Claims PMPM	$477.61	$451.56	$410.87	$384.55	$348.94	$574.83	$498.70	$425.49	$420.90	$353.74	$355.61	$173.84	$446.71
Risk Adjustment Transfer Payments PMPM	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36	-$1.36
Adjustments for Health Care Quality PMPM*	$5.12	$5.14	$5.10	$5.12	$5.11	$2.79	$2.78	$2.78	$2.78	$2.78	$2.78	$5.10	$3.44
MLR Claims	**$481.36**	**$455.34**	**$414.60**	**$388.32**	**$352.68**	**$576.25**	**$500.12**	**$426.91**	**$422.32**	**$355.16**	**$357.03**	**$177.57**	**$448.79**
Premium PMPM	$528.70	$502.18	$460.26	$433.56	$397.68	$623.68	$547.80	$472.92	$468.28	$400.12	$402.05	$217.33	$495.07
Licensing and regulatory fees	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13	-$0.13
Taxes & Fees PMPM	-$1.14	-$1.09	-$1.01	-$0.95	-$0.89	-$1.33	-$1.18	-$1.04	-$1.03	-$0.90	-$0.90	-$0.54	-$1.08
MLR Premium	**$527.43**	**$500.97**	**$459.12**	**$432.48**	**$396.67**	**$622.22**	**$546.49**	**$471.76**	**$467.12**	**$399.10**	**$401.03**	**$216.67**	**$493.86**
Expected Loss Ratio	91.3%	90.9%	90.3%	89.8%	88.9%	92.6%	91.5%	90.5%	90.4%	89.0%	89.0%	82.0%	90.9%
Projected Membership	1,588	6,356	5,938	3,893	4,033	12,995	7,299	19,148	9,970	2,949	3,200	169	77,538

*Approximately 8.3% of current BCBSVT Administrative Charges are for health care quality plus the Blue Rewards PMPM

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 9

CONSUMER ADJUSTED PREMIUM RATES

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium for Inforce Contracts
Plan Level Adjusted Index Rate	$528.70	$502.18	$460.26	$433.56	$397.68	$623.68	$547.80	$472.92	$468.28	$400.12	$402.05	$217.33	
PMPM to Single Contract Conversion Factor	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	
2017 Proposed Rates													
Single Rate	$587.23	$557.77	$511.21	$481.56	$441.70	$692.72	$608.44	$525.27	$520.12	$444.41	$446.56	$241.39	
Couple Rate	$1,174.46	$1,115.54	$1,022.42	$963.12	$883.40	$1,385.44	$1,216.88	$1,050.54	$1,040.24	$888.82	$893.12	$482.78	
Adult and Child(ren) Rate	$1,133.35	$1,076.50	$986.64	$929.41	$852.48	$1,336.95	$1,174.29	$1,013.77	$1,003.83	$857.71	$861.86	$465.88	
Family Rate	$1,650.12	$1,567.33	$1,436.50	$1,353.18	$1,241.18	$1,946.54	$1,709.72	$1,476.01	$1,461.54	$1,248.79	$1,254.83	$678.31	$420,111,873
2016 Approved Rates													
Single Rate	$531.33	$506.32	$465.16		$401.92	$656.63	$573.36	$484.49	$468.90	$409.17	$406.84	$229.41	
Couple Rate	$1,062.66	$1,012.64	$930.32		$803.84	$1,313.26	$1,146.72	$968.98	$937.80	$818.34	$813.68	$458.82	
Adult and Child(ren) Rate	$1,025.47	$977.20	$897.76		$775.71	$1,267.30	$1,106.58	$935.07	$904.98	$789.70	$785.20	$442.76	
Family Rate	$1,493.04	$1,422.76	$1,307.10		$1,129.40	$1,845.13	$1,611.14	$1,361.42	$1,317.61	$1,149.77	$1,143.22	$644.64	$388,384,890
2017 Proposed Rate Increases													
Single Rate	10.5%	10.2%	9.9%		9.9%	5.5%	6.1%	8.4%	10.9%	8.6%	9.8%	5.2%	
Couple Rate	10.5%	10.2%	9.9%		9.9%	5.5%	6.1%	8.4%	10.9%	8.6%	9.8%	5.2%	
Adult and Child(ren) Rate	10.5%	10.2%	9.9%		9.9%	5.5%	6.1%	8.4%	10.9%	8.6%	9.8%	5.2%	
Family Rate	10.5%	10.2%	9.9%		9.9%	5.5%	6.1%	8.4%	10.9%	8.6%	9.8%	5.2%	**8.2%**
Inforce Contracts													
Single Rate	727	1,598	2,560		1,649	4,272	2,767	7,151	3,122	1,245	1,477	153	
Couple Rate	185	623	663		453	1,607	777	2,181	1,049	330	354	3	
Adult and Child(ren) Rate	42	155	85		89	390	187	325	164	57	95	2	
Family Rate	183	844	203		371	1,270	700	1,041	850	206	320	2	

May 9, 2016

Mr. Dana Houlihan
Director, Enrollment Policy & Plan Management
VT Health Connect
Department of Vermont Health Access
Via Email Only

RE: State of Vermont Actuarial Value Certification for 2017 Standard Plan Designs

Dear Dana:

This memo replaces an earlier version provided on February 29, 2016. The Internal Revenue Code for 2017 per § 223(c)(2)(A), released on May 3, 2016, stated that the individual maximum out of pocket (MOOP) limit for High Deductible Health Plans (HDHP) would remain unchanged from the 2016 limit at $6,550. The prior memo included two bronze HSA plans with a MOOP of $6,600, which was estimated based on the historical increase in the IRS limit over the last several years as the limit had not yet been released. This iteration of the memo updates these plans to have a MOOP equal to the IRS limit of $6,550. In order to maintain compliance with the bronze metal tier, the deductible on both of these plans has been increased $50.

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 2017 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.

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

The State contracted with Wakely Consulting Group, Inc. (Wakely) to assist in the development of the standard plan designs. A list of the changes from the 2016 standard plan designs is in Appendix B. At a high level the changes for each base standard plan are:

- Platinum – changes made to the medical deductible, medical MOOP, drug MOOP, specialist copay, and preferred brand drug copay
- Gold – changes made to the medical deductible, drug deductible, medical MOOP, drug MOOP, specialist copay, and preferred brand drug copay
- Silver Deductible – changes made to the medical deductible, medical MOOP, drug MOOP, integrating the medical MOOP to a combined medical and drug MOOP, and specialist copay
- Bronze Deductible – changes made to the medical deductible, drug deductible, combined medical/drug MOOP, drug MOOP, and specialist and preferred brand copays
- Silver HDHP – changes made to the medical deductible and combined medical/drug MOOP
- Bronze HDHP – changes made to the medical deductible and combined medical/drug MOOP

For the Silver and Bronze HDHP plans, there are two options from which the issuers may choose one at each level, consistent with the 2016 standard plan designs. Beginning in 2016, the regulations[2] require that all individuals, even those in non-self only contracts, have an out of pocket limit no more than the single limit ($6,850 in 2016 and $7,150 in 2017). This impacts HDHPs where the aggregate MOOP application could require an individual to have out of pocket costs higher than the individual limit. Compliance with this regulation can be done by adjusting the family MOOP in two ways. The first option has an aggregate family medical MOOP with an embedded $7,150 individual maximum. The second option has a stacked family medical MOOP. Both options comply with the federal regulations on individual maximum out of pocket costs. Since the first option has operational challenges, the issuers are allowed to choose one from either Option for the HDHP standard plans.

In addition to the standard plans, starting in 2016 the State of Vermont is requesting that issuers offer a Gold plan where the deductible and MOOP are set at the same amount. This means that once the deductible is met, the plan pays 100% of all services. Unlike the standard plans, it is not required that issuers offer this plan, but it is highly recommended. The issuer may determine the amount at which to set the deductible and MOOP, as long as they are equal and the resulting plan falls in the Gold tier. Since the amounts are to be determined by the issuers, these plans are not included within this memo.

Four of the standard plan designs (and the cost sharing reduction plan designs) have features not supported by the AVC and thus an actuarial certification is required. The remaining standard plan designs 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; and*
- ASOP No. 41 *Actuarial Communications*.
- ASOP No. 50 *Determining Minimum Value and Actuarial Value under the Affordable Care Act*

[2] http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

EXECUTIVE SUMMARY

A summary of Vermont's standard plan designs is in Appendix D. 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[3]. 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. Note that due to the new regulation in 2016, if the family MOOP is more than the single limit of $7,150, the MOOP must either be stacked or there must be an embedded individual MOOP of $7,150. Wakely had previously developed a model to account for aggregate family deductibles and has modified this model to account for stacked and embedded MOOPs for HDHPs. Thus, a specific adjustment has been made to the appropriate AVs for HDHPs.

2. Vermont implemented a statute (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 ($1,300 and $2,600 for individual and family coverage in 2017). The requirement also states that for HDHPs the cost sharing benefit for prescription drugs must start after the minimum deductible amount for HDHPs (same $1,300 and $2,600 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 $1,300 for individual or $2,600 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 $1,300 or $2,600, 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 statute has a

[3] 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.

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. Wakely has not analyzed the exact portion of drugs this represents and this may vary by issuer. 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. Appendix E contains a list of the dental procedure codes that are classified as Class I and have no cost sharing. 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 dental services would be highest for the bronze plan where the deductible is highest and the impact would decrease as deductibles decrease (and AVs increase).

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 table in Appendix F 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 and the impact to higher AV plans is less significant.

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 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. For the 2016 AV adjustments, this model was updated with more recent data and an option was added to account for embedded/stacked MOOPs.

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 2012
- 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 2.3 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 six structural selections available in the model, described in the table below. Option 5 is most closely aligned to the federal AVC. Option 6 represents the design of the Vermont HDHPs. This changed from Option 1 due to the new federal regulations in 2016.

	Costs that Accumulate			
		Maximum Out-of-Pocket (MOOP)		
Options	Deductible	Medical	Rx	Deductible / MOOP Type
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
6	Medical & Rx	Medical & Rx	Rx Only	Aggregate Deductible /Aggregate MOOP with Embedded Ind MOOP (can also be used for Stacked MOOP)

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 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). The application of deductible and MOOP was also changed to use an aggregate family deductible and either a stacked MOOP or an aggregate family MOOP with an embedded individual MOOP. For the stacked application of the MOOP, all individuals are subject to a MOOP equal to the individual MOOP in addition to the family MOOP. The aggregate family MOOP has an embedded individual MOOP equal to $7,150.

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 and Silver deductible plans (and associated CSR plans) need 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 and Silver Deductible plans.

1. Same as for HDHPs, as much of the plan design as possible was entered into the AVC. This is the unadjusted AV. The Bronze and Silver Deductible plans then need to be adjusted for the lower and separate prescription drug MOOP.

2. The HDHP model was used to develop the AV adjustments in a slightly different process than for the HDHPs.
   a. Instead of normalizing the HDHP model to the AVC, the normalization factor for the Bronze or Silver HDHP was used.
   b. 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.
   c. 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.

3. The final AV is the ratio of the AV from 2c and 2b applied to the AV from the AVC in 1.

Appendix G 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 and Silver Deductible plans, a calculation of the adjustment.

RELIANCES

We have relied on others for information used in the actuarial value adjustments. For the original AV, the final 2017 federal AVC model was relied on. While reasonability tests have shown 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
Partner and Senior Consulting Actuary

Brittney Phillips, ASA, MAAA
Associate Actuary

APPENDIX A

Actuarial Certification
State of Vermont
Actuarial Value of Standard Plan Designs
Effective January 1, 2017

I, Julie A. Peper, am associated with the firm of Wakely Consulting Group, LLC. (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, 2017 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 2017 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 develop 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 Deductible, Silver HDHP CSR 73%, Silver HDHP CSR 77%, Silver HDHP CSR 87%, Silver HDHP CSR 94%, Silver Deductible CSR 73%, and Silver Deductible CSR 77%) that will be effective as of January 1, 2017 for individual and group coverage sold 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
May 9, 2016

APPENDIX B

Summary of Plan Design Changes from 2016 designs

	Deductible Plans	
Plan	**Platinum**	**Gold**
Changes	Increase medical deductible to $250 from $150 Increase medical MOOP to $1,300 from $1,250 Increase pharmacy MOOP to $1,300 from $1,250 Increase specialist office visit copay to $30 from $20 Increase Rx preferred brand copay to $50 from $40	Increase medical deductible to $850 from $750 Increase pharmacy deductible to $100 from $50 Increase medical MOOP to $4,500 from $4,250 Increase pharmacy MOOP to $1,300 from $1,250 Increase specialist office visit copay to $30 from $25 Increase Rx preferred brand copay to $50 from $40

	Deductible Plans	
Plan	**Silver**	**Bronze**
Changes	Increase medical deductible to $2,150 from $2,000 Increase medical MOOP to $6,000 from $5,600 Increase pharmacy MOOP to $1,300 from $1,250 Integrate the medical MOOP to medical/Rx MOOP Increase specialist office visit copay to $65 from $50	Increase medical deductible to $4,600 from $4,000 Increase pharmacy deductible to $700 from $500 Increase medical/Rx MOOP to $7,150 from $6,850 Increase pharmacy MOOP to $1,300 from $1,250 Increase specialist office visit copay to $90 from $85 Increase Rx preferred brand copay to $85 from $80

	HDHPs	
Plan	**Silver - Embedded MOOP**	**Silver - Stacked MOOP**
Changes	Increase medical deductible to $1,550 from $1,425 Increase medical/Rx MOOP to $6,400 from $5,750 Increase embedded single MOOP to $7,150 from $6,850	Increase medical deductible to $1,600 from $1,550 Increase medical/Rx MOOP to $6,400 from $5,750

	HDHPs	
Plan	**Bronze - Embedded MOOP**	**Bronze - Stacked MOOP**
Changes	Increase medical deductible to $5,050 from $4,100 Increase medical/Rx MOOP to $6,550 from $6,500 Increase embedded single MOOP to $7,150 from $6,850	Increase medical deductible to $5,300 from $4,400 Increase medical/Rx MOOP to $6,550 from $6,500

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*;
- ASOP No. 41, Actuarial Communications; and
- ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act.

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.

ASOP 41: 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.

ASOP 50: Determining Minimum Value and Actuarial Value under the Affordable Care Act

3.1 Use of AVC or MVC – The federal AVC was used.

3.2 Exceptions to the AVC – The federal AV was determined by making adjustments to the results of the federal AVC based on provisions that could not be appropriate modeled in the AVC.

3.3 Exceptions to the MVC – Not applicable.

3.4 Evaluating Non-Standard Plan Designs – The HDHP model was normalized to the federal AVC.

3.5 Reasonableness of Assumptions for Non-Standard Plan Designs – The assumptions used to modify the federal AVs were reviewed for reasonability.

3.6 Unreasonable Results – Not applicable.

3.7 Documentation – See ASOP 41 documentation above.

APPENDIX D

Standard Plan Designs –Deductible Plans

	2017 Plan Designs - Deductible Plans			
Deductible/OOP Max	**Platinum**	**Gold**	**Silver**	**Bronze**
Type of Plan	Deductible	Deductible	Deductible	Deductible
Medical Ded	$250	$850	$2,150	$4,600
Rx Ded	$0	$100	$150	$700
Integrated Ded	No	No	No	No
Medical OOPM	$1,300	$4,500	$6,000	$7,150
Rx OOPM	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	No	No	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb	Preventive
Drug Deductible waived for:	N/A	Generic scripts	Generic scripts	Applies to all scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	10%	20%	40%	50%
Outpatient [2]	10%	20%	40%	50%
ER [3]	$100	$150	$250	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%
Preventive	$0	$0	$0	$0
PCP Office Visit	$10	$15	$25	$35
MH/SA Office Visit	$10	$15	$25	$35
Specialist Office Visit [4]	$30	$30	$65	$90
Urgent Care	$40	$45	$60	$100
Ambulance	$50	$50	$100	$100
Rx Generic	$5	$5	$15	$20
Rx Preferred Brand	$50	$50	$60	$85
Rx Non-Preferred Brand	50%	50%	50%	60%
Actuarial Value				
2017 Final Federal AVC, Adjusted if Necessary	89.1%	82.0%	71.5%	61.3%

Standard Plan Designs – Cost Sharing Reduction Plans (Deductibles)

	2017 Plan Designs – Deductible CSR Plans			
Deductible/OOP Max	**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
Medical Ded	$2,150	$1,600	$600	$100
Rx Ded	$150	$150	$100	$0
Integrated Ded	No	No	No	No
Medical OOPM	$4,900	$3,700	$1,300	$700
Rx OOPM	$1,200	$1,000	$400	$200
Integrated OOPM	Rx -No, Medical - Yes	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
Medical Deductible waived for:	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	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	40%	40%	40%	10%
Outpatient [2]	40%	40%	40%	10%
ER [3]	$250	$250	$250	$75
Radiology (MRI, CT, PET)	40%	40%	40%	10%
Preventive	$0	$0	$0	$0
PCP Office Visit	$25	$20	$10	$5
MH/SA Office Visit	$25	$20	$10	$5
Specialist Office Visit [4]	$65	$40	$30	$15
Urgent Care	$60	$60	$50	$35
Ambulance	$100	$100	$100	$50
Rx Generic	$12	$12	$10	$5
Rx Preferred Brand	$60	$60	$50	$20
Rx Non-Preferred Brand	50%	50%	50%	30%
Actuarial Value				
2017 Final Federal AVC, Adjusted if Necessary	73.8%	77.4%	87.5%	94.8%

Standard Plan Designs – HDHP Plans

	2017 Plan Designs - HDHP Plans Option 1: Embedded MOOP		2017 Plan Designs - HDHP Plans Option 2: Stacked MOOP	
Deductible/OOP Max	**Silver**	**Bronze**	**Silver**	**Bronze**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$1,550	$5,050	$1,600	$5,300
Rx Ded	$1,300	$1,300	$1,300	$1,300
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$6,400	$6,550	$6,400	$6,550
Rx OOPM	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Aggregate with Combined Medical/Rx embedded $7,150 Single MOOP; 2x Individual	Aggregate with Combined Medical/Rx embedded $7,150 Single MOOP; 2x Individual	Ded and Rx MOOP-Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual	Ded and Rx MOOP-Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	25%	50%	25%	50%
Outpatient [2]	25%	50%	25%	50%
ER [3]	25%	50%	25%	50%
Radiology (MRI, CT, PET)	25%	50%	25%	50%
Preventive	0%	0%	0%	0%
PCP Office Visit	10%	50%	10%	50%
MH/SA Office Visit	10%	50%	10%	50%
Specialist Office Visit [4]	25%	50%	25%	50%
Urgent Care	25%	50%	25%	50%
Ambulance	25%	50%	25%	50%
Rx Generic	$10	$12	$10	$12
Rx Preferred Brand	$40	40%	$40	40%
Rx Non-Preferred Brand	50%	60%	50%	60%
Actuarial Value				
2017 Final Federal AVC, Adjusted if Necessary	70.0%	60.9%	70.0%	61.0%

Standard Plan Designs – Cost Sharing Reduction Plans (HDHP – Embedded MOOP)

	2017 Plan Designs – HDHP Option 1: Embedded MOOP CSR Plans			
Deductible/OOP Max	**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	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,550	$1,300	$1,250	$550
Rx Ded	$1,300	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,100	$3,000	$1,250	$550
Rx OOPM	$1,300	$1,300	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate with Combined Medical/Rx embedded $7,150 Single MOOP; 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	25%	25%	0%	0%
Outpatient [2]	25%	25%	0%	0%
ER [3]	25%	25%	0%	0%
Radiology (MRI, CT, PET)	25%	25%	0%	0%
Preventive	0%	0%	0%	0%
PCP Office Visit	10%	10%	0%	0%
MH/SA Office Visit	10%	10%	0%	0%
Specialist Office Visit [4]	25%	25%	0%	0%
Urgent Care	25%	25%	0%	0%
Ambulance	25%	25%	0%	0%
Rx Generic	$10	$10	$0	$0
Rx Preferred Brand	$40	$40	$0	$0
Rx Non-Preferred Brand	50%	50%	0%	0%
Actuarial Value				
2017 Final Federal AVC, Adjusted if Necessary	72.8%	76.7%	86.7%	93.8%

Standard Plan Designs – Cost Sharing Reduction Plans (HDHP – Stacked MOOP)

	HDHP Stacked MOOP CSR Plan Options			
Deductible/OOP Max	**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	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,600	$1,400	$1,300	$550
Rx Ded	$1,300	$1,300	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,700	$3,400	$1,300	$550
Rx OOPM	$1,300	$1,300	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Ded and Rx MOOP- Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual	Ded and Rx MOOP- Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual	Ded and Rx MOOP- Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual	Ded and Rx MOOP- Aggregate, Combined Medical/Rx MOOP - Stacked; 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	25%	25%	0%	0%
Outpatient [2]	25%	25%	0%	0%
ER [3]	25%	25%	0%	0%
Radiology (MRI, CT, PET)	25%	25%	0%	0%
Preventive	0%	0%	0%	0%
PCP Office Visit	10%	10%	0%	0%
MH/SA Office Visit	10%	10%	0%	0%
Specialist Office Visit [4]	25%	25%	0%	0%
Urgent Care	25%	25%	0%	0%
Ambulance	25%	25%	0%	0%
Rx Generic	$10	$10	$0	$0
Rx Preferred Brand	$40	$40	$0	$0
Rx Non-Preferred Brand	50%	50%	0%	0%
Actuarial Value				
2017 Final Federal AVC, Adjusted if Necessary	72.7%	76.8%	86.7%	93.9%

APPENDIX E

Class I Pediatric Dental Codes

These procedures are diagnostic and preventive in nature. Under the definition of what is essential they may have limits. The services and limits are described in the Department of Vermont Health Access, Dental Procedure/Fee Schedule (Effective for services provided on or after 11/01/2013)

D0120 Periodic Oral Evaluation
D0140 Limited Oral Evaluation – Problem Focused
D0145 Oral Evaluation for a patient under three years of age and counseling with primary caregiver
D0150 Comprehensive Oral Evaluation
D0170 Re-evaluation – Limited, Problem Focused
D0210 Intraoral Radiographs– Complete Series (including bitewings)
D0220 Intraoral Radiographs – Periapical – First Film
D0230 Intraoral Radiographs– Periapical – Each Additional Film
D0240 Intraoral – Occlusal Film
D0250 Extraoral – First Film
D0260 Extraoral – Each Additional Film
D0270 Bitewing – Single Film
D0272 Bitewings – 2 Films
D0273 Bitewings – 3 Films
D0274 Bitewings – 4 Films
D0330 Panoramic Film
D0340 Cephalometric Film
D0350 Oral/Facial Photographic Images
D0364 Cone Beam CT Capture and Interpretation with Limited Field of View - Less Than One Whole Jaw
D0365 Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch - Mandible
D0366 Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch - Maxilla, with or without Cranium
D0367 Cone Beam CT Capture and Interpretation with Limited Field of View of Both Jaws, With or Without Cranium
D0368 Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures
D0391 Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including the Report
D0470 Diagnostic Models
D1120 Prophylaxis – Child
D1208 Topical Application of Fluoride
D1330 Oral Hygiene Instructions
D1351 Sealant – Per Tooth
D1351 U9 Sealant – Per Tooth-Deciduous second molars and bicuspids*
D1352 Preventive resin restoration in a moderate to high caries risk patient -permanent tooth
D1510 Space Maintainer - Fixed – Unilateral
D1515 Space Maintainer – Fixed – Bilateral
D1525 Space Maintainer – Removable – Bilateral
D1550 Recementation of Space Maintainer

APPENDIX F

Summary of Adjustments Considered and Final Adjusted AVs

Adjustments Considered	Aggregate Ded	Aggregate MOOP, Embedded $7,150	Stacked MOOP	Drug Regulation	Preventive Drugs	Pediatric Dental	AV from AVC	Final Adjusted AV
Silver HDHP – Embedded $7,150 Individual MOOP	Yes	Yes	No	Yes	Yes	Yes	72.2%	70.0%
Bronze HDHP– Embedded $7,150 Individual MOOP	Yes	Yes	No	Yes	Yes	Yes	61.8%	60.9%
Silver HDHP – Stacked MOOP	Yes	No	Yes	Yes	Yes	Yes	71.9%	70.0%
Bronze HDHP– Stacked MOOP	Yes	No	Yes	Yes	Yes	Yes	61.6%	61.0%
Silver Deductible	No	No	No	Yes	No	Yes	71.0%	71.5%
Bronze Deductible	No	No	No	Yes	No	Yes	60.4%	61.3%
Silver HDHP - Embedded $7,150 Individual MOOP CSR 73%	Yes	Yes	No	Yes	Yes	Yes	75.3%	72.8%
Silver HDHP - Embedded $7,150 Individual MOOP CSR 77%	Yes	Yes	No	Yes	Yes	Yes	79.0%	76.7%
Silver HDHP - Embedded $7,150 Individual MOOP CSR 87%	Yes	Yes	No	No	Yes	Yes	87.2%	86.7%
Silver HDHP - Embedded $7,150 Individual MOOP CSR 94%	Yes	Yes	No	No	Yes	Yes	93.8%	93.8%
Silver HDHP - Stacked MOOP CSR 73%	Yes	No	Yes	Yes	Yes	Yes	74.0%	72.7%
Silver HDHP - Stacked MOOP CSR 77%	Yes	No	Yes	Yes	Yes	Yes	77.6%	76.8%
Silver HDHP - Stacked MOOP CSR 87%	Yes	No	Yes	No	Yes	Yes	86.8%	86.7%
Silver HDHP - Stacked MOOP CSR 94%	Yes	No	Yes	No	Yes	Yes	93.8%	93.9%
Silver Deductible CSR – 73%	No	No	No	Yes	No	Yes	73.3%	73.8%
Silver Deductible CSR – 77%	No	No	No	Yes	No	Yes	77.1%	77.4%
Silver Deductible CSR – 87%	No	No	No	Yes	No	Yes	87.5%	87.5%
Silver Deductible CSR – 94%	No	No	No	Yes	No	Yes	94.7%	94.8%

APPENDIX G

Screen shots and AV Development

1. Silver HDHP – Embedded MOOP
2. Bronze HDHP – Embedded MOOP
3. Silver HDHP – Stacked MOOP
4. Bronze HDHP – Stacked MOOP
5. Silver Deductible Plan
6. Bronze Deductible Plan
7. Silver HDHP – Embedded MOOP CSR – 73%
8. Silver HDHP – Embedded MOOP CSR – 77%
9. Silver HDHP – Embedded MOOP CSR – 87%
10. Silver HDHP – Embedded MOOP CSR – 94%
11. Silver HDHP – Stacked MOOP CSR – 73%
12. Silver HDHP – Stacked MOOP CSR – 77%
13. Silver HDHP – Stacked MOOP CSR – 87%
14. Silver HDHP – Stacked MOOP CSR – 94%
15. Silver Deductible CSR – 73%
16. Silver Deductible CSR – 77%
17. Silver Deductible CSR – 87%
18. Silver Deductible CSR – 94%

1. **Silver HDHP – Embedded MOOP**

AV from AVC = 72.2%
Adjusted AV = 70.0%

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,400.00			
OOP Maximum if Separate ($)						

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	Copay applies only after deductible? Tier 1	Copay applies only after deductible? Tier 2
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 72.20%
Metal Tier:

2017 AV Calculator

1. Silver HDHP – Embedded MOOP, 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	6,400	6,400
Family Out-of-Pocket	12,800	12,800
Coinsurance (50% or Less)	23%	29%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$189.07	$23.34	$212.42
Actuarial Value	74.3%	58.9%	72.2%

1. **Silver HDHP – Embedded MOOP, 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	6,400	1,300
Family Out-of-Pocket	12,800	2,600
Coinsurance (50% or Less)	23%	29%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$180.71	$25.20	$205.91
Actuarial Value	71.0%	63.6%	70.0%

2. **Bronze HDHP – Embedded MOOP**

AV from AVC = 61.8%
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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,050.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,550.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name:	[Input Plan Name]
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.83%
Metal Tier:	Bronze

2017 AV Calculator

2. Bronze HDHP – Embedded MOOP, 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	5,050	5,050
Family Deductible	10,100	10,100
Individual Out-of-Pocket	6,550	6,550
Family Out-of-Pocket	13,100	13,100
Coinsurance (50% or Less)	48%	43%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$313.31	$48.83	$362.14
Plan PMPM	$200.78	$23.17	$223.95
Actuarial Value	64.1%	47.5%	61.8%

2. Bronze HDHP – Embedded MOOP, 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	5,050	1,300
Family Deductible	10,100	2,600
Individual Out-of-Pocket	6,550	1,300
Family Out-of-Pocket	13,100	2,600
Coinsurance (50% or Less)	48%	43%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$311.98	$48.62	$360.60
Plan PMPM	$190.80	$28.89	$219.68
Actuarial Value	61.2%	59.4%	60.9%

3. Silver HDHP – Stacked MOOP

AV from AVC = 71.9%
Adjusted AV = 70.0%

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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,600.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$6,400.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.94%
Metal Tier:	Silver

2017 AV Calculator

3. **Silver HDHP – Stacked MOOP, 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	1,600	1,600
Family Deductible	3,200	3,200
Individual Out-of-Pocket	6,400	6,400
Family Out-of-Pocket	12,800	12,800
Coinsurance (50% or Less)	23%	29%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$188.26	$23.16	$211.42
Actuarial Value	74.0%	58.4%	71.9%

4.

3. **Silver HDHP – Stacked MOOP, 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	1,600	1,300
Family Deductible	3,200	2,600
Individual Out-of-Pocket	6,400	1,300
Family Out-of-Pocket	12,800	2,600
Coinsurance (50% or Less)	23%	29%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$180.78	$25.12	$205.90
Actuarial Value	71.1%	63.4%	70.0%

4. **Bronze HDHP – Stacked MOOP**

AV from AVC = 61.6%
Adjusted AV = 61.0%

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	$0.00

Narrow Network Options	
Blended Network/POS Plan?	☐
1st Tier Utilization:	100%
2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,300.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,550.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name:	[Input Plan Name]
Plan HIOS ID:	[Input Plan HIOS ID]
Issuer HIOS ID:	[Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.64%
Metal Tier:	Bronze

2017 AV Calculator

4. Bronze HDHP – Stacked MOOP, 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	5,300	5,300
Family Deductible	10,600	10,600
Individual Out-of-Pocket	6,550	6,550
Family Out-of-Pocket	13,100	13,100
Coinsurance (50% or Less)	48%	43%
Individual Embedded Moop:	6,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$311.98	$48.62	$360.60
Plan PMPM	$199.11	$22.94	$222.05
Actuarial Value	63.8%	47.2%	61.6%

4. **Bronze HDHP – Stacked MOOP, 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	5,300	1,300
Family Deductible	10,600	2,600
Individual Out-of-Pocket	6,550	1,300
Family Out-of-Pocket	13,100	2,600
Coinsurance (50% or Less)	48%	43%
Individual Embedded Moop:	6,550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$311.98	$48.62	$360.60
Plan PMPM	$191.32	$28.76	$220.08
Actuarial Value	61.3%	59.1%	61.0%

5.

Silver Deductible

AV from AVC = 71.0%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 68.4%/67.9% = 1.007 x .710 = 71.5%

Adjusted AV = 71.5%

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: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,150.00	$150.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$6,000.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$65.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$65.00	☑	☑			☐	☐
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			☐ All	☐ All
Generics	☐	☐		$15.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.01%
Metal Tier: Silver

2017 AV Calculator

5. Silver 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	2,150	150
Family Deductible	4,300	300
Individual Out-of-Pocket	6,000	6,000
Family Out-of-Pocket	12,000	12,000
Coinsurance (50% or Less)	36%	38%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$172.25	$27.28	$199.53
Actuarial Value	67.7%	68.8%	67.9%

5. **Silver 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	2,150	150
Family Deductible	4,300	300
Individual Out-of-Pocket	6,000	1,300
Family Out-of-Pocket	12,000	2,600
Coinsurance (50% or Less)	36%	38%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$254.40	$39.65	$294.05
Plan PMPM	$171.52	$29.53	$201.06
Actuarial Value	67.4%	74.5%	68.4%

6. Bronze Deductible

AV from AVC = 60.4%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 63.0%/62.1% = 1.014 x .604 = 61.3%

Adjusted AV = 61.3%

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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$4,600.00	$700.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
OOP Maximum ($)	$7,150.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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	☑	☐		$90.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☐		$90.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$90.00	☑	☑			☑	☐
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			☐ All	☐ All
Generics	☑	☐		$20.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$85.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 60.44%
Metal Tier: Bronze

2017 AV Calculator

6. **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	4,600	700
Family Deductible	9,200	1,400
Individual Out-of-Pocket	7,150	7,150
Family Out-of-Pocket	14,300	14,300
Coinsurance (50% or Less)	47%	52%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$311.98	$48.62	$360.60
Plan PMPM	$195.70	$28.22	$223.92
Actuarial Value	62.7%	58.0%	62.1%

6. **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	4,600	700
Family Deductible	9,200	1,400
Individual Out-of-Pocket	7,150	1,300
Family Out-of-Pocket	14,300	2,600
Coinsurance (50% or Less)	47%	52%

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$311.98	$48.62	$360.60
Plan PMPM	$193.80	$33.44	$227.24
Actuarial Value	62.1%	68.8%	63.0%

7. Silver HDHP – Embedded MOOP CSR – 73%

AV from AVC = 75.3%
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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$4,100.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	☐

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 75.32%
Metal Tier:

2017 AV Calculator

7. **Silver HDHP – Embedded MOOP 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	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	4,100	4,100
Family Out-of-Pocket	8,200	8,200
Coinsurance (50% or Less)	23%	29%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$281.18	$43.82	$325.00
Plan PMPM	$217.35	$27.31	$244.66
Actuarial Value	77.3%	62.3%	75.3%

7. **Silver HDHP – Embedded MOOP 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	1,550	1,300
Family Deductible	3,100	2,600
Individual Out-of-Pocket	4,100	1,300
Family Out-of-Pocket	8,200	2,600
Coinsurance (50% or Less)	23%	29%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$281.18	$43.82	$325.00
Plan PMPM	$208.11	$28.62	$236.73
Actuarial Value	74.0%	65.3%	72.8%

8. Silver HDHP – Embedded MOOP CSR – 77%

AV from AVC = 79.0%
Adjusted AV = 76.7%

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: Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$3,000.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	☐

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 79.01%
Metal Tier:

2017 AV Calculator

8. **Silver HDHP – Embedded MOOP 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	3,000	3,000
Family Out-of-Pocket	6,000	6,000
Coinsurance (50% or Less)	23%	28%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$294.57	$45.91	$340.48
Plan PMPM	$238.20	$30.83	$269.02
Actuarial Value	80.9%	67.2%	79.0%

8. Silver HDHP – Embedded MOOP 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	3,000	1,300
Family Out-of-Pocket	6,000	2,600
Coinsurance (50% or Less)	23%	28%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$294.57	$45.91	$340.48
Plan PMPM	$230.43	$30.87	$261.29
Actuarial Value	78.2%	67.2%	76.7%

9. Silver HDHP – Embedded MOOP CSR – 87%

AV from AVC = 87.2%
Adjusted AV = 86.7%

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	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,250.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.22%
Metal Tier:	Gold

2017 AV Calculator

9. **Silver HDHP – Embedded MOOP 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	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	1,250	1,250
Family Out-of-Pocket	2,500	2,500
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$291.30	$40.84	$332.14
Actuarial Value	88.4%	79.6%	87.2%

9. **Silver HDHP – Embedded MOOP 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	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	1,250	1,250
Family Out-of-Pocket	2,500	2,500
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$289.59	$40.60	$330.19
Actuarial Value	87.9%	79.1%	86.7%

10. **Silver HDHP – Embedded MOOP CSR – 94%**

AV from AVC = 93.8%
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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$550.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$550.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.77%
Metal Tier:	Platinum

2017 AV Calculator

10. **Silver HDHP – Embedded MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$329.10	$48.50	$377.59
Actuarial Value	94.5%	89.4%	93.8%

10. **Silver HDHP – Embedded MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$329.12	$48.44	$377.56
Actuarial Value	94.5%	89.3%	93.8%

11. **Silver HDHP – Stacked MOOP CSR – 73%**

AV from AVC = 74.0%
Adjusted AV = 72.7%

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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,600.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$4,700.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 74.01%
Metal Tier:

2017 AV Calculator

11. **Silver HDHP – Stacked MOOP 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	1,600	1,600
Family Deductible	3,200	3,200
Individual Out-of-Pocket	4,700	4,700
Family Out-of-Pocket	9,400	9,400
Coinsurance (50% or Less)	23%	29%
Individual Embedded Moop:	4,700	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$273.15	$42.57	$315.71
Plan PMPM	$207.57	$25.91	$233.48
Actuarial Value	76.0%	60.9%	74.0%

11. **Silver HDHP – Stacked MOOP 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	1,600	1,300
Family Deductible	3,200	2,600
Individual Out-of-Pocket	4,700	1,300
Family Out-of-Pocket	9,400	2,600
Coinsurance (50% or Less)	23%	29%
Individual Embedded Moop:	4,700	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$273.15	$42.57	$315.71
Plan PMPM	$202.04	$27.51	$229.55
Actuarial Value	74.0%	64.6%	72.7%

12. **Silver HDHP – Stacked MOOP CSR – 77%**

AV from AVC = 77.6%
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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,400.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$3,400.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ 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:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 77.55%
Metal Tier:

2017 AV Calculator

12. **Silver HDHP – Stacked MOOP 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	1,400	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)	23%	28%
Individual Embedded Moop:	3,400	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$291.89	$45.49	$337.38
Plan PMPM	$232.16	$29.76	$261.92
Actuarial Value	79.5%	65.4%	77.6%

12. **Silver HDHP – Stacked MOOP 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	1,400	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)	23%	28%
Individual Embedded Moop:	3,400	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$291.89	$45.49	$337.38
Plan PMPM	$228.70	$30.35	$259.05
Actuarial Value	78.3%	66.7%	76.8%

13. **Silver HDHP – Stacked MOOP CSR – 87%**

AV from AVC = 86.8%
Adjusted AV = 86.7%

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	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,300.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	☐

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.80%
Metal Tier:	Gold

2017 AV Calculator

13. **Silver HDHP – Stacked MOOP 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	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	1,300	1,300
Family Out-of-Pocket	2,600	2,600
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	1,300	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$290.08	$40.55	$330.63
Actuarial Value	88.1%	79.0%	86.8%

13. **Silver HDHP – Stacked MOOP 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	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	1,300	1,300
Family Out-of-Pocket	2,600	2,600
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	1,300	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$291.44	$38.70	$330.14
Actuarial Value	88.5%	75.4%	86.7%

14. **Silver HDHP – Stacked MOOP CSR – 94%**

AV from AVC = 93.8%
Adjusted AV = 93.9%

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: Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$550.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$550.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ 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			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 93.77%
Metal Tier: Platinum

2017 AV Calculator

14. Silver HDHP – Stacked MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$329.10	$48.50	$377.59
Actuarial Value	94.5%	89.4%	93.8%

14. **Silver HDHP – Stacked MOOP 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	550	550
Family Deductible	1,100	1,100
Individual Out-of-Pocket	550	550
Family Out-of-Pocket	1,100	1,100
Coinsurance (50% or Less)	0%	0%
Individual Embedded Moop:	550	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate Plus	6

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$330.45	$47.56	$378.02
Actuarial Value	94.9%	87.7%	93.9%

15. **Silver Deductible CSR – 73%**

AV from AVC = 73.3%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 71.1%/70.7% = 1.006 x .733 = 73.8%

Adjusted AV = 73.8%

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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,150.00	$150.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$4,900.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$65.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$65.00	☑	☑			☐	☐
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			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	☐

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 73.34%
Metal Tier: Silver

2017 AV Calculator

15. **Silver Deductible CSR – 73%**

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	2,150	150
Family Deductible	4,300	300
Individual Out-of-Pocket	4,900	4,900
Family Out-of-Pocket	9,800	9,800
Coinsurance (50% or Less)	36%	36%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$277.16	$43.20	$320.36
Plan PMPM	$195.60	$30.80	$226.40
Actuarial Value	70.6%	71.3%	70.7%

15. **Silver Deductible CSR – 73%**

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	2,150	150
Family Deductible	4,300	300
Individual Out-of-Pocket	4,900	1,200
Family Out-of-Pocket	9,800	2,400
Coinsurance (50% or Less)	36%	36%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$277.16	$43.20	$320.36
Plan PMPM	$194.75	$32.99	$227.74
Actuarial Value	70.3%	76.4%	71.1%

16. **Silver Deductible CSR – 77%**

AV from AVC = 77.1%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 76.1%/75.8% = 1.004 x .771 = 77.4%

Adjusted AV = 77.4%

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: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$1,600.00	$150.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$3,700.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$40.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$20.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
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			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☐		$60.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 77.14%
Metal Tier:

2017 AV Calculator

16. **Silver Deductible CSR – 77%**

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	1,600	150
Family Deductible	3,200	300
Individual Out-of-Pocket	3,700	3,700
Family Out-of-Pocket	7,400	7,400
Coinsurance (50% or Less)	34%	36%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$293.23	$45.70	$338.93
Plan PMPM	$222.98	$33.83	$256.80
Actuarial Value	76.0%	74.0%	75.8%

16. **Silver Deductible CSR – 77%**

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	1,600	150
Family Deductible	3,200	300
Individual Out-of-Pocket	3,700	1,000
Family Out-of-Pocket	7,400	2,000
Coinsurance (50% or Less)	34%	36%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$293.23	$45.70	$338.93
Plan PMPM	$222.04	$35.86	$257.89
Actuarial Value	75.7%	78.5%	76.1%

17. **Silver Deductible CSR – 87%**

AV from AVC = 87.5%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 88.5%/88.5% = 1.000 x .875 = 87.5%

Adjusted AV = 87.5%

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: Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$100.00				
Coinsurance (%, Insurer's Cost Share)	60.00%	50.00%				
OOP Maximum ($)	$1,300.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$30.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00	☑	☑			☐	☐
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			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☐		$50.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost? ☐
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):

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.48%
Metal Tier: Gold

2017 AV Calculator

17. **Silver Deductible CSR – 87%**

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	600	100
Family Deductible	1,200	200
Individual Out-of-Pocket	1,300	1,300
Family Out-of-Pocket	2,600	2,600
Coinsurance (50% or Less)	33%	31%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$292.99	$44.03	$337.01
Actuarial Value	89.0%	85.8%	88.5%

17. **Silver Deductible CSR – 87%**

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	600	100
Family Deductible	1,200	200
Individual Out-of-Pocket	1,300	400
Family Out-of-Pocket	2,600	800
Coinsurance (50% or Less)	33%	31%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$329.38	$51.33	$380.71
Plan PMPM	$291.97	$45.15	$337.12
Actuarial Value	88.6%	88.0%	88.5%

18. **Silver Deductible CSR – 94%**

AV from AVC = 94.7%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 96.0%/95.9% = 1.001 x .947 = 94.8%

Adjusted AV = 94.8%

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:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$100.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	90.00%	70.00%				
OOP Maximum ($)	$700.00					
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$75.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☐	☐		$15.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$15.00	☑	☑			☐	☐
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			☐ All	☐ All
Generics	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$20.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
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):	

Plan Description:

Name: [Input Plan Name]
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.74%
Metal Tier: Platinum

2017 AV Calculator

18. **Silver Deductible CSR – 94%**

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	100	0
Family Deductible	200	0
Individual Out-of-Pocket	700	700
Family Out-of-Pocket	1,400	1,400
Coinsurance (50% or Less)	9%	14%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked	5

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$334.86	$51.18	$386.04
Actuarial Value	96.2%	94.3%	95.9%

18. **Silver Deductible CSR – 94%**

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	100	0
Family Deductible	200	0
Individual Out-of-Pocket	700	200
Family Out-of-Pocket	1,400	400
Coinsurance (50% or Less)	9%	14%
Individual Embedded Moop:	7,150	

	Costs that Accumulate				
		OOP		Deductible /	
	Deductible	Medical	Rx	OOP Type	
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked	2

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$348.13	$54.25	$402.38
Plan PMPM	$334.49	$51.78	$386.27
Actuarial Value	96.1%	95.4%	96.0%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Introduction

On January 21, 2016, CMS released the final methodology on the Actuarial Value and the final Actuarial Value Calculator (AVC) for 2017. CMS made few changes in the 2017 AVC. Most notably, they trended the underlying claims to calendar year.

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 Blue Rewards (Non-Standard) plans are:

- The AVC does not support the Rx OOPM Limit as dictated by Act 171.
- 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 measure all cost sharing elements for that plan. We created a model to calculate the ratio of expected benefits to allowed charges. See the description of the BCBSVT AV Model (BAVM) below. We used the BAVM to calculate both the complete benefit design and the benefit design for items supported by the AVC. We then applied the ratio of the two values to the AVC output for items supported by the AVC.

BCBSVT AV Model Methodology

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). The in-network claims from BCBSVT Insured Groups and Individuals expected to be in the Qualified Health Plans in 2017, representing 771,212 member months, are included in the analysis. Claims have been adjusted to reflect the network used for BCBSVT QHPs. Calendar year 2013 claims, trended to 2017 using 6.5% trend[1], were used in the model. The claims were categorized based on the cost sharing applied for each service, and one record was generated for each unique combination of member and service

[1] BCBSVT used the same trend that CMS used in the 2017 Final AV Calculator (see page 6 of https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf)

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

The tables following the Actuarial Opinion show the relationship between the BAVM and the AVC.

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

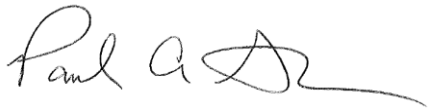
The purpose of this calculation is to comply with the requirements of 45 CFR 156.135(b)(3). The Actuarial Values were determined based on the plans' benefits and coverage data, the standard population, utilization and continuance tables published by HHS for purposes of valuation of Actuarial Value. These 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 2017.

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 A. Schultz, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Blue Rewards CDHP Plans

Plan : Blue Rewards (Non-Standard) CDHP Plan - Gold			
Items supported by the AV Calculator	Deductible	$2,500	
	Coinsurance	0%	
	OOPM	$2,500	
AVC Output for items supported by the AVC		(a)	78.2%
BCBSVT Model Output for items supported by the AVC		(b)	80.5%
BCBSVT Model Output for complete benefit design		(c)	81.2%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**78.8%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
In 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):

Plan Description:
Name: Blue Rewards CDHP - Gold
Plan HIOS ID: 13627VT0390001 and 13627VT0370001
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.19%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Silver			
Items supported by the AV Calculator	Deductible	$4,500	
	Coinsurance	0%	
	OOPM	$4,500	
AVC Output for items supported by the AVC		(a)	67.6%
BCBSVT Model Output for items supported by the AVC		(b)	72.3%
BCBSVT Model Output for complete benefit design		(c)	73.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**69.0%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
On 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):

Plan Description:
Name: Blue Rewards CDHP - Silver
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 67.64%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan – Silver 73% CSR			
Items supported by the AV Calculator	Deductible	$3,500	
	Coinsurance	0%	
	OOPM	$3,500	
AVC Output for items supported by the AVC		(a)	72.3%
BCBSVT Model Output for items supported by the AVC		(b)	76.0%
BCBSVT Model Output for complete benefit design		(c)	77.0%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**73.2%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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	Medical	Drug	Combined
Deductible ($)			$3,500.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$3,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
On 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 73%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 72.29%
Metal Tier: Silver

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan – Silver 77% CSR			
Items supported by the AV Calculator	Deductible	$2,800	
	Coinsurance	0%	
	OOPM	$2,800	
AVC Output for items supported by the AVC		(a)	76.1%
BCBSVT Model Output for items supported by the AVC		(b)	79.1%
BCBSVT Model Output for complete benefit design		(c)	79.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**76.7%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$2,800.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,800.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
In 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 77%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 76.11%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan – Silver 87% CSR			
Items supported by the AV Calculator	Deductible	$1,300	
	Coinsurance	0%	
	OOPM	$1,300	
AVC Output for items supported by the AVC		(a)	86.8%
BCBSVT Model Output for items supported by the AVC		(b)	87.6%
BCBSVT Model Output for complete benefit design		(c)	87.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**86.9%**

Items not supported by the AV Calculator for this plan are Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,300.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 87%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

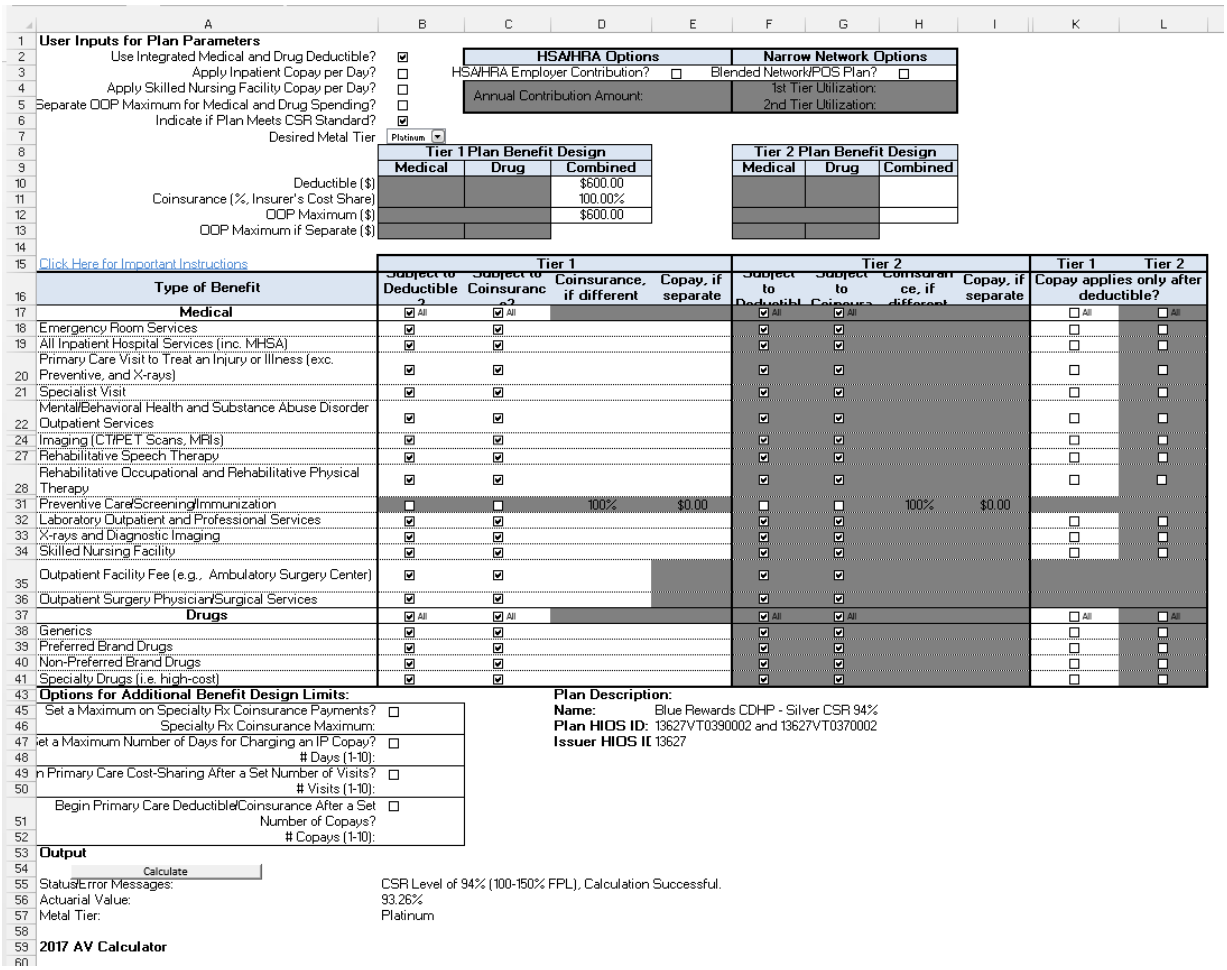
Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 86.80%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan – Silver 94% CSR			
Items supported by the AV Calculator	Deductible	$600	
	Coinsurance	0%	
	OOPM	$600	
AVC Output for items supported by the AVC		(a)	93.3%
BCBSVT Model Output for items supported by the AVC		(b)	93.3%
BCBSVT Model Output for complete benefit design		(c)	93.3%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**93.3%**

Items not supported by the AV Calculator for this plan are Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.



User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
In 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 94%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 93.26%
Metal Tier: Platinum

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Bronze			
Items supported by the AV Calculator	Deductible	$7,150	
	Coinsurance	0%	
	OOPM	$7,150	
AVC Output for items supported by the AVC		(a)	59.4%
BCBSVT Model Output for items supported by the AVC		(b)	64.6%
BCBSVT Model Output for complete benefit design		(c)	66.9%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**61.6%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$7,150.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):	
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):	

Plan Description:
Name: Blue Rewards CDHP - Bronze
Plan HIOS ID: 13627VT0390003 and 13627VT0370003
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 59.43%
Metal Tier: Bronze

2017 AV Calculator

Blue Rewards Copayment Plans

Items not supported by the AV Calculator for these plans are

- Pharmacy MOOP of $1,300
- Three Mental Health office visits at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care

For Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, we blended the Office Visit copayment and the Outpatient Facility copayment based on the frequency of services from the continuance tables in the AVC to calculate the input needed in the AVC.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan - Gold			
Items supported by the AV Calculator	Deductible	$1,250	
	Coinsurance	0%	
	OOPM	$4,250	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	79.4%
BCBSVT Model Output for items supported by the AVC		(b)	82.5%
BCBSVT Model Output for complete benefit design		(c)	84.2%
Estimated AVC value		(d)=(c)/(b)*(a)	**81.0%**

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	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$4,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
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 different	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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$20.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$30.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$19.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$30.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):

Plan Description:

Name: Blue Rewards Gold
Plan HIOS ID: 13627VT0380001 and 13627VT0360001
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.35%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver			
Items supported by the AV Calculator	Deductible	$2,300	
	Coinsurance	0%	
	OOPM	$7,150	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	69.5%
BCBSVT Model Output for items supported by the AVC		(b)	74.2%
BCBSVT Model Output for complete benefit design		(c)	76.4%
Estimated AVC value		(d)=(c)/(b)*(a)	**71.6%**

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 ($)			$2,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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 Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):

Plan Description:
Name: Blue Rewards Silver
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 69.48%
Metal Tier: Silver

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 73%			
Items supported by the AV Calculator	Deductible	$2,100	
	Coinsurance	0%	
	OOPM	$5,700	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	71.8%
BCBSVT Model Output for items supported by the AVC		(b)	75.7%
BCBSVT Model Output for complete benefit design		(c)	77.7%
Estimated AVC value		(d)=(c)/(b)*(a)	**73.6%**

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 ($)			$2,100.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,700.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☐ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):

Plan Description:
Name: [Input Plan Name]
Plan HIOS ID [Input Plan HIOS ID]
Issuer HIOS [Input Issuer HIOS ID]

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 71.78%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 77%			
Items supported by the AV Calculator	Deductible	$1,300	
	Coinsurance	0%	
	OOPM	$5,200	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	75.7%
BCBSVT Model Output for items supported by the AVC		(b)	79.5%
BCBSVT Model Output for complete benefit design		(c)	80.8%
Estimated AVC value		(d)=(c)/(b)*(a)	**76.9%**

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if different	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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):		

Plan Description:

Name: Blue Rewards Silver CSR 77%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 75.67%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 87%			
Items supported by the AV Calculator	Deductible	$200	
	Coinsurance	0%	
	OOPM	$2,250	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	87.1%
BCBSVT Model Output for items supported by the AVC		(b)	90.2%
BCBSVT Model Output for complete benefit design		(c)	90.3%
Estimated AVC value		(d)=(c)/(b)*(a)	**87.2%**

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 ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to 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	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):	

Plan Description:

Name: Blue Rewards Silver CSR 87%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.09%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
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Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 94%

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[2] 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.

	A	B	C	D	E	F	G	H	I	K	L
1	**User Inputs for Plan Parameters**										
2	Use Integrated Medical and Drug Deductible?	☑									
3	Apply Inpatient Copay per Day?	☐									
4	Apply Skilled Nursing Facility Copay per Day?	☐									
5	Use Separate OOP Maximum for Medical and Drug Spending?	☐									
6	Indicate if Plan Meets CSR Standard?	☑									
7	Desired Metal Tier	Platinum									
8		**Tier 1 Plan Benefit Design**				**Tier 2 Plan Benefit Design**					
9		**Medical**	**Drug**	**Combined**		**Medical**	**Drug**	**Combined**			
10	Deductible ($)			$0.00							
11	Coinsurance (%, Insurer's Cost Share)			100.00%							
12	OOP Maximum ($)			$1,100.00							
13	OOP Maximum if Separate ($)										
14											
15	Click Here for Important Instructions	**Tier 1**				**Tier 2**				**Tier 1**	**Tier 2**
16	**Type of Benefit**	**Subject to Deductible?**	**Subject to Coinsuranc**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductibl**	**Subject to Coinsuran**	**Coinsurance, if**	**Copay, if separate**	**Copay applies only after deductible?**	
17	**Medical**	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
18	Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
19	All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑			☑	☐
20	Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑			☑	☐
21	Specialist Visit	☑	☐		$35.00	☑	☑			☑	☐
22	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$14.00	☑	☑			☑	☐
24	Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑			☑	☐
27	Rehabilitative Speech Therapy	☑	☐		$35.00	☑	☑			☑	☐
28	Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$35.00	☑	☑			☑	☐
31	Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
32	Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑			☑	☐
33	X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑			☑	☐
34	Skilled Nursing Facility	☑	☐		$0.00	☑	☑			☑	☐
35	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
36	Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
37	**Drugs**	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
38	Generics	☑	☐		$5.00	☑	☑			☑	☐
39	Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
40	Non-Preferred Brand Drugs	☑	☑	40%		☑	☑			☐	☐
41	Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑			☐	☐
43	**Options for Additional Benefit Design Limits:**										
45	Set a Maximum on Specialty Rx Coinsurance Payments?	☐									
46	Specialty Rx Coinsurance Maximum:										
47	Set a Maximum Number of Days for Charging an IP Copay?	☐									
48	# Days (1-10):										
49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑									
50	# Visits (1-10):	3									
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐									
52	# Copays (1-10):										
53	**Output**										
54	Calculate										
55	Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.									
56	Actuarial Value:	94.09%									
57	Metal Tier:	Platinum									
58											
59	**2017 AV Calculator**										
60											

Plan Description:
Name: Blue Rewards Silver CSR 94%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

[2] The AV calculator produces an AV of 94.13% 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.

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Appendix – Complete Benefit Designs

	Gold	Silver	73% AV	77% AV	87% AV	94% AV
Deductible/OOP Max	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Medical Ded	$1,250	$2,300	$2,100	$1,300	$200	$0
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$7,150	$5,700	$5,200	$2,250	$1,100
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,100
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family	Aggregate, 2x Family
Medical Deductible waived for:	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I
Drug Deductible waived for:	N/A	N/A	N/A	N/A	N/A	N/A
Service Category						
Preventive	$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	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						
Specialist Office Visit	$30	$50	$50	$50	$50	$35
Urgent Care	$30	$50	$50	$50	$50	$35
Ambulance	$30	$50	$50	$50	$50	$35
DME	$30	$50	$50	$50	$50	$35
ER	$250	$400	$400	$400	$250	$250
Radiology (MRI, CT, PET)	$500	$1,500	$1,500	$1,500	$500	$0
Outpatient	$500	$1,500	$1,500	$1,500	$500	$0
Inpatient	$500	$1,500	$1,500	$1,500	$500	$0
Rx Generic	$5	$5	$5	$5	$5	$5
Rx Preferred Brand	40%	40%	40%	40%	40%	40%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	60%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

	Gold	Silver	73% AV	77% AV	87% AV	94% AV	Bronze
Deductible/OOP Max	**CDHP**	**CDHP**	**CDHP**	**CDHP**	**CDHP**	**CDHP - Not HSAQ**	**CDHP - Not HSAQ**
Medical Ded	$2,500	$4,500	$3,500	$2,800	$1,300	$600	$7,150
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$2,500	$4,500	$3,500	$2,800	$1,300	$600	$7,150
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Family	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family, Embedded Individual OOPM of $7,150
Medical Deductible waived for:	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care
Drug Deductible waived for:	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts
Service Category							
Preventive	$0	$0	$0	$0	$0	$0	$0
PCP Office Visit	0%	0%	0%	0%	0%	0%	0%
MH/SA Office Visit	0%	0%	0%	0%	0%	0%	0%
Specialist Office Visit	0%	0%	0%	0%	0%	0%	0%
Urgent Care	0%	0%	0%	0%	0%	0%	0%
Ambulance	0%	0%	0%	0%	0%	0%	0%
DME	0%	0%	0%	0%	0%	0%	0%
ER	0%	0%	0%	0%	0%	0%	0%
Radiology (MRI, CT, PET)	0%	0%	0%	0%	0%	0%	0%
Outpatient	0%	0%	0%	0%	0%	0%	0%
Inpatient	0%	0%	0%	0%	0%	0%	0%
Rx Generic	$5	$15	$15	$15	$15	$15	$25
Rx Preferred Brand	40%	40%	40%	40%	40%	40%	40%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	60%	60%

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

May 31, 2016

Sent by Email only:
GMCB.Board@Vermont.gov

Alfred Gobeille, Chair
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: BCBSVT Exchange Filing, GMCB Docket 8-16rr

Dear Chairman Gobeille:

BCBSVT has revised its nonstandard 73 percent Cost Sharing Reduction (CSR) plan to comply with 45 CFR 156.420(f). This rule requires at least a two percent difference from the base silver plan and the 73 percent CSR silver plan. The original benefit submitted by BCBSVT for the 73 percent CSR plan variation of the nonstandard silver plan was 1.8 percent richer than the base silver plan. To meet this standard, we decreased the deductible for the silver 73 percent CSR plan by $100. This change was filed with Department of Financial Regulation in a revised BCBSVT actuarial certification. This change does not affect the rate calculations in the qualified health plan rate filing. We are informing you of this change because the original actuarial certification was an attachment to the qualified health plan rate filing in this docket. A copy of the revised certification is attached with the changes highlighted on pages 13 and 17.

Please let me know if you have any questions.

Sincerely,

Jacqueline A. Hughes

cc: Judy Henkin, Esq.
Noel Hudson, Esq.
Lila Richardson, Esq.
Kaili Kuiper, Esq.

P.O. Box 186 · Montpelier, VT 05601-0186
Corporate Office (802) 223-6131 · Subscriber Service (800) 247-BLUE
www.bcbsvt.com

2017 Rates Table Template v6.0

*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. 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 + H. All plans must have the same dates on a sheet.

HIOS Issuer ID*	13627
Federal TIN*	03-0277307
Rate Effective Date*	1/1/2017
Rate Expiration Date*	12/31/2017

					Family Tier						
Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Couple ***	**Primary Subscriber and One Dependent***	**Primary Subscriber and Two Dependents***	**Primary Subscriber and Three or More Dependents***	**Couple and One Dependent***	**Couple and Two Dependents***	**Couple and Three or More Dependents***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	**Required:** Enter the rate of a family based on a single parent with one dependent	**Required:** Enter the rate of a family based on a single parent with two dependents	**Required:** Enter the rate of a family based on a single parent with three or more dependents	**Required:** Enter the rate of a family based on a couple with one dependent	**Required:** Enter the rate of a family based on a couple with two 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	587.23	1174.46	1133.35	1133.35	1133.35	1650.12	1650.12	1650.12
13627VT0380002	Rating Area 1	No Preference	Family Option	511.21	1022.42	986.64	986.64	986.64	1436.50	1436.50	1436.50
13627VT0390001	Rating Area 1	No Preference	Family Option	557.77	1115.54	1076.50	1076.50	1076.50	1567.33	1567.33	1567.33
13627VT0390002	Rating Area 1	No Preference	Family Option	481.56	963.12	929.41	929.41	929.41	1353.18	1353.18	1353.18
13627VT0390003	Rating Area 1	No Preference	Family Option	441.70	883.40	852.48	852.48	852.48	1241.18	1241.18	1241.18
13627VT0340002	Rating Area 1	No Preference	Family Option	692.72	1385.44	1336.95	1336.95	1336.95	1946.54	1946.54	1946.54
13627VT0340003	Rating Area 1	No Preference	Family Option	608.44	1216.88	1174.29	1174.29	1174.29	1709.72	1709.72	1709.72
13627VT0340004	Rating Area 1	No Preference	Family Option	525.27	1050.54	1013.77	1013.77	1013.77	1476.01	1476.01	1476.01
13627VT0350001	Rating Area 1	No Preference	Family Option	520.12	1040.24	1003.83	1003.83	1003.83	1461.54	1461.54	1461.54
13627VT0340005	Rating Area 1	No Preference	Family Option	444.41	888.82	857.71	857.71	857.71	1248.79	1248.79	1248.79
13627VT0350002	Rating Area 1	No Preference	Family Option	446.56	893.12	861.86	861.86	861.86	1254.83	1254.83	1254.83
13627VT0340001	Rating Area 1	No Preference	Family Option	241.39	482.78	465.88	465.88	465.88	678.31	678.31	678.31
13627VT0360001	Rating Area 1	No Preference	Family Option	587.23	1174.46	1133.35	1133.35	1133.35	1650.12	1650.12	1650.12
13627VT0360002	Rating Area 1	No Preference	Family Option	511.21	1022.42	986.64	986.64	986.64	1436.50	1436.50	1436.50
13627VT0370001	Rating Area 1	No Preference	Family Option	557.77	1115.54	1076.50	1076.50	1076.50	1567.33	1567.33	1567.33
13627VT0370002	Rating Area 1	No Preference	Family Option	481.56	963.12	929.41	929.41	929.41	1353.18	1353.18	1353.18
13627VT0370003	Rating Area 1	No Preference	Family Option	441.70	883.40	852.48	852.48	852.48	1241.18	1241.18	1241.18
13627VT0320001	Rating Area 1	No Preference	Family Option	692.72	1385.44	1336.95	1336.95	1336.95	1946.54	1946.54	1946.54
13627VT0320002	Rating Area 1	No Preference	Family Option	608.44	1216.88	1174.29	1174.29	1174.29	1709.72	1709.72	1709.72
13627VT0320003	Rating Area 1	No Preference	Family Option	525.27	1050.54	1013.77	1013.77	1013.77	1476.01	1476.01	1476.01
13627VT0330001	Rating Area 1	No Preference	Family Option	520.12	1040.24	1003.83	1003.83	1003.83	1461.54	1461.54	1461.54
13627VT0320004	Rating Area 1	No Preference	Family Option	444.41	888.82	857.71	857.71	857.71	1248.79	1248.79	1248.79
13627VT0330002	Rating Area 1	No Preference	Family Option	446.56	893.12	861.86	861.86	861.86	1254.83	1254.83	1254.83

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	XXX
Date of Submission	5/11/2016
Proposed Effective Date	1/1/2017

	Average Annual Premium
Before Rate Change	$9,133
After Rate Change	$9,879

		Amount in SERFF's Rate Review Detail Sectior	Explanation for differences
Proposed Overall Rate Change	8.17%	8.17%	N/A
Proposed Minimum Rate Change	5.22%	5.22%	N/A
Proposed Maximum Rate Change	10.92%	10.92%	N/A

If the difference between the maximum and minimum rate increase is greater than 10%, Provide a statement and clear delineation of contributing factors explaining why certain individual will receive a rate decrease as low as the minimum while others will face rate increases as high as the maximum

N/A

Relationship of Proposed Rate Scale to Current Rate Scale:
Provide a detailed breakdown of the average rate change from the previous approved filing by using the chart below to itemize the drivers of the average rate change. The table should include the previous assumption, current assumption, and the resulting change. Include additional lines as necessary.

Source of Change	Previous filing Assumption	Current Filing Assumption	Relativity Current Filing / Previous filing	
Base Period Experience	488.72	503.97	1.080	e.g. previous filing experience period index rate compared to the current filing experience index rate
Base Period Utilization Factor	0.99	0.99	0.991	If applicable, the change in this factor is based on the average copay impact difference between previous filing and current filing.
Pricing Trend	1.14	1.11	0.970	The change in this factor is based on the change the trend assumption in previous filing and current filing (e.g. 1.075^2 / 1.08^2)
Morbidity Adjustment	0.97	1.00	1.041	The change in this factor is based on the change in the morbidity assumptions between previous filing and current filing.
Risk Adjustment Recoveries	0.99	1.00	1.005	The change in this factor is based on the change in the risk adjustment recoveries assumptions between previous filing and current filing.
Pent Up Demand	1.00	1.00	1.000	
Reinsurance Recoveries	0.97	1.00	1.030	
Reinsurance Premium	1.01	1.00	0.995	
Average Age Impact	1.01	1.01	0.992	
Additional EHB	1.01	1.00	0.994	
Exchange Fee	1.00	1.00	1.000	
Fixed Cost Adjustment	1.07	1.08	1.004	
SG&A	1.00	1.00	1.000	
Margin	1.01	1.02	1.013	
Taxes and Fees	1.04	1.01	0.973	
Benefit Design Changes	0.78	0.80	1.020	
Geography	1.00	1.00	1.000	
Tobacco	1.00	1.00	1.000	
Provider Networks Changes	1.01	1.00	0.988	
Non System Claims	1.01	1.00	0.995	
Impact of Selection	1.02	1.01	0.990	
Pharmacy Contract	1.00	0.99	0.991	
Membership distribution by plan	1.00	1.01	1.015	
xxxxxx			1.000	
Total Rate Change			1.085	
If applicable, Provide an explanation for difference between the Calculated Rate change and the average rate change in cell B17			1.082	
The small difference between the calculated rate change and the average rate change is due to contract mix, order of operations and methodology.				

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%	0	0	0
Increase of 5.01% to 10.00%	32,985	53,016	4,433
Increase of 10.01% to 14.99%	9,542	17,407	1,425
Increase of 15.00% or more	0	0	0
Total	42,527	70,423	5,858

History of Rate Changes

For Year	Average Annual Proposed Rate Change	Average Annual Approved Rate Change
2014	N/A	N/A
2015	9.81%	7.70%
2016	8.40%	5.90%

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
Dates	January 2015 - December 2015	January 2016 - December 2016	January 2017 - December 2017		
Commissions & Brokers Fees	$0.00	$0.00	$0.00		
Taxes, Licenses & Fees	$0.45	$0.55	$0.46	1.53%	-15.80%
Exchange Fee	$0.00	$0.00	$0.00		
Reinsurance	$0.00	$0.00	$0.00		
All Other Admin Expense	$32.15	$29.24	$33.76	5.01%	15.47%
Profit/Risk Margin	-$8.10	$4.63	$11.14	-237.52%	140.49%

	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
Commissions & Brokers Fees	0.00%	0.00%	0.00%		
Taxes, Licenses & Fees	0.11%	0.12%	0.09%	-12.00%	-21.22%
Exchange Fee	0.00%	0.00%	0.00%		
Reinsurance	0.00%	0.00%	0.00%		
All Other Admin Expense	7.49%	6.31%	6.82%	-8.99%	8.03%
Profit/Risk Margin	-1.89%	1.00%	2.25%	-219.19%	125.00%

The Department is requesting each carrier provide a detailed commission schedule. Include in the following text box or state where in the filing it is located.

N/A

Trend & Projection Assumptions

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
	Jan-2013	64,537	$476.13			
	Feb-2013	64,270	$427.24			
	Mar-2013	64,320	$469.95			
	Apr-2013	64,235	$488.84			
	May-2013	64,091	$499.30			
	Jun-2013	64,386	$451.74			19.74%
	Jul-2013	64,639	$471.29			11.99%
	Aug-2013	65,000	$469.21			-14.08%
	Sep-2013	64,831	$477.29			-2.09%
	Oct-2013	64,548	$554.87			26.85%
	Nov-2013	64,535	$515.46			51.60%
	Dec-2013	63,944	$545.82		17.37%	63.20%
	Jan-2014	62,896	$470.14		16.41%	1.99%
	Feb-2014	62,582	$441.96		9.33%	-28.02%
	Mar-2014	62,518	$462.26		6.19%	-52.93%
	Apr-2014	62,483	$458.72		-6.19%	-42.20%
	May-2014	64,662	$459.74		-10.98%	-19.42%
	Jun-2014	64,867	$462.27		-20.72%	10.85%
	Jul-2014	65,492	$458.16		-19.51%	22.85%
	Aug-2014	65,776	$454.53		-14.98%	12.46%
	Sep-2014	65,567	$480.90		-10.54%	14.58%
	Oct-2014	65,382	$538.63		3.76%	34.64%
	Nov-2014	65,226	$481.45		9.84%	42.15%
	Dec-2014	64,856	$560.32	-2.12%	24.10%	60.78%
	Jan-2015	67,503	$514.72	-0.44%	29.57%	26.47%
	Feb-2015	67,897	$453.59	0.34%	27.46%	16.10%
	Mar-2015	69,167	$519.33	2.57%	29.25%	-5.69%
	Apr-2015	69,332	$514.78	5.22%	20.88%	-0.31%
	May-2015	68,710	$493.96	7.00%	21.69%	15.20%
	Jun-2015	68,748	$529.90	8.48%	13.96%	19.39%
	Jul-2015	68,363	$519.71	10.14%	9.43%	14.35%
	Aug-2015	67,824	$477.96	10.99%	10.09%	-4.53%
	Sep-2015	67,533	$513.05	11.66%	4.14%	-12.59%
	Oct-2015	67,492	$522.82	11.86%	3.26%	-12.88%
	Nov-2015	67,076	$506.20	13.12%	0.76%	-1.71%
Last Month in Experience Period	Dec-2015	66,988	$543.63	12.70%	0.66%	12.67%

Solvency

	Most Recent Quarterly Financial Statement	Most Recent Annual Financial Statement
Total Adjusted Capital	N/A	N/A
Authorized Control Level	N/A	N/A
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	Quality Improvement Expenses	Adjustments to Earned Premium	Adj Medical Loss Ratio
Historical Year -4	1/1/2011	12/31/2011	0	0	0		0		0	0	#DIV/0!
Historical Year -3	1/1/2012	12/31/2012	0	0	0		0		0	0	#DIV/0!
Historical Year -2	1/1/2013	12/31/2013	0	0	0		0		0	0	#DIV/0!
Historical Year -1	1/1/2014	12/31/2014	638,492	223,000,143	250,396,313	89.1%	228,210,878	97.7%	1,942,476	8,962,200	93.2%
Historical Year 0	1/1/2015	12/31/2015	768,293	302,548,070	329,668,002	91.8%	287,438,814	105.3%	2,113,072	7,798,968	94.7%
Historical Totals			1,406,785	525,548,214	580,064,314	90.6%	515,649,692	101.9%	4,055,548	16,761,168	94.0%
Interim Time Period	1/1/2016	3/31/2016	210,235	79,055,180	94,653,390	83.5%	76,208,530	103.7%			83.5%
Future Year 1	1/1/2017	12/31/2017	930,456	416,675,406	458,525,193	90.9%	416,675,406	100.0%	3,196,799	1,122,737	91.8%

Anticipated Pricing Loss Ratio (no adjustments)	91%
Anticipated LR using Federally-prescribed MLR methodology	91%

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.
The interim time period the time periods available in the current year.
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	$560.66
Risk Adjustment PMPM	($1.55)
Net Reinsurance Contributions PMPM	$0.00
Exchange User Fees PMPM	$0.00
Market Adjusted Index Rate PMPM	$559.11

Product	BCBSVT EPO		BCBSVT EPO	SVT EPO Blue Rewards C	CBSVT EPO Blue Reward	BSVT EPO Blue Rewards CDH	VT EPO Blue Rewards	BCBSVT EPO CDHP	BCBSVT EPO
Product ID	13627VT034 and 13627VT032		13627VT034 and 13627VT03	627VT037 and 13627VT0	627VT036 and 13627VT0	13627VT037 and 13627VT039	27VT037 and 13627VT	13627VT033 and 13627VT035	13627VT034
Plan ID	13627VT0340002 and 13627VT0320001		13627VT0340003 and 13627VT033	T0370001 and 13627VT0	T0360002 and 13627VT0	27VT0370002 and 13627VT039	T0370003 and 13627VT	27VT0330002 and 13627VT0350	13627VT0340001
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	0.891		0.820	0.788	0.716	0.690	0.619	0.609	0.620
Pricing AV Value	1.116		0.980	0.898	0.823	0.775	0.711	0.719	0.389
Projected Member Months	12,995		7,299	6,356	5,938	3,893	4,033	3,200	169
Market Adjusted Index Rate PMPM	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11	$559.11
Plan Adjustments (in multiplicative format)									
Actuarial value and cost-sharing design of the plan	1.020		0.889	0.805	0.733	0.686	0.624	0.636	0.620
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	0.504
Plan Adjustments (in % format)									
Distribution and administration costs	8.8%		9.3%	10.4%	10.9%	11.5%	12.2%	11.5%	19.6%
Plan Adjusted Index Rate	$623.68	$559.11	$547.80	$502.18	$460.26	$433.56	$397.68	$402.05	$217.33
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	$623.68	$559.11	$547.80	$502.18	$460.26	$433.56	$397.68	$402.05	$217.33

Calculated Pricing AV	1.115	1.000	0.980	0.898	0.823	0.775	0.711	0.719	0.389
Pricing AV in URRT	1.115		0.980	0.898	0.823	0.775	0.711	0.719	0.389
Difference	0.0%	-100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Explanation for differences between implied Pricing AV and URRT	N/A								

Age 40 Factor	1.111
Geographic Rating Area #1	1.000
Geographic Rating Area #3	1.000
Geographic Rating Area #5	1.000

*Note if a particular plan is not offered in a rating area, please override the formula and enter "N/A" below .

Calculated Premium Rate (Age 40, Area 1)	$692.72	$621.00	$608.44	$557.77	$511.21	$481.55	$441.71	$446.56	$241.39
Calculated Premium Rate (Age 40, Area 3)	$692.72	$621.00	$608.44	$557.77	$511.21	$481.55	$441.71	$446.56	$241.39
Calculated Premium Rate (Age 40, Area 5)	$692.72	$621.00	$608.44	$557.77	$511.21	$481.55	$441.71	$446.56	$241.39
Proposed Premium Rate (Age 40, Area 1)	$692.72	N/A	$608.44	$557.77	$511.21	$481.56	$441.70	$446.56	$241.39
Proposed Premium Rate (Age 40, Area 3)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Proposed Premium Rate (Age 40, Area 5)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Difference (Age 40, Area 1)	0.0%	#VALUE!	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Difference (Age 40, Area 3)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Difference (Age 40, Area 5)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Explanation for differences	N/A								

Actuarial value and cost-sharing design of the plan

Actuarial value and cost-sharing design of the plan	1.020	0.000	0.889	0.805	0.733	0.686	0.624	0.636	0.620
Paid/Allowed Ratio (Cost-Sharing only)	0.931		0.860	0.805	0.754	0.717	0.666	0.676	0.666
Used Induced utilization factors	1.096		1.033	1.000	0.972	0.957	0.938	0.941	0.470
Calculated	1.020	0.000	0.889	0.805	0.733	0.686	0.624	0.636	0.313

Experience Period Start Date	1/1/2015
Date at which the most recent experience is available	12/31/2015

Provide the information in the table below in an Excel format. The information in the first row should be consistent with what is required by the URRT.

Experience Period Start Date	Experience Period End Date	Category of Insureds	Member Months	Premiums	Incurred Claims	Allowed Claims	Average Age	HHS Age Factor	Allowed PMPM	Age Normal Allowed PMPM	Morb Relativity	LossRatio
1/1/2015	12/31/2015	**Persons who purchased a ACA compliant plan**	766,083	$332,392,760	$292,325,366	$384,634,210		1.000	$502.08	$502.08	#DIV/0!	87.9%
1/1/2015	12/31/2015	**Persons who did not purchased a ACA compliant plan**						1.000	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
1/1/2015	12/31/2015	**All**	766,083	$332,392,760	$292,325,366	$384,634,210		1.000	$502.08	$502.08		87.9%

Experience Period Start Date	Experience Period End Date	Category of Insureds	Member Months	Premiums	Incurred Claims	Allowed Claims	Average Age	HHS Age Factor	Allowed PMPM	Age Normal Allowed PMPM	Morb Relativity	LossRatio
1/1/2016	12/31/2015	**Persons included in the experience period**						1.000	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
1/1/2016	12/31/2015	**Persons not included in the experience period**						1.000	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
1/1/2016	12/31/2015	**All**	0	$0	$0	$0		1.000	#DIV/0!	#DIV/0!		#DIV/0!

Experience Period Start Date	Experience Period End Date	Category of Insureds	Member Months	Premiums	Incurred Claims	Allowed Claims	Average Age	HHS Age Factor	Allowed PMPM	Age Normal Allowed PMPM		LossRatio
1/1/2015	12/31/2015	**All**	766,083	$332,392,760	$292,325,366	$384,634,210		1.000	$502.08	$502.08		87.9%

Risk Adjustment

	Actual Risk Adjustment Received	Assumed in Most Recent Approved Rate Filing	Assumed in Current Rate Filing	Proposed Change in PMPM Compared to Prior 12 months	Proposed Change in PMPM Compared to Most Recently Approved Filing
Time Period	January 2014 - December 2014	January 2016 - December 2016	January 2017 - December 2017		
Total Risk adjustment (Dollar amount)	($2,670,249)	($3,105,503)	($1,268,182)		
Membership Member Months	638,492	840,169	930,456	45.73%	10.75%
PMPM	($4.18)	($3.70)	($1.36)	-67.41%	-63.13%
Premium	$250,396,313	$395,836,846	$459,647,300	83.57%	16.12%
As a % of Premium	-1%	-1%	0%	-74.13%	-64.83%

If the actual risk adjustment payable/receivable was materially different than what was estimated in the previous filing, please provide details on how the current risk adjustment estimate has addressed the issue

Please see section 3.7.1 of the actuarial memorandum

Please provide an exhibit, in excel with working formulas, demonstrating the calculation of the rate increase assuming that the current membership in terminated plans are mapped to renewal/proposed plans closest to the member's current benefit structure or Pricing AV. Include a quantitative calculation of the differences in benefits and cost sharing, as well as the Pricing and Metal AVs for the current and renewal/proposed 2016 plans. In the following text box state where in the filing the requested exhibit is located.

N/A - BCBSVT is not terminating any 2016 plans

Uniform Compliance

Please clearly demonstrate how the Company complies with the guaranteed renewability of coverage regulations (45 CFR 147.106) including the following:

Actuarial Memorandum Section 4.1

a) A list of all products that are terminated, renewed or are new in the current filing

b) For products that were renewed, please demonstrate compliance with all provisions of the uniform modification of coverage.

Actuarial Memorandum Section 2.1

i. The product is offered as the same product type (for example, preferred provider organization (PPO) or health maintenance organization (HMO));

Actuarial Memorandum Section 2.1

ii. The product covers a majority of the same counties in its service area;

Actuarial Memorandum Section 2.1 and Exhibit 1

iii. Each plan has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act (for example, bronze, silver, gold, platinum or catastrophic); and

Actuarial Memorandum Section 2.1 and Exhibit 6A

iv. The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

May 31, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 05/23/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated May 23, 2016, here are *your questions* and our answers:

1. This question involves confidential and proprietary information and will be provided under separate cover.

2. This question involves confidential and proprietary information and will be provided under separate cover.

3. *Provide quantitative support for the considerably unfavorable paid claims experience. Source: Actuarial Memorandum page 4*

   Responses to BCBSVT 2017 QHP filing inquiries - 05.23.2016.xlsx, tab Q3 provides a comparison of actual 2015 paid fee-for-service claims to the projected 2015 fee-for-service claims implicit in the 2016 rate filing. Driven primarily by actuarial values that were significantly higher than expected, actual paid fee-for-service claims were 7.7 percent higher than projected.

   This was modestly offset by experience in other than fee-for-service claims, which had a 1.2 percent favorable impact on claims, as shown in the table below:

CY 2015 PMPM	2016 QHP Rate Filing	2017 QHP Rate Filing	Increase
Medical and Pharmacy Allowed Charges	$491.19	$503.97	2.6%
Other Claims (Pediatric Dental and Vision, Rebates, Blueprint, ITS fees)	$7.67	$1.81	-1.2%
Total	$498.86	$505.78	+1.4%

   In aggregate, 2015 paid claims were approximately 6.5 percent higher than the projection implicit within the 2016 QHP rate filing, driving a premium increase of 5.4 percent.

4. *Please provide an actual to expected comparison of the contributions to reserves for the most recent 5 years based on the final premiums after amendments made by regulators.*

   The chart below shows the expected contribution to reserves based on our forecasting model, which incorporates final premiums including amendments ordered by regulators for the Individual and Small Group markets. Note that the expected result for 2014 also

recognizes the impact of the decision to allow individuals and small groups to continue in their 2013 plan through the first quarter of 2014.

The actual results for 2014 and 2015 include the impacts of the Transitional Reinsurance and Risk Adjustment program in the year they were incurred, not in the year when they were booked.

Year	Expected	Actual
2011	-0.3%	1.9%
2012	0.9%	-3.4%
2013	-2.0%	-2.0%
2014	-1.6%	2.8%
2015	0.8%	-1.8%
Cumulative	-0.4%	-0.7%

As the chart demonstrates, actual results have fluctuated uniformly around our expectation, implying that filed pricing assumptions have been free of implicit margin over the past five years.

5. *Please provide quantitative support for the increase in the experience period administrative costs from $28.40 in the prior filing to $32.93 in the current filing.*
Source: Actuarial Memorandum page 24 and 2016 Actuarial Memorandum page 28

There are three main drivers of the increase in the experience period administrative cost. First, the fee for the Vermont Collaborative Care ($0.87 PMPM) is now included in the experience period.

Second, there was a 5.7 percent increase in enterprise operating expenses on a per member per month basis from 2014 to 2015. This was largely driven by the commencement of a multi-year project to migrate to a new operating platform, along with some significant upgrades to our cybersecurity protocols.

Finally, BCBSVT completed a comprehensive cost accounting study for the first time in a number of years. As part of the study, each department was asked to reassess the direct attribution of allocation of their resources by line of business. The resulting costs of operations by segment increased the QHP administrative cost PMPM by 6.4 percent.

	2016 QHP Rate Filing	Updated Experience Period	2017 QHP Rate Filing
Experience Period	CY 2014	CY 2015	CY 2015
Base Administrative Charges	$28.40		
Vermont Collaborative Care fee	$0.87		
Total Administrative Charges	$29.27	$30.94	$32.93
Change		+5.7%	+12.5%

6. *Confirm that the projected period membership in the exhibit on the top of page 25 in the Actuarial Memorandum is correctly allocated between "Enrolled through VHC" and "Directly Enrolled with BCBSVT."*

The projected membership in the table on page 25 of the Actuarial Memorandum was typed in the wrong column. Below is the corrected table.

	Enrolled through VHC	Directly Enrolled with BCBSVT	Total
Experience Member Months	336,288	429,765	766,083
Experience PMPM	$37.97	$28.99	$32.93
Projected Period Membership	27,708	49,830	77,538
Projected PMPM			$32.20
Impact			= $32.20/$32.93 = 0.9778

7. *What percentage of groups with 51 - 100 employees that were expected in the prior filing to offer a QHP, have offered or have informed you that they intend to offer a QHP? Source: Actuarial Memorandum page 9*

   In the 2016 QHP rate filing, we expected 43 groups with 51-100 employees to offer QHPs. 15 of those 43 groups have decided to offer QHPs in 2016.

   The table in *Responses to BCBSVT 2017 QHP filing inquiries - 05.23.2016.xlsx, tab Q7* summarizes the member months and allowed charges PMPM for each category of groups from the 2016 QHP Rate Filing and the 2017 QHP Rate Filing.

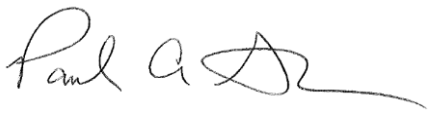
   While fewer groups than expected selected QHPs in January 2016, a number of groups changed their renewal date to December, thereby allowing themselves an additional eleven months to make a final decision. Our assumption for the total impact of these groups in the 2016 filing was directionally accurate, and we expect the total number of groups joining the single risk pool to be consistent with the 2016 assumption. Experience for this subset of groups worsened considerably from 2014 to 2015.

8. *Please reconcile Exhibit 2B with the table in section 3.4.1 of the Actuarial Memorandum.*
   The table in section 3.4.1 of the Actuarial Memorandum shows experience allowed claims and experience member months while Exhibit 2B uses projected membership and allowed claims adjusted for the network, as shown on Exhibit 2E. Please see attached *Responses to BCBSVT 2017 QHP filing inquiries - 05.23.2016.xlsx, tab Q8* for a detailed reconciliation.

9. *Please provide the projected number of contracts by plan by tier.*
   Please see attached *Responses to BCBSVT 2017 QHP filing inquiries - 05.23.2016.xlsx, tab Q9* for the projected number of contracts by plan and by tier.

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.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

Comparison of fee-for-service claims: 2015 Actual vs. 2015 Projected implicit in 2016 QHP Filing

	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
Filed 2015 Paid Claims	$387.02	$339.05	$296.97	$487.39	$421.48	$361.00	$348.56	$304.76	$313.40	$163.22	**$383.08**
Filed 2015 Allowed Charges	$496.78	$477.32	$460.98	$530.83	$502.96	$479.90	$481.72	$462.25	$466.44	$241.42	**$491.19**
Filed Paid:Allowed	77.9%	71.0%	64.4%	91.8%	83.8%	75.2%	72.4%	65.9%	67.2%	67.6%	**78.0%**
Actual 2015 Paid	$348.36	$247.58	$180.08	$738.06	$444.08	$370.57	$337.91	$196.03	$208.07	$43.42	**$412.39**
Actual 2015 Allowed Charges	$432.27	$348.33	$290.25	$787.15	$523.06	$482.96	$445.64	$302.75	$317.51	$105.76	**$503.97**
Actual Paid:Allowed	80.6%	71.1%	62.0%	93.8%	84.9%	76.7%	75.8%	64.8%	65.5%	41.1%	**81.8%**
Actual 2015 member months	33,562	57,252	40,214	161,992	90,848	177,220	116,772	32,771	54,377	1,075	**766,083**
Paid Claims Actual:Filed											**7.7%**
Allowed Charges Actual:Filed											**2.6%**
AV Actual:Filed											**4.9%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

Member months and allowed charge PMPM for each category of groups from the 2016 QHP Rate Filing and the 2017 QHP Rate Filing

2016 QHP Filing	2017 QHP Filing	Group Count	Member Months in 2016 QHP Filing	Allowed PMPM in 2016 QHP Filing	Member Months in 2017 QHP Filing	Allowed PMPM in 2017 QHP Filing
Included	Included as Expected to Join	5	3,624	$387.53	3,758	$558.74
Included	Included as Known to have Joined	15	14,440	$464.40	14,407	$576.56
Included	Excluded	23	20,052	$511.29	0	
Excluded	Included as Expected to Join	20	0		28,701	$590.05
Excluded	Included as Known to have Joined	4	0		3,684	$618.90

	Member Months in 2016 QHP Filing	Allowed PMPM in 2016 QHP Filing	Member Months in 2017 QHP Filing	Allowed PMPM in 2017 QHP Filing
All other members included in the filing	735,603	472.23	766,083	$503.97
Total Groups with 51-100 employees Included in 2016 filing	38,116	$481.76	18,165	$572.87
Total if we only included groups included in 2016 filing	773,719	$472.70	784,248	$505.57
Impact on Total Allowed		0.1%		0.3%
Total Groups with 51-100 employees Known to have Joined	14,440	$464.40	18,091	$585.18
Total Groups with 51-100 employees included in the 2017 QHP rate filing			50,550	$585.98
Total included in 2017 QHP rate filing			816,633	$509.05
Impact on Total Allowed				1.0%

Table in Section 3.4.1 of the Actuarial Memorandum

	Single Risk Pool	Groups with 51-100 employees offering QHP in 2016	Groups with 51-100 employees expected to offer QHP in 2017	Total
Experience Period Allowed Claims	$386,083,348	$25,727,986	$4,425,372	$416,236,706
Experience Period Member Months	766,083	43,108	7,442	816,633
PMPM	$503.97	$596.83	$594.65	$509.70

Exhibit 2B

Coverage Category in the Experience	Projected Membership	CY 2015 Allowed PMPM Adjuted for Network
Individual Non-Subsidized QHP	10,872	$561.82
Individual Subsidized QHP	17,836	$561.46
Small Group QHP	37,286	$458.88
Groups with 51-100 employees known to have joined QHP	4,429	$585.54
Groups with 51-100 employees expected to join QHP	615	$588.52
Weighted Average before adjustment for new membership	**71,038**	**$509.41**

Summary of Exhibit 2E

Coverage Category in the Experience	CY 2015 Allowed PMPM (Medical and Pharmacy)	CY 2015 Allowed PMPM Adjuted for Network (Medical and Pharmacy)	Experience Membership
Individual Non-Subsidized QHP	$561.82	$561.82	124,629
Individual Subsidized QHP	$561.46	$561.46	211,659
Small Group QHP	$458.88	$458.88	429,795
Groups with 51-100 employees known to have joined QHP	$596.83	$585.54	43,108
Groups with 51-100 employees expected to join QHP	$594.65	$588.52	7,442
Weighted Average PMPM	**$509.70**	**$509.05**	**816,633**

Average PMPM using Projected Membership and Allowed Charges Adjusted for Network

CY 2015 Allowed PMPM Adjuted for Network (Medical and Pharmacy)	Projected Membership
$561.82	10,872
$561.46	17,836
$458.88	37,286
$585.54	4,429
$588.52	615
$509.41	71,038

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

	NON-STANDARD PLANS					STANDARD PLANS						
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Projected 2017 Contracts												
Single Rate	607	1,571	3,182	1,427	1,593	4,129	2,678	8,511	3,557	1,287	1,293	153
Couple Rate	155	608	841	416	435	1,552	754	2,679	1,223	343	313	3
Adult and Child(ren) Rate	35	151	100	89	85	376	180	377	178	60	82	2
Family Rate	151	815	233	359	349	1,218	673	1,167	904	216	272	2

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

June 13, 2016

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/09/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated June 9, 2016, here are *your questions* and our answers:

1. *We note that Viekira is the only hepatitis C drug on ESI's formulary for 2017. Please describe the expected impact, if any, of the FDA approval of Zepatier for claims in 2017 and for future years.*

   We do not expect any impact on utilization of drugs for treatment of hepatitis C due to the FDA approval of Zepatier. Its uses will be limited as there are significant issues of resistance to the drug for the most common type of Hepatitis C as per local Vermont subject matter experts at our academic medical center at UVM. Please also note that BCBSVT has recently decided to include Harvoni and Sovaldi back on the preferred brand list since Viekira has many interactions. This will not impact our projected claims for treatment of hepatitis C since the overall expected costs are similar for all drugs.

2. *How long are the increased costs of the multi-year project to migrate to a new operating platform and the significant upgrades to cybersecurity protocols expected to remain at elevated levels?*

   The platform migration was incorrectly cited in the as a source of the higher-than-typical increase in enterprise operating expenses. In fact, the migration has been absorbed into the annual project budget. The 5.7% increase in enterprise operating expenses from 2014 to 2015 was largely driven by normal inflationary increases, higher than expected spend on new cyber security protocols and timing related to annual technology project spend. Cyber security protocols and annual project spend are expected to continue as part of the normal operating budget.

3. *Please reconcile the 6.4% increase in administrative costs due to the comprehensive cost accounting study with the response to question #12 dated March 14, 2016 in the 3Q 2016 Large Group filing.*

   The response dated March 14, 2016 concerning the Large Group filing administrative charges was based on year ending October 2015. Since the QHP administrative charges were calculated based on the calendar year 2015 information, we restated our Large Group answer to have consistent timing. The table below compares the PMPM before and after the comprehensive cost accounting study for Large Groups (including Cost Plus), QHP, and other lines of business included in BCBSVT's overall administrative budget. Note that other lines of business include BCBSVT and TVHP Medicare Supplement products, the Federal Employee

Health Benefits Program, CBA (a TPA subsidiary of BCBSVT), ASO and costs of administering the BlueCard program for non-Vermont members.

Line of Business	Before Cost Study	After Cost Study	Change
Large Groups	$26.07	$26.07	0.0%
QHP	$30.94	$32.93	6.4%
Other lines	$23.42	$21.76	-7.1%
Total	$26.63	$26.63	0.0%

4. *Please confirm that the labels in column B for rows 7 and 8 should be switched in the response to question #7 dated March 31, 2016.*

   Yes, the labels in column B for rows 7 and 8 were switched in the response to question 7 dated May 31, 2016. This also minimally impacted row 18. Please see attached *Responses to BCBSVT 2017 QHP filing inquiries - 06.09.2016.xlsx, tab Q4* for an updated exhibit.

5. This question involves confidential and proprietary information and will be provided under separate cover.

6. *Please provide quantitative support for the 0.25% risk margin for bad debt.*

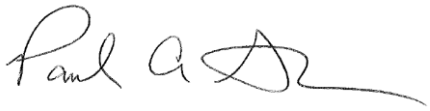
   For the 2015 calendar year, the total amount of non-paid premium for the first 30 days for members that were terminated for non-payment was $800,040. Dividing that number by the total gross premium of $334,972,631 and rounding to the nearest twentieth of a percent yields the estimate of 0.25% for risk margin for bad debt.

7. *Please provide the number of inforce members by plan that is consistent with the number of inforce contracts provided in Exhibit 9.*

   Please see attached *Responses to BCBSVT 2017 QHP filing inquiries - 06.09.2016.xlsx, tab Q7* for the inforce members by plan consistent with inforce contracts provided in Exhibit 9.

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.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

Member months and allowed charge PMPM for each category of groups from the 2016 QHP Rate Filing and the 2017 QHP Rate Filing

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Total Groups with 51-100 employees included in the 2017 QHP rate filing			50,550	$585.98
Total included in 2017 QHP rate filing			816,633	$509.05
Impact on Total Allowed				1.0%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

Product	Inforce Members at the time of Filing	Inforce Contract on Exhibit 9
Blue Rewards Gold	1,912	1,137
Blue Rewards Gold CDHP	6,541	3,220
Blue Rewards Silver	4,826	3,511
Blue Rewards Silver CDHP	0	0
Blue Rewards Bronze CDHP	4,224	2,562
Standard Platinum	13,492	7,539
Standard Gold	7,556	4,431
Standard Silver	16,222	10,698
Standard Silver CDHP	8,954	5,185
Standard Bronze	2,839	1,838
Standard Bronze CDHP	3,688	2,246
Catastrophic	169	160
Total	**70,423**	**42,527**

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

June 22, 2016

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/21/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated June 21, 2016, here is *your question* and our answer:

1. *We note that all issuers in Vermont submitted at least 3 quarters of data to CCIIO in order for the Interim Summary Report on Risk Adjustment for 2015 to be issued for Vermont. However, it is not clear from the report whether each carrier submitted 3 or 4 quarters of data. Does the Interim Summary Report on Risk Adjustment reflect 3 or 4 quarters of BCBSVT data?*

   The CCIIO Interim Summary Report reflects three quarters of BCBSVT claims data.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the information 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

June 24, 2016

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/21/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated June 21, 2016, here are *your questions* on behalf of the Health Care Advocate and our answers:

1. *Please list and quantify the services included in the projected "Other Medical" benefit category on the URRT.*
   Please see the table below:

Other Medical URRT	Utilization per 1,000	Average Cost/Service	PMPM
Other Medical Categories	**1,454.54**	**$ 175.42**	**$ 21.26**
Durable Medical Equipment	230.42	$ 378.70	$ 7.27
Drugs administered other than oral	149.09	$ 529.17	$ 6.57
Enteral and Parenteral Therapy	0.98	$ 355.21	$ 0.03
Physical Therapy	1,061.14	$ 81.85	$ 7.24
Radiation Treatment Delivery	12.91	$ 136.79	$ 0.15

2. *Was the experience period adjusted for an unusually high amount of large claims? If it was, please explain the adjustment.*
   The 2015 experience period did not have an unusual amount of large claims; therefore, no such adjustment was made.

3. *The product of all Population Risk Morbidity Adjustments in Exhibit 5 equal an adjustment of 1.004. Please explain why this is different than the 0.995 included on the URRT.*
   The difference between the factors lies within the selection of factors used, as illustrated in the tables below. Please note that Exhibit 5 was not intended to reflect the URRT definition of population risk morbidity adjustments.

Description	Index Label	Factor
Impact of the Change in Small Group definition	1+b1	1.0114
Impact of the Health Status of the newly insured	1+b3	1.0086
Changes in pool morbidity	1+b9	0.9896
Impact of different benefit plans (in experience vs projection)	1+c1	0.9859
Total used in URRT		**0.995**

Description	Index Label	Factor
Impact of the Health Status of the newly insured	1+b3	1.0086
Changes in pool morbidity	1+b9	0.9896
Changes in demographics (age, gender, region, etc.)	1+c3	1.0058
Total		**1.004**

4. *Regarding the "Other" Adjustments in Exhibit 5 and the URRT, please reconcile the Other Adjustments in Exhibit 5 to the URRT.*
   As noted in the response to Question 3 above, "Impact of different benefit plans," Other Adjustment 1+c1, is part of the Population Risk Morbidity factor in the URRT. The remaining "Other" adjustments within Exhibit 5 are part of the "Other" factor within Section II of the URRT. The balance of the URRT "Other" factor consists of Item 1+b8, "Impact of VHC Settlement," along with the total of the additive adjustments in section E of Exhibit 5.

5. *Please explain why the Taxes and Fees PMPM in the MLR calculation (Exhibit 8) only amount to $1.08 PMPM as opposed to the $4.61 in Exhibit 7C and the URRT.*
   Vermont HCCA taxes are included as claims in the Exhibit 8 calculation of the MLR, but are included within Taxes and Fees within the URRT.

6. *Please provide the Part II justification for all plans with more than a 10% rate increase.*
   Please see our Plain Language Summary, available here on the GMCB rate filing website: http://ratereview.vermont.gov/sites/dfr/files/2016/BCBSVT/Plain%20Language%20Summary.pdf

7. *Section 3.4.3 of the Actuarial Memorandum at page 10 discusses changes in the morbidity of the population insured. It describes upward pressure attributable to those members migrating from Medicaid and downward pressure resulting from adverse experience for voluntary cancellations. It does not discuss new enrollees that were previously uninsured. Do you have any estimates regarding the morbidity of this group?*
   We do not make an explicit assumption that there will be new enrollees who were previously uninsured.

8. This question involves confidential and proprietary information and will be provided under separate cover.

9. *On page 13 of the Actuarial Memorandum, you explain that VHC agreed to pay you for 2014 claims for which members had been retroactively cancelled. What settlement amount was received for 2014? What settlement amount is anticipated for 2015? What is the timing of any payments or expected payments?*
   VHC reimbursed BCBSVT $1,572,974, or about 0.5% of allowed claims, for 2014 claims incurred by members whom VHC had retroactively cancelled. The settlement for 2015 will take place upon completion of the financial reconciliation, which is ongoing. Until this work is completed, we do not know the settlement amount. As such, we included an assumption of 0.5% of total 2015 claims, equivalent to the outcome for 2014.

10. *On page 17 of the Actuarial Memorandum you describe the Pharmacy Trend Development. You indicated: "In this filing, we removed the contract adjustment from the cost trend calculation and added a factor to the overall trend calculation to account for the contracting changes. Accordingly, we based our cost trend calculation on Average Wholesale Price (AWP), which does not reflect contracted discounts, instead of contract-adjusted allowed charges as in previous filings." How were contracted discounts and rebates considered in the trend calculation?*
    Discounts and rebates are known contracting changes that are separate from the determination of underlying pharmacy trend. Rather than reflecting these in the trend calculation itself, they are included separately in the Index Rate development as Changes in Pharmacy Contract (1+c5) and Projected Pharmacy Rebates (e1), respectively.

11. *At the end of page 19 and continuing onto page 20 of the Actuarial Memorandum, you discuss how you have incorporated the impact of Viekira. At the top of page 20 you state: "There is no discount reflected in the claim, however we do receive large rebates from ESI for Viekira claims. As drug rebates are credited to groups in a separate part of the renewal formula, we used the claim cost of $30,000 per month in the trend development." Since there are no renewals formula that apply to small groups in this pool, please explain why rebates for all the specialty drugs that you have singled out in this section should not be incorporated into the cost estimates?*
    The phrase "As drug rebates are credited to groups in a separate part of the renewal formula" was extraneous. As with all other rebates, those for specialty drugs are included separately from trend in our estimate of Projected Pharmacy Rebates, item e1 in the Index rate development.

12. *On Page 24 of your Actuarial Memorandum you report that you completed an extensive cost accounting study. Please quantify the impact of any changes to your cost accounting on the administrative costs of the Qualified Health Plans. What other insurance lines were adjusted to offset any changes to the allocated administrative costs for the Qualified Health Plans?*
    Please see our response to Question 3 of the inquiries received on June 9, 2016.

13. *In 2016, how many small businesses with 51-100 employees purchased plans from you on the Exchange and how many were self-funded? How did the number of small groups and morbidity of these small groups compare to the estimates you made in your 2016 Vermont Health Connect filing? How many additional small groups do you expect to enroll in 2017?*
    Please see our response to Question 4 of the inquiries received on June 9, 2016. None of our previous large group customers of 51-100 employees who purchased QHPs from us in 2016 had previously been self-funded.

14. *Please explain your provider contracting timeline. When do you establish the rates you will pay different providers and how often are they renegotiated?*
    Negotiations with Vermont hospitals occur annually, concluding after the release of hospital budget orders by the GMCB. Most changes are implemented in October, with the exception of hospitals that have a January fiscal year.

    Our New Hampshire hospital negotiations also occur annually. Like most Vermont hospitals, updates are generally reflected in October, with the exception of Dartmouth Hitchcock negotiations, which occur on a July fiscal year basis. Non-facility contract review,

negotiations and updates occur throughout the year reliant upon the premium approval obtained through rate review process.

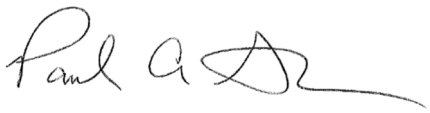
15. *Please explain any assumptions you made in your filing based on current Health Care reform initiatives in Vermont.*
    We have not included in our filing any assumptions, positive or negative, related to Vermont health care reform efforts. Apart from the continued inclusion of the cost of the Blueprint fees in the filing, we do not anticipate that any potential reforms would impact the cost of health care in 2017.

16. *Your predicted federal risk adjustment payment is one third of the amount MVP predicts it will pay. Can you explain this discrepancy?*
    We have no detailed knowledge of the methodology or calculations MVP used in their rate filing, and we are therefore unable to comment.

17. *Please indicate whether you believe that it is necessary to make any adjustments to this filing as the result of legislative changes in Vermont during the 2016 session or to federal changes that were not included in your original filing and that will affect rates. Please provide details about each such necessary adjustment.*
    Vermont legislators mandated the coverage of vasectomies at no cost share for non-CDHP plans. They also mandated a special enrollment period for pregnant women. Neither of these pieces of legislation have a material impact on rates. We are aware of no state or federal legislation that would require an adjustment to rates.

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 6, 2016

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 07/01/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated July 1, 2016, here are *your questions* and our answers:

1. *We note that House Bill 873 allocates the expenses incurred by the Office of the Health Care Advocate for services related to the Green Mountain Care Board's and Department of Financial Regulation's regulatory and supervisory duties. Was the allocation of these expenses accounted for in the proposed rates?*
   We did not specifically adjust our projected administrative expenses for this bill. The difference between the new allocations included in H873 and the amount included in our experience administrative charges for the Office of the HCA is estimated to be less than $20,000.

2. *Per page 19 of the 2017 URRT Instructions, "Utilization Trend also includes any effects of selection since this cannot be reflected in the relative cost of the various products and plans offered." Please justify including the impact of selection (line C6 in Exhibit 5) in the other factor in the URRT or modify the URRT to comply. We note that this will not have an impact on the rates.*
   After reviewing the 2017 URRT instructions, we agree with your interpretation that the impact of selection is more appropriately included in the Utilization Trend rather than the Other factor. We will reflect this change in our revised URRT submitted at the conclusion of the rate review process.

3. *Please provide additional detailed descriptions for the calculations of the values in rows 19 and 20 in Exhibit 2F.*
   Row 19 in Exhibit 2F was calculated by comparing the actual allowed PMPM for each metal level to the average allowed PMPM. The comparison was done at the metal level, rather than the plan level, for credibility purposes.

Metal	Actual CY 2015 Allowed PMPM	Projected CY 2017 Membership	Benefit Richness Adjustment
Platinum	$787.46	12,995	1.5891
Gold	$499.88	15,243	1.0088
Silver	$447.83	38,949	0.9037
Bronze	$305.25	10,182	0.6160
Catastrophic	$120.01	169	0.2422
Total	$495.55	77,538	

Please note that we noticed an error on exhibit 2F, where the Benefit Richness Adjustment (row 19) is not the value in the table above. This error has a de minimis impact on rates.

Row 20 in Exhibit 2F is the Base Paid to Allowed ratio also shown on Exhibit 6B, row 11.

4. *Please confirm that cells O6 and AK6 should be labeled as GMCB in the confidential response provide on May 31, 2016.*

   Yes, cells O6 and AK6 should have been labeled as GMCB.

5. *Please provide additional detail for the "potential up-take in 2015" on the top of page 16 in the Actuarial Memorandum.*

   While reviewing the data used to calculate the utilization trend, it became apparent that the monthly patterns for QHP claims were not as expected based on our re-adjudication models. With approximately three-quarters of the membership enrolled in plans with high deductibles (of over $1,000), we expected that monthly claims would follow a more seasonal pattern than that experienced in 2015 (see Exhibit 3C for monthly claims details). While hard evidence of up-take is difficult to quantify, it is commonly experienced in plans that have seen a major change in benefits – the rollout of QHPs in this case. This phenomenon is referred to in the literature as the "hush, rush, crush cycle[1]". In the period preceding the change, there is an increase (rush) in claims due to the impending change in benefit. This then dampens the claims in the period following the benefit change (hush), due to members having already received elective services, along with uncertainty in how to use the new benefit package. Finally, the last period (crush – calendar year 2015 in this case) experiences an increase in claims as members better understand their benefits and revert to a more typical pattern of utilization. This year-over-year increase in utilization artificially increases trend. We therefore do not believe that the artificially high trend experienced in early 2015 is indicative of future expectations, and have adjusted our assumptions accordingly.

6. *Does BCBSVT have any concerns with the proposed rates in light of the updated 2015 risk adjustment information released on June 30th by CMS?*

   The final risk adjustment information published by CMS leads us to believe that our projection of the 2017 risk adjustment payment was overly optimistic. The actual 2015 transfer is $581,288, which is some $2 million less than originally anticipated and included in our financial statements.

   We updated our estimate of the 2017 projected risk adjustment transfer in light of this new information. Pursuant to earlier conversations with you, we also adjusted the calculation to reflect the impact of groups with 51-100 employees (estimated to have risk scores proportional to their claims, both relative to other small group members) and members previously in Medicaid expected to join MVP (10% of former Medicaid members expected to join QHPs). In adding the groups of 51-100, we updated the membership used in the calculation to match our 2017 projection (the original calculation simply referred to 2015 membership). The updated risk adjustment for 2017 is a *payment* from BCBSVT to MVP of approximately $680,000. This would increase our projected rate increase to 8.6 percent.

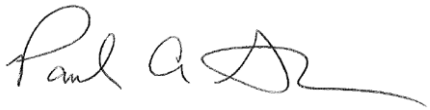
   Please find attached *Reponses to BCBSVT 2017 QHP Filing Inquiries Letter 5*.xlsx, which includes versions of Exhibits 4 and 9 that have been updated for details of the final 2015 risk adjustment transfer calculation and its projected impact on rates.

[1] Skwire, Daniel D. (2016) Group Insurance, Seventh Edition, New Hartford, CT: ACTEX Publications

Please note that the restated contribution to reserve for 2015, including the final 2015 risk adjustment information along with the final coinsurance percentage for transitional reinsurance (and with 3R payments reflected in the year they were incurred), is negative 2.4 percent, while the cumulative five year CTR is negative 0.8 percent for the Small Group and Individual markets.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the information above.

Sincerely,



Paul Schultz, F.S.A., M.A.A.A.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

	Transfer Amounts		
	Combined Market	**Catastrophic Market**	**Total**
Actual 2014	-$2,691,752	$21,502	-$2,670,249
Actual 2015	-$503,587	-$77,701	-$581,288
Estimated 2016, includes a 7.7% average premium increase	-$542,472	-$83,075	-$625,547
Estimated 2016, includes a 7.7% average premium increase and 1.5% coding growth assumption for Other Carriers	-$159,925	-$83,075	-$243,000
Estimated 2016, includes a 7.7% average premium increase and 1.5% coding growth assumption for Other Carriers and updating BCBSVT enrollment to the 2016 projection, including the impact of Groups with 51-100 employees that joined QHP in 2016	-$86,409	-$100,566	-$186,975
Estimated 2017 before Medicaid Membership adjustment, includes a 8.2% average premium increase and updating BCBSVT enrollment to the 2017 projection, including the impact of Groups with 51-100 employees expected to join QHP during 2016	$9,131	-$108,812	-$99,681
Estimated 2017 before Medicaid Membership adjustment, includes a 8.2% average premium increase and 1.5% coding growth assumption for Other Carriers, and updating BCBSVT enrollment to the 2017 projection, including the impact of Groups with 51-100 employees expected to join QHP during 2016	$432,611	-$108,812	$323,799
Estimated 2017 after Medicaid Membership adjustment, includes a 8.2% average premium increase and 1.5% coding growth assumption for Other Carriers, and updating BCBSVT enrollment to the 2017 projection, including the impact of Groups with 51-100 employees expected to join QHP during 2016	$788,796	-$108,812	$679,984

* receivable are expressed as negative numbers

Projected Risk Adjusment Transfer	$679,984
Projected Risk Adjustment Fee ($1.56 per enrollee per year)	$120,959
Net Projected Risk Adjusment	**$800,943**
Member Months	930,456
Net Projected Risk Adjusment PMPM	$0.86
Paid to Allowed Ratio (from Exh 6C)	79.32%
Market Wide Adjustment for the Risk Adjustment Program	**$1.08**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS RATE FILING
RESPONSES TO ACTUARIAL INQUIRIES

	NON-STANDARD PLANS					STANDARD PLANS							
	GOLD	Gold	SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium for Inforce Contracts
Plan Level Adjusted Index Rate	$530.86	$504.35	$462.43	$435.73	$399.85	$625.84	$549.97	$475.09	$470.45	$402.29	$404.22	$219.50	
PMPM to Single Contract Conversion Factor	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	1.1107	
2017 Proposed Rates													
Single Rate	$589.63	$560.18	$513.62	$483.96	$444.12	$695.13	$610.85	$527.68	$522.52	$446.82	$448.97	$243.80	
Couple Rate	$1,179.26	$1,120.36	$1,027.24	$967.92	$888.24	$1,390.26	$1,221.70	$1,055.36	$1,045.04	$893.64	$897.94	$487.60	
Adult and Child(ren) Rate	$1,137.99	$1,081.15	$991.29	$934.04	$857.15	$1,341.60	$1,178.94	$1,018.42	$1,008.46	$862.36	$866.51	$470.53	
Family Rate	$1,656.86	$1,574.11	$1,443.27	$1,359.93	$1,247.98	$1,953.32	$1,716.49	$1,482.78	$1,468.28	$1,255.56	$1,261.61	$685.08	$421,935,363
2016 Approved Rates													
Single Rate	$531.33	$506.32	$465.16		$401.92	$656.63	$573.36	$484.49	$468.90	$409.17	$406.84	$229.41	
Couple Rate	$1,062.66	$1,012.64	$930.32		$803.84	$1,313.26	$1,146.72	$968.98	$937.80	$818.34	$813.68	$458.82	
Adult and Child(ren) Rate	$1,025.47	$977.20	$897.76		$775.71	$1,267.30	$1,106.58	$935.07	$904.98	$789.70	$785.20	$442.76	
Family Rate	$1,493.04	$1,422.76	$1,307.10		$1,129.40	$1,845.13	$1,611.14	$1,361.42	$1,317.61	$1,149.77	$1,143.22	$644.64	$388,384,890
2017 Proposed Rate Increases													
Single Rate	11.0%	10.6%	10.4%		10.5%	5.9%	6.5%	8.9%	11.4%	9.2%	10.4%	6.3%	
Couple Rate	11.0%	10.6%	10.4%		10.5%	5.9%	6.5%	8.9%	11.4%	9.2%	10.4%	6.3%	
Adult and Child(ren) Rate	11.0%	10.6%	10.4%		10.5%	5.9%	6.5%	8.9%	11.4%	9.2%	10.4%	6.3%	
Family Rate	11.0%	10.6%	10.4%		10.5%	5.9%	6.5%	8.9%	11.4%	9.2%	10.4%	6.3%	**8.6%**
Inforce Contracts													
Single Rate	727	1,598	2,560		1,649	4,272	2,767	7,151	3,122	1,245	1,477	153	
Couple Rate	185	623	663		453	1,607	777	2,181	1,049	330	354	3	
Adult and Child(ren) Rate	42	155	85		89	390	187	325	164	57	95	2	
Family Rate	183	844	203		371	1,270	700	1,041	850	206	320	2	

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/11/2016		Supporting Document	Attachments A & B	05/31/2016	Attachment A - Standard Plans AV Certification - 2017.pdf Attachment B - Blue Rewards (Non-Standard) Plans AV Certification - 2017.pdf (Superceded)

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Introduction

On January 21, 2016, CMS released the final methodology on the Actuarial Value and the final Actuarial Value Calculator (AVC) for 2017. CMS made few changes in the 2017 AVC. Most notably, they trended the underlying claims to calendar year.

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 Blue Rewards (Non-Standard) plans are:

- The AVC does not support the Rx OOPM Limit as dictated by Act 171.
- 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 measure all cost sharing elements for that plan. We created a model to calculate the ratio of expected benefits to allowed charges. See the description of the BCBSVT AV Model (BAVM) below. We used the BAVM to calculate both the complete benefit design and the benefit design for items supported by the AVC. We then applied the ratio of the two values to the AVC output for items supported by the AVC.

BCBSVT AV Model Methodology

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). The in-network claims from BCBSVT Insured Groups and Individuals expected to be in the Qualified Health Plans in 2017, representing 771,212 member months, are included in the analysis. Claims have been adjusted to reflect the network used for BCBSVT QHPs. Calendar year 2013 claims, trended to 2017 using 6.5% trend[1], were used in the model. The claims were categorized based on the cost sharing applied for each service, and one record was generated for each unique combination of member and service

[1] BCBSVT used the same trend that CMS used in the 2017 Final AV Calculator (see page 6 of https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf)

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

The tables following the Actuarial Opinion show the relationship between the BAVM and the AVC.

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

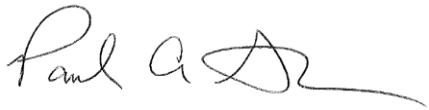
The purpose of this calculation is to comply with the requirements of 45 CFR 156.135(b)(3). The Actuarial Values were determined based on the plans' benefits and coverage data, the standard population, utilization and continuance tables published by HHS for purposes of valuation of Actuarial Value. These 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 2017.

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 A. Schultz, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont

Blue Rewards CDHP Plans

Plan : Blue Rewards (Non-Standard) CDHP Plan - Gold			
Items supported by the AV Calculator	Deductible	$2,500	
	Coinsurance	0%	
	OOPM	$2,500	
AVC Output for items supported by the AVC		(a)	78.2%
BCBSVT Model Output for items supported by the AVC		(b)	80.5%
BCBSVT Model Output for complete benefit design		(c)	81.2%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**78.8%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
In 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):

Plan Description:
Name: Blue Rewards CDHP - Gold
Plan HIOS ID: 13627VT0390001 and 13627VT0370001
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.19%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Silver			
Items supported by the AV Calculator	Deductible	$4,500	
	Coinsurance	0%	
	OOPM	$4,500	
AVC Output for items supported by the AVC		(a)	67.6%
BCBSVT Model Output for items supported by the AVC		(b)	72.3%
BCBSVT Model Output for complete benefit design		(c)	73.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**69.0%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$4,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
On 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):

Plan Description:
Name: Blue Rewards CDHP - Silver
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 67.64%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Silver 73% CSR			
Items supported by the AV Calculator	Deductible	$3,500	
	Coinsurance	0%	
	OOPM	$3,500	
AVC Output for items supported by the AVC		(a)	72.3%
BCBSVT Model Output for items supported by the AVC		(b)	76.0%
BCBSVT Model Output for complete benefit design		(c)	77.0%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**73.2%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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	Medical	Drug	Combined
Deductible ($)			$3,500.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$3,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
On 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 73%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 72.29%
Metal Tier: Silver

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Silver 77% CSR			
Items supported by the AV Calculator	Deductible	$2,800	
	Coinsurance	0%	
	OOPM	$2,800	
AVC Output for items supported by the AVC		(a)	76.1%
BCBSVT Model Output for items supported by the AVC		(b)	79.1%
BCBSVT Model Output for complete benefit design		(c)	79.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**76.7%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$2,800.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,800.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):	
In 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):	

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 77%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 76.11%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Silver 87% CSR			
Items supported by the AV Calculator	Deductible	$1,300	
	Coinsurance	0%	
	OOPM	$1,300	
AVC Output for items supported by the AVC		(a)	86.8%
BCBSVT Model Output for items supported by the AVC		(b)	87.6%
BCBSVT Model Output for complete benefit design		(c)	87.7%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**86.9%**

Items not supported by the AV Calculator for this plan are Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,300.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 87%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 86.80%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan – Silver 94% CSR			
Items supported by the AV Calculator	Deductible	$600	
	Coinsurance	0%	
	OOPM	$600	
AVC Output for items supported by the AVC		(a)	93.3%
BCBSVT Model Output for items supported by the AVC		(b)	93.3%
BCBSVT Model Output for complete benefit design		(c)	93.3%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**93.3%**

Items not supported by the AV Calculator for this plan are Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):
In 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):

Plan Description:
Name: Blue Rewards CDHP - Silver CSR 94%
Plan HIOS ID: 13627VT0390002 and 13627VT0370002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 93.26%
Metal Tier: Platinum

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Bronze			
Items supported by the AV Calculator	Deductible	$7,150	
	Coinsurance	0%	
	OOPM	$7,150	
AVC Output for items supported by the AVC		(a)	59.4%
BCBSVT Model Output for items supported by the AVC		(b)	64.6%
BCBSVT Model Output for complete benefit design		(c)	66.9%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**61.6%**

Items not supported by the AV Calculator for this plan are the Pharmacy MOOP of $1,300 and Wellness (Safe Harbor) pharmaceuticals not subject to the deductible.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☑
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
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 ($)			$7,150.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ 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			☐ 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):	
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):	

Plan Description:
Name: Blue Rewards CDHP - Bronze
Plan HIOS ID: 13627VT0390003 and 13627VT0370003
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 59.43%
Metal Tier: Bronze

2017 AV Calculator

Blue Rewards Copayment Plans

Items not supported by the AV Calculator for these plans are

- Pharmacy MOOP of $1,300
- Three Mental Health office visits at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care

For Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, we blended the Office Visit copayment and the Outpatient Facility copayment based on the frequency of services from the continuance tables in the AVC to calculate the input needed in the AVC.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan - Gold			
Items supported by the AV Calculator	Deductible	$1,250	
	Coinsurance	0%	
	OOPM	$4,250	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	79.4%
BCBSVT Model Output for items supported by the AVC		(b)	82.5%
BCBSVT Model Output for complete benefit design		(c)	84.2%
Estimated AVC value		(d)=(c)/(b)*(a)	**81.0%**

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 ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if different	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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$20.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$30.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$19.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$30.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):

Plan Description:
Name: Blue Rewards Gold
Plan HIOS ID: 13627VT0380001 and 13627VT0360001
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.35%
Metal Tier: Gold

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver			
Items supported by the AV Calculator	Deductible	$2,300	
	Coinsurance	0%	
	OOPM	$7,150	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	69.5%
BCBSVT Model Output for items supported by the AVC		(b)	74.2%
BCBSVT Model Output for complete benefit design		(c)	76.4%
Estimated AVC value		(d)=(c)/(b)*(a)	**71.6%**

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 ($)			$2,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$7,150.00			
OOP Maximum if Separate ($)						

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 Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):

Plan Description:
Name: Blue Rewards Silver
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 69.48%
Metal Tier: Silver

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 73%			
Items supported by the AV Calculator	Deductible	$2,200	
	Coinsurance	0%	
	OOPM	$5,700	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	71.4%
BCBSVT Model Output for items supported by the AVC		(b)	75.3%
BCBSVT Model Output for complete benefit design		(c)	77.4%
Estimated AVC value		(d)=(c)/(b)*(a)	**73.4%**

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 ($)			$2,200.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,700.00			
OOP Maximum if Separate ($)						

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	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):	

Plan Description:

Name: Blue Rewards Silver CSR 73%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 71.42%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
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Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 77%			
Items supported by the AV Calculator	Deductible	$1,300	
	Coinsurance	0%	
	OOPM	$5,200	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	75.7%
BCBSVT Model Output for items supported by the AVC		(b)	79.5%
BCBSVT Model Output for complete benefit design		(c)	80.8%
Estimated AVC value		(d)=(c)/(b)*(a)	**76.9%**

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if different	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	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$400.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$1,500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$1,500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):		

Plan Description:

Name: Blue Rewards Silver CSR 77%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 75.67%
Metal Tier:

2017 AV Calculator

BLUE CROSS AND BLUE SHIELD OF VERMONT
2017 VERMONT QUALIFIED HEALTH PLANS
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Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 87%			
Items supported by the AV Calculator	Deductible	$200	
	Coinsurance	0%	
	OOPM	$2,250	
	Copayments after the deductible	See print below	
	PCP visits at no cost share before the deductible	3	
AVC Output for items supported by the AVC		(a)	87.1%
BCBSVT Model Output for items supported by the AVC		(b)	90.2%
BCBSVT Model Output for complete benefit design		(c)	90.3%
Estimated AVC value		(d)=(c)/(b)*(a)	**87.2%**

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 ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to 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	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$28.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$500.00	☑	☑			☑	☐
Rehabilitative Speech Therapy	☑	☐		$50.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$50.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$50.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$50.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
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):	

Plan Description:

Name: Blue Rewards Silver CSR 87%
Plan HIOS ID: 13627VT0380002 and 13627VT0360002
Issuer HIOS ID: 13627

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.09%
Metal Tier: Gold

2017 AV Calculator

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 94%

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[2] 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.

	A	B	C	D	E	F	G	H	I	K	L
1	**User Inputs for Plan Parameters**										
2	Use Integrated Medical and Drug Deductible?	☑									
3	Apply Inpatient Copay per Day?	☐									
4	Apply Skilled Nursing Facility Copay per Day?	☐									
5	Use Separate OOP Maximum for Medical and Drug Spending?	☐									
6	Indicate if Plan Meets CSR Standard?	☑									
7	Desired Metal Tier	Platinum									
8											
9											
10	Deductible ($)			$0.00							
11	Coinsurance (%, Insurer's Cost Share)			100.00%							
12	OOP Maximum ($)			$1,100.00							
13	OOP Maximum if Separate ($)										
14											
15	Click Here for Important Instructions										
16	**Type of Benefit**										
17	**Medical**	☑ All	☑ All			☑ All	☑ All			☑ All	☐ All
18	Emergency Room Services	☑	☐		$250.00	☑	☑			☑	☐
19	All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑			☑	☐
20	Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑			☑	☐
21	Specialist Visit	☑	☐		$35.00	☑	☑			☑	☐
22	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$14.00	☑	☑			☑	☐
24	Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑			☑	☐
27	Rehabilitative Speech Therapy	☑	☐		$35.00	☑	☑			☑	☐
28	Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$35.00	☑	☑			☑	☐
31	Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
32	Laboratory Outpatient and Professional Services	☑	☐		$35.00	☑	☑			☑	☐
33	X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑			☑	☐
34	Skilled Nursing Facility	☑	☐		$0.00	☑	☑			☑	☐
35	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
36	Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
37	**Drugs**	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
38	Generics	☑	☐		$5.00	☑	☑			☑	☐
39	Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
40	Non-Preferred Brand Drugs	☑	☑	40%		☑	☑			☐	☐
41	Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑			☐	☐

2	HSA/HRA Options	Narrow Network Options	
3	HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐	
4–5	Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
9	Medical	Drug	Combined	Medical	Drug	Combined

	Tier 1				Tier 2				Tier 1	Tier 2
16	Subject to Deductible?	Subject to Coinsuranc	Coinsurance, if different	Copay, if separate	Subject to Deductibl	Subject to Coinsuran	Coinsurance, if	Copay, if separate	Copay applies only after deductible?	

43	**Options for Additional Benefit Design Limits:**	
45	Set a Maximum on Specialty Rx Coinsurance Payments?	☐
46	Specialty Rx Coinsurance Maximum:	
47	Set a Maximum Number of Days for Charging an IP Copay?	☐
48	# Days (1-10):	
49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
50	# Visits (1-10):	3
51–52	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
	# Copays (1-10):	

Plan Description:	
Name:	Blue Rewards Silver CSR 94%
Plan HIOS ID:	13627VT0380002 and 13627VT0360002
Issuer HIOS ID:	13627

53	**Output**	
54	Calculate	
55	Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
56	Actuarial Value:	94.09%
57	Metal Tier:	Platinum
58		
59	**2017 AV Calculator**	

[2] The AV calculator produces an AV of 94.13% 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.

BLUE CROSS AND BLUE SHIELD OF VERMONT
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METAL ACTUARIAL VALUES CERTIFICATION

Appendix – Complete Benefit Designs

	Gold	Silver	73% AV	77% AV	87% AV	94% AV
Deductible/OOP Max	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Medical Ded	$1,250	$2,300	$2,200	$1,300	$200	$0
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$7,150	$5,700	$5,200	$2,250	$1,100
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,100
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family	Aggregate, 2x Family
Medical Deductible waived for:	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Pediatric Dental Class I
Drug Deductible waived for:	N/A	N/A	N/A	N/A	N/A	N/A
Service Category						
Preventive	$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	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						
Specialist Office Visit	$30	$50	$50	$50	$50	$35
Urgent Care	$30	$50	$50	$50	$50	$35
Ambulance	$30	$50	$50	$50	$50	$35
DME	$30	$50	$50	$50	$50	$35
ER	$250	$400	$400	$400	$250	$250
Radiology (MRI, CT, PET)	$500	$1,500	$1,500	$1,500	$500	$0
Outpatient	$500	$1,500	$1,500	$1,500	$500	$0
Inpatient	$500	$1,500	$1,500	$1,500	$500	$0
Rx Generic	$5	$5	$5	$5	$5	$5
Rx Preferred Brand	40%	40%	40%	40%	40%	40%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	60%

BLUE CROSS AND BLUE SHIELD OF VERMONT
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METAL ACTUARIAL VALUES CERTIFICATION

	Gold	Silver	73% AV	77% AV	87% AV	94% AV	Bronze
Deductible/OOP Max	**CDHP**	**CDHP**	**CDHP**	**CDHP**	**CDHP**	**CDHP - Not HSAQ**	**CDHP - Not HSAQ**
Medical Ded	$2,500	$4,500	$3,500	$2,800	$1,300	$600	$7,150
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$2,500	$4,500	$3,500	$2,800	$1,300	$600	$7,150
Rx OOPM	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Family	Aggregate, 2x Family, Embedded Individual OOPM of $7,150	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family	Aggregate, 2x Family, Embedded Individual OOPM of $7,150
Medical Deductible waived for:	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care
Drug Deductible waived for:	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts	Wellness Scripts
Service Category							
Preventive	$0	$0	$0	$0	$0	$0	$0
PCP Office Visit	0%	0%	0%	0%	0%	0%	0%
MH/SA Office Visit	0%	0%	0%	0%	0%	0%	0%
Specialist Office Visit	0%	0%	0%	0%	0%	0%	0%
Urgent Care	0%	0%	0%	0%	0%	0%	0%
Ambulance	0%	0%	0%	0%	0%	0%	0%
DME	0%	0%	0%	0%	0%	0%	0%
ER	0%	0%	0%	0%	0%	0%	0%
Radiology (MRI, CT, PET)	0%	0%	0%	0%	0%	0%	0%
Outpatient	0%	0%	0%	0%	0%	0%	0%
Inpatient	0%	0%	0%	0%	0%	0%	0%
Rx Generic	$5	$15	$15	$15	$15	$15	$25
Rx Preferred Brand	40%	40%	40%	40%	40%	40%	40%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	60%	60%