Filing at a Glance

Company:	BCBSVT
Product Name:	2016 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:	05/15/2015
SERFF Tr Num:	BCVT-130082559
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Vince Mace, Jude Daye, Martine Brisson-Lemieux, Paul Shultz
Reviewer(s):	Thomas Crompton (primary), Kelly Macnee, David Dillon, Judith Henkin, Jacqueline Lee
Disposition Date:	08/13/2015
Disposition Status:	Approved
Implementation Date:	01/01/2016

State Filing Description:

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 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: 08/21/2015
State Status Changed:
Created By: Jude Daye
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: To be sold on the Vermont Health Connect effective 01/01/2016.

Filing Description:
May 15, 2015

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

Subject:Blue Cross and Blue Shield of Vermont - NAIC # 53295
2016 Vermont Qualified Health Plans Rate Filing

Dear Ms. Henkin:

Attached for the Green Mountain Care Board's review and approval is Blue Cross and Blue Shield of Vermont's 2016 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

Company and Contact

Filing Contact Information

Jude Daye, Executive Assistant dayej@bcbsvt.com

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

445 Industrial Lane
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802-371-3244 [Phone]

Filing Company Information

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

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

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Thomas Crompton	08/21/2015	08/21/2015

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Response	Jacqueline Lee	07/01/2015	07/01/2015
Pending Response	Jacqueline Lee	06/30/2015	06/30/2015
Pending Response	Jacqueline Lee	06/30/2015	06/30/2015
Pending Response	Jacqueline Lee	06/25/2015	06/25/2015
Pending Response	Jacqueline Lee	06/18/2015	06/18/2015
Pending Response	Jacqueline Lee	06/11/2015	06/11/2015
Pending Response	Jacqueline Lee	06/01/2015	06/01/2015
Pending Response	Jacqueline Lee	05/21/2015	05/21/2015

Response Letters

Responded By	Created On	Date Submitted
Martine Brisson-Lemieux	07/08/2015	07/08/2015
Martine Brisson-Lemieux	07/01/2015	07/01/2015
Martine Brisson-Lemieux	06/30/2015	06/30/2015
Jude Daye	06/26/2015	06/26/2015
Martine Brisson-Lemieux	06/22/2015	06/22/2015
Jude Daye	06/15/2015	06/15/2015
Martine Brisson-Lemieux	06/04/2015	06/04/2015
Martine Brisson-Lemieux	05/27/2015	05/27/2015

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
2016 Vermont Qualified Health Plans Rate Filing - Amended per GMCB Order	Note To Reviewer	Jude Daye	08/18/2015	08/18/2015
Updated Actuarial Dataset	Note To Reviewer	Jude Daye	06/09/2015	06/09/2015

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Disposition

Disposition Date: 08/13/2015
Implementation Date: 01/01/2016
Status: Approved

HHS Status: HHS Approved
State Review: Reviewed by Actuary

Comment: This filing is approved as amended per GMCB order "GMCB-008-15rr" dated 08/13/15.

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	5.899%	5.899%	$20,688,763	40,864	$350,712,794	11.493%	0.513%

Percent Change Approved:
Minimum: 0.513%
Maximum: 11.493%
Weighted Average: 5.899%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Actuarial Memorandum		No
Supporting Document	Actuarial Memorandum and Certifications		No
Supporting Document	Civil Union Rating Requirements		No
Supporting Document	Consumer Disclosure Form		No
Supporting Document	Filing Compliance Certification		No
Supporting Document	Third Party Filing Authorization		No
Supporting Document	Unified Rate Review Template		No
Supporting Document	Exhibits		No
Supporting Document	Attachments A, B & C		No
Supporting Document	Rate Data Template		No
Supporting Document	Actuarial Data Set		No

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 05.21.2015		No
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015		No
Supporting Document	Response to BCBSVT 2016 QHP Filing Inquiries 06-11-2015		No
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.22.2015		No
Supporting Document	Response to Inquiries dated 06-25-2015		No
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.29.2015		No
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.30.2015		No
Supporting Document	Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015		No

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2016 Vermont Health Connect Rate Filing SERFF No. BCVT-130082559	)))))	GMCB-008-15-rr

DECISION & ORDER

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) requires that health insurance exchanges—marketplaces where individuals, families and small businesses can shop for qualified health insurance coverage—be established in each state by January 2014. In Act 48 of 2011, Vermont's seminal health care reform law, the Vermont legislature created this state's exchange, Vermont Health Connect (VHC).

The Green Mountain Care Board, also created by Act 48, is the independent board tasked with ensuring that changes in the health system improve the quality and accessibility of health care while stabilizing its costs. Among its regulatory tasks,[1] the Board reviews major medical health insurance rates. The Board first reviewed rates offered on VHC in 2013 when Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Plan, Inc. (MVP) each filed proposed 2014 rates; accordingly, this is the third year that the Board has reviewed health insurance rates offered through the exchange.

In this filing, BCBSVT proposes an 8.6%[2] average annual rate increase for health plans offered on VHC with coverage beginning January 1, 2016. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. Starting in January 2014, the ACA requires that individuals and families have qualifying health insurance coverage or pay a penalty on their personal income tax returns.

[1] The Legislature assigned the Board three main responsibilities: regulation, innovation, and evaluation. In its regulatory role, the Board regulates health insurance rates, hospital budgets and major health care expenditures.

[2] As explained in the decision, BCBSVT originally filed for an 8.4% increase, and amended its filing to reflect an 8.6% increase on June 26, 2015. *See* Finding of Fact (Finding) ¶ 9.

Qualifying coverage includes coverage from an employer, health insurance purchased through the exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

2. Vermont Health Connect offers qualified health plans (QHPs) to individuals, families and small employers, with rates based on a single risk pool that includes the individual and small group markets. *See* 33 V.S.A. §§ 1803 ("Vermont Health Benefit Exchange"); 1811 ("Health benefit plans for individuals and small employers"). For plan years 2014 and 2015, a small employer was defined as employing up to 50 employees. Beginning in 2016, Section 1304(b) of the ACA expands the small employer definition to include employers with 51-100 employees.[3] *See also* 33 V.S.A. §1811 (a)(3)(B) (defines small employer to include up to 100 employees as of January 1, 2016).

3. Plans are offered to consumers in four "metal levels": bronze, silver, gold and platinum. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.[4]

4. In order to make health insurance plans offered on the exchange more affordable, individuals enrolling for coverage who do not have employer-sponsored insurance may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan"). In addition, Vermont caps the percentage of household income that eligible individuals and families pay for health insurance premiums and offers subsidies for lower deductibles[5] and copayments.[6]

5. The ACA requires that all exchange plans include ten categories of services, called "essential health benefits" (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and

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[3] Small employers with 51-100 employees may also choose to self-insure, particularly if their populations are young and healthy. *See* American Academy of Actuaries Issue Brief, *Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees* (March 2015) at 5-6, *available at* http://www.actuary.org/files/Small_group_def_ib_030215.pdf

[4] Catastrophic coverage is characterized by low premiums and high deductibles. Individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

[5] A deductible is the amount a patient pays for covered services before his or her health plan begins to pay.

[6] A copayment is a fixed amount a patient pays for a covered health care service, usually at the time the service is delivered.

habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

6. The ACA includes three risk spreading mechanisms intended to stabilize costs and provide incentives for insurers to participate in the exchanges. The transitional reinsurance program is funded through fees levied on health insurance plans and ends with the 2016 plan year. Under this temporary program, the federal government reimburses an insurer for a percentage of an individual's high cost claim that falls within specified parameters.

7. The risk corridors program, also ending in 2016, protects against pricing uncertainty by requiring insurers to calculate allowable costs and targets for each QHP based on a specific formula. If a plan earns a profit under the formula, the insurer must share it with the federal government; conversely, if a plan shows a loss, the federal government shares some of the loss.

8. The risk adjustment program applies to ACA-compliant plans in both the individual and small group markets. Under this program, plans with an enrolled population with lower than average actuarial risk will make payments to those plans that have an enrolled population with higher than average actuarial risks. The program is intended to protect against adverse selection among QHPs.

Procedural History

9. On May 15, 2015, BCBSVT filed its 2016 Vermont Health Connect Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed exchange rates for coverage commencing January 1, 2016. *See* Exhibit 1;[7] *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_SERFF_7_8_15.pdf. The initial SERFF filing showed a proposed rate increase of 8.4%; on June 26, 2015, BCBSVT amended the filing to request an 8.6% average rate increase to account for legislative changes to Vermont's Blueprint for Health.[8]

10. On May 27, 2015, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of

[7] The exhibits referred to in this decision were either stipulated to by the parties or admitted into evidence upon motion at hearing.

[8] Pursuant to Vermont law, insurers are required to participate in the Blueprint for Health, Vermont's initiative to improve population health and control costs by promoting prevention and care coordination. 18 V.S.A. § 706 ("Health insurer participation"); § 703 ("Health prevention; chronic care management").

Appearance as an interested party to the proceeding. *See* http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_HCA_NOA.pdf.

11. On July 6, 2015, the Department of Financial Regulation (Department) issued an opinion and analysis of the impact of BCBSVT's rate filing on the company's solvency. The Department advised the Board that "downward adjustments to rate components should not be made unless GMCB's consulting actuary explicitly opines that the filed rates, without any modification, are excessive." Exhibit 15 at 3, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_Solvency_Analysis.pdf.

12. Lewis & Ellis (L&E), the Board's contract actuary, conducted a review of the filing and issued an actuarial memorandum summarizing its analysis and recommendations. The memorandum was posted to the Board's website on July 15, 2015. *See* Exhibit 14; *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_Actuarial_Memo.pdf.

13. The Board held a public administrative hearing on July 29, 2015. Judith Henkin served as hearing officer by designation of Board Chair Al Gobeille. Jacqueline Hughes, Esq. represented BCBSVT. BCBSVT's Chief Financial Officer (CFO) Ruth Greene and Actuarial Director Paul Schultz testified on the company's behalf. Lila Richardson, Esq. and Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Consulting. Ryan Chieffo, Assistant General Counsel for the Department, testified regarding the Department's solvency analysis. Mike Donofrio, General Counsel, represented the Board and conducted the examination of Jackie Lee, Vice President and consulting actuary for L&E, who testified about the firm's actuarial review of the filing and recommendations for modification.

14. The Board accepted public comments on the proposed rates from May 15, 2015 through July 29, 2015[9] and received 484 comments concerning both BCBSVT's and MVP's filings. 450 of the comments are based on a template provided to consumers by the Vermont Public Interest Research Group (VPIRG); many include personal statements along with the submissions. In addition to the 450 VPIRG comments, 19 of the remaining written comments specifically address BCBSVT's proposed rate increase, and seven comments were verbally submitted to the Board during the BCBSVT rate hearing. The comments overwhelmingly discuss

[9] Although the deadline for accepting comment expired on July 29, 2015, additional comments were received and reviewed by the Board subsequent to that date.

the issue of affordability for Vermonters and oppose any increase in premium rates. *See* Public Comments, *available at* http://ratereview.vermont.gov/sites/dfr/files/VPIRG_Rate_Comments_2015.pdf; http://ratereview.vermont.gov/sites/dfr/files/Public_Comment_2016_Exchange_Final.pdf.

Findings of Fact

Nature of the Filing

15. BCBSVT is a non-profit hospital and medical service corporation that provides major medical, Medicare supplement and prescription drug coverage to Vermonters. As the larger of the two issuers offering plans on the exchange, BCBSVT has 40,864 policyholders and 67,050 covered lives in its Vermont Health Connect plans. Of the covered lives, 31,147 are individual policyholders and 35,903 are covered through small group plans.

16. BCBSVT offers consumers in the exchange both standard and non-standard plans. The standard plans are not unique to the carrier and provide benefits approved by the Board, offer members access to a nationwide network of providers, and include coverage for all EHBs. The two health and wellness-based non-standard plans, Blue Rewards and Blue Rewards CDHP, are carrier-specific but still must comply with all requirements for participation in the exchange.

17. Enrollment for the 2016 exchange plans begins in November 2015 for coverage beginning on January 1, 2016.

Summary of the Data, Analysis, and Testimony Presented at Hearing

18. BCBSVT developed its 2016 VHC rates based on claims incurred by its individual, small group and QHP membership, and by members enrolled in small group products offered by The Vermont Health Plan (TVHP)[10] for an experience period from January 1, 2014 through December 31, 2014, and paid through February 28, 2015. Exhibit 1 (Actuarial Memorandum) at 6-7.

19. BCBSVT adjusted its rate projection to account for the expansion of small groups to include employers with 51-100 employees. BCBSVT assumed that slightly less than half of such groups will realize lower premiums and enter the exchange; of the remaining, it assumed that none would purchase exchange plans. *Id*. at 17-18. At hearing, BCBSVT's actuary explained the rationale for the latter assumption, citing the "well developed marketplace in Vermont for self-

[10] TVHP is a fully owned subsidiary of BCBSVT.

funded groups of smaller size," the possibility that brokers will steer the groups to the captive insurance market, and the likelihood that many of these small groups will postpone their decisions by choosing an earlier plan renewal date, allowing them to retain their current plans until late in 2016. Transcript (TR) at 82-83.

20. BCBSVT projected the experience period claims forward to the rating period using an allowed medical trend[11] factor of 7.4% and pharmacy trend of 6.5%. The medical trend comprised a 2.0% utilization factor and a 5.3% unit cost trend. Exhibit 1 (Actuarial Memorandum) at 14-22. Following discussions with L&E, BCBSVT agreed to reduce its unit cost trend to 5.1%, reducing the overall medical trend to 7.2%. According to L&E, the most likely actual trend centers around its best estimate and ranges from 7.1% to 7.3%. Exhibit 14 at 4; *id*. at n 5.

21. BCBSVT's proposed rates include an administrative load of $28.40 PMPM, equaling 6.4% of total premium. Salary and benefits comprise 74.9% of the administrative load. Exhibit 1 (Actuarial Memorandum) at 28-29.

22. The proposed rates also include a 2.0% contribution to reserves (CTR).[12] BCBSVT contends that a 2.0% CTR is needed in case of regulatory action that impacts surplus, membership growth that creates a need for additional Risk Based Capital (RBC),[13] or an unexpected adverse event such as a flu epidemic. *Id*. at 30-31.

23. On review of the filing, L&E recommends four modifications. First, it recommends that the carrier reduce the total allowed medical trend from 7.4% to 7.2%, the midpoint of L&E's "best estimate" range of 7.1% to 7.3. *See* Finding ¶ 20. Second, L&E recommends that BCBSVT reduce its administrative costs by 0.1% to reflect an increase in membership. Third, L&E recommends that the carrier recalculate its federal risk adjustment to account for a $2.7M

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[11] In most basic terms, trend refers to the change in the cost of health care and consists of utilization (frequency of use of the product or service) and unit cost.

[12] Though often used interchangeably, "reserves" are costs that a health care insurer estimates it will be obligated to pay for services that its members will use during the course of coverage. In contrast, "surplus" (retained earnings) consists of funds that are not allocated to pay for known liabilities. Instead, surplus may be used to cover unexpectedly high claims costs or unforeseen adverse occurrences such as a flu pandemic. *See, e.g.,* Report by the Department of Financial Regulation, *When a Health Insurer Ceases Business in Vermont*, (July 15, 2014) at 16-20 (distinguishes reserves from surplus), *available at* http://www.dfr.vermont.gov/sites/default/files/Act%20144%20DFR%20Surplus%20Report_0.pdf .For purposes of our decision, we employ the terminology as used by the carrier.

[13] Risk-Based Capital is a method of measuring the capital required by an insurer to support its overall business operations in consideration of its size and risk profile.

payment to BCBSVT from MVP. Last, L&E recommends that BCBSVT modify the insurer fee calculation, as proposed by the carrier. L&E calculates that the cumulative effect of the modifications would reduce the proposed annual rate increase from 8.6% to 7.3%. Exhibit 14 at 10. In addition, L&E opines that the requested 2.0% CTR is reasonable. *Id*. at 9.

24. BCBSVT agrees to each of the recommended modifications, and calculates that the rates will decrease from 8.6% to 7.2%. BCBSVT Post Hearing Memorandum of Law (BCBSVT Memo) at 1; *see also* TR at 134-135 (Jackie Lee explains that BCBSVT's calculation is more precise than L&E's).

25. The HCA's independent actuary, Donna Novak, agrees with each of L&E's recommendations and proposes two additional modifications to the filing. First, Novak disputes BCBSVT's assumption that none of the small employers with 51-100 employees that do not realize a decrease in premiums will migrate to the exchange. Novak assumes that half of these employers will choose to enter the exchange, producing a 0.25% decrease in rates. Exhibit 16 at 8.

26. Second, Novak proposes that BCBSVT reduce the CTR, characterizing the carrier's solvency as "strong" and improving. *Id*. at 9. Although she does not recommend a specific decrease in her report, Novak testified that reducing the CTR to 1.52% could maintain the carrier's current level of solvency, and that if the CTR were eliminated entirely, BCBSVT would remain in its target RBC range. TR at 150-152; 156.

27. BCBSVT's witnesses each testified about the company's need for adequate surplus and reserves. Noting that BCBSVT has realized negative CTR of -0.4% over the past four years, BCBSVT's actuary testified that "reserves are a consumer protection" and that maintaining adequate reserves allows the company to continue to pay claims in the event of a significant adverse event. *Id.* at 84-87.

28. CFO Greene testified that the company's target range for RBC is between 500% and 700%, and that its "surplus and member reserves is hovering sometimes modestly above and sometimes below the midpoint of the target range." *Id*. at 16, 27.

29. Assistant General Counsel Chieffo discussed the Department's role in monitoring insurer solvency and the difficulty of projecting future solvency from a fixed point in the past. Chieffo testified that the Department's opinion that a 2.0% CTR is appropriate and necessary in

this filing had not changed, despite BCBSVT's agreement to modifications reducing the rate to 7.2%. *Id.* at 112-116.

30. Both witnesses for BCBSVT were questioned by Board members about the impact of the hospital budget process on the carrier's medical trend. After commenting that the rate review and hospital budget processes are "out of sync," Chair Gobeille asked CFO Greene about the importance of knowing the "commercial ask"[14] when determining BCBSVT's medical trend. Greene acknowledged that it is "very important," but due to timing of the respective processes, BCBSVT does not know what the projected hospital increases will be when it develops its rates. For the 2016 VHC filing, BCBSVT incorporated last year's actual hospital budget results into its rate projections. *Id.* at 53.

31. In response to questions from Board member Ramsay, BCBSVT's actuary suggested that the carrier's medical trend would have been lower had it known, at the time it was developing its 2016 VHC rates, the projected rate of increase in the recently submitted hospital budgets. *Id*. at 105 (a projected 4.3% median increase for hospital budgets "would have been great to know at the time.")

32. At the end of the hearing, the Board took comments from members of the public. Several speakers covered by BCBSVT plans through VHC underscored the impact of the rising costs of health insurance on their families and their household budgets. *Id*. at 160-175. One consumer told the Board that her family currently pays approximately $20,000 annually for coverage through a BCBSVT gold plan, and that the percentage of her family income to pay for coverage will rise from 20% to 25% if the proposed rates are approved. *Id*. at 163.

Standard of Review

1. Vermont law provides that the Board shall review health insurance rate filings to ensure that rates are affordable, that they are not "excessive, inadequate or unfairly discriminatory," that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. §§ 4512(b); 4062(a)(2),(3); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6).

[14] The term "commercial ask" refers to the increase in rates that hospitals negotiate with commercial payers.

2. As part of its review, the Board will consider the Department's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, § 2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id*. § 2.104(c).

Conclusions of Law

I. BCBSVT Must Reduce its Medical Trend from 7.2% to 7.1%, the Low End of Probable Trend Factors, Because its Unit Cost Trend is Likely Overstated.

We first address BCBSVT's requested medical trend. Although the carrier reduced its initially-filed trend downward—its requested 7.4% trend was "unintentionally inflated due to methodology used," *see* Exhibit 14 at 4—the resulting unit cost component does not account for recent hospital budget submissions, and therefore likely remains overstated.

Our questions at hearing, and the responses from BCBSVT, highlight the need to work towards alignment of the hospital budget and exchange rate review processes. Currently, the carriers cannot incorporate into their rate projections information garnered during the hospital budget process. At this point in time, however—well beyond the filing date for VHC rates —we reasonably expect that hospitals, as a group, will not raise the prices they charge their commercial payers as much as they have in the past, and know that this factor is not reflected in the proposed rates. Indeed, both witnesses for BCBSVT acknowledge that the hospital budget information is important and ideally should be reflected in the carrier's projected medical trend. Findings ¶¶ 31, 32.

In addition, on review of this filing, neither the Board nor our actuary has a mechanism by which we can readily incorporate current hospital budget projections into the carrier's proposed medical trend. It is not a one-to-one mapping; BCBSVT's medical unit cost increase includes services in addition to those provided by the hospitals. We therefore acknowledge that our actuary's recommended medical trend may be slightly overstated. Nonetheless, L&E calculated a recommended trend of 7.2% based on its extensive review of information and data provided by BCBSVT during the course of this filing, and based on its review, advises the Board that the highest probability of actual trend ranges from 7.1% to 7.3%. Finding ¶ 20. Accordingly,

we choose the lowest point within the range—7.1%—which further reduces the medical trend and produces more affordable rates for consumers.

This modification reduces the requested rate by 0.2 %.

II. BCBSVT's CTR Must be Reduced from 2.0% to 1.0%, Allowing the Carrier to Realize Growth in Surplus While Providing Lower Rates for Vermonters.

BCBSVT requests a 2.0% CTR for this filing. The Department has voiced its support of the requested CTR,[15] and L&E has stated that the request is reasonable. The HCA opposes the request, opining that BCBSVT's solvency won't be markedly impacted by a reduction to CTR. For the following reasons, we agree and reduce the requested CTR to 1.0%.

The testimony at hearing from BCBSVT, coupled with our continuing assessments of BCBSVT's financial condition, indicates that the company's RBC is stable and falls in the middle of its target range. Finding ¶ 28. While we recognize that adequate surplus is needed as a cushion against unforeseen adverse events, we find that a 1.0% contribution in this filing allows the carrier to add to its surplus, albeit by a smaller amount than requested.

In addition, we again express our concern that notwithstanding our decision to nominally reduce the medical trend, BCBSVT's trend and therefore its overall rates likely remain overstated; L&E's recommendation, from which we derived the trend value we approve today, was similarly made without the benefit of current hospital budget projections. *See* Section I, above. Adding to our concern, we find the HCA's contention that some portion of the expanded small group market will enter the exchange—despite higher premiums—to be credible, although we find no empirical evidence to conclude that half of such groups will do so. Rather, we find it reasonable to assume that some percentage of this population will migrate—more than BCBSVT's 0% assumption—and that as a result, BCBSVT's rate request is likely overstated. Based on the HCA's assertion that half of such groups migrating to the exchange reduces the rates by 0.25%, however, we expect that the actual impact on the rates will be minimal.

Accordingly, we conclude that reducing the CTR from 2.0% to 1.0% adequately protects BCBSVT's solvency and therefore its continued ability to provide health insurance coverage to Vermonters, offsets the rate impact of a likely overstated medical trend, and produces more affordable rates for consumers purchasing through VHC.

[15] The Department has supported each of the company's surplus requests since the Board began its expanded review of rate filings on January 1, 2014.

This modification reduces the requested rate by 1.1%.

Conclusion

The Legislature has charged this Board with ensuring that all Vermonters gain access to affordable, quality health care. Exerting downward pressure on health insurance rates, while remaining mindful of our obligation to protect insurer solvency, is one of the ways that we continue to move closer to achieving that goal. As a result of our decision today, BCBSVT's average annual 2016 Vermont Health Connect rate increase is reduced from 8.6% to 5.9%.

Order

Based on the reasons discussed above, the Board modifies and then approves BCBSVT's 2016 Vermont Health Connect Rate Filing. Specifically, we order that BCBSVT: (1) reduce its administrative costs by 0.1% to account for an increase in membership; (2) recalculate the federal risk adjustment to account for a $2.7M payment to BCBSVT from MVP; (3) modify the insurer fee as proposed and agreed to by the carrier during review of the filing; (4) reduce the allowed medical trend to 7.1%; and (5) reduce the CTR from 2.0% to 1.0%.

As modified, the average annual rate increase is reduced from the proposed 8.6% to 5.9%.

So ordered.

Dated: August 13, 2015 at Montpelier, Vermont

s/ Alfred Gobeille	)	
	)	
s/ Cornelius Hogan	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Jessica Holmes	)	OF VERMONT
	)	
s/ Betty Rambur	)	

** Board Member Allan Ramsay has filed a separate dissent to this decision, which is attached.*

Filed: August 13, 2015

Attest: s/ Janet Richard
Green Mountain Care Board, Administrative Services Coordinator

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail address: Janet.Richard@ vermont.gov). Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days.

Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.

Ramsay, dissenting:

For the following reasons, I do not agree with the majority's decision in this rate filing.

Health insurance plans offered on Vermont Health Connect (VHC) must be affordable for Vermonters. In addition, they must promote access to health care, promote quality, protect insurer solvency, and be fair. Rate increases that are excessive have a profound financial effect on Vermonters and their families, and limit access to high quality health care.

The Board's decision for VHC plans commencing in 2015 allowed BCBSVT to increase its rate by 7.7%. For 2016 plans, the Board is increasing BCBSVT rates for VHC products by close to 6.0%. I do not believe this large two-year increase is affordable; nor does it align with rising cost increases in other sectors of our economy. I also do not believe that a smaller rate increase for 2016 than the one now approved by the Board will threaten the solvency of the company, as outlined below.

I.

When developing the unit cost increase for determining its 2016 VHC medical trend, BCBSVT assumes providers within the BCBSVT service area will experience budget increases similar to the 5.9% hospital budget increase implemented for FY 2015. Based on that assumption, BCBSVT utilizes a 5.3% unit cost trend. In its 2015 VHC rate filing, however, BCBSVT utilized a lower unit cost trend of 4.4%. *See* BCBSVT 2015 VHC Rate Filing, GMCB-18-14rr at 6, ¶ 21, *available at* http://ratereview.vermont.gov/sites/dfr/files/GMCB%20018-14rr.pdf. Given that hospital budget rate increases for 2016 are projected at 4.3%—significantly lower than the 5.9% implemented for FY 2015—it is likely that BCBSVT's unit cost trend will also be lower than the 4.4% trend used in its 2015 rates. BCBSVT could not have known when it developed its proposed 2016 rates that the aggregate hospital rate increase would be lower than the prior year's; nonetheless, as BCBSVT's actuary testified at hearing, had it known, it may have used a lower unit cost trend in its calculations.

After review of BCBSVT filing, including a series of requests for additional information and responses from the carrier, Lewis & Ellis (L&E) estimated the range of actual allowed medical trend would be 4.5% to 10.0%. The wide range is due to random fluctuations and

unpredictable changes in the use of medical services. L&E determined the mid-range for medical trend would be 7.1% to 7.3%, and chose 7.2% as its "best estimate" which is 50% more likely to occur than the trends at either end of the range. L&E performed these calculations, as had BCBSVT, without knowing that the hospital rate increase would be lower for FY 2016 than in FY 2015. I therefore believe that a 4.3% unit cost trend—the estimated aggregate hospital rate increase for 2016—more closely reflects the unit cost trend than does L&E's recommended medical trend as a result of the information contained in the recent hospital budget submissions.

In addition, BCBSVT originally proposed a higher medical trend of 7.4% and agreed with L&E that the error was due to a "flawed methodology." Given the expected rate increase request of the Vermont hospital system and uncertain methodology employed by BCBSVT to calculate medical trend, I believe a 4.3% unit cost trend is most appropriate, reducing the overall medical trend to 6.4%.

II.

During the hearing, BCBSVT was asked about its strategic vision for moderating the growth in health care costs. The Board has a responsibility for assuring that all those who pay for or provide health care in Vermont work toward the common goal of an affordable, high quality, and accessible health care system. Every commercial insurer in Vermont should be focused on investing in programs, such as primary care, that are likely to moderate the increase in health care costs, as well as work diligently to reduce the administrative costs in the system. BCBSVT described several important efforts to control rising administrative costs; *see* Exhibit 8 at 3; even with these efforts, the administrative costs in this filing rose from $25.78 PMPM to $28.43 PMPM, a 10.3% increase.

III.

BCBSVT has requested a 2.0% increase in contribution to its reserve fund. Both BCBSVT witnesses testified that this increase would protect the company from unusual events that could threaten its solvency. These events included regulatory actions, epidemics or unusual events, membership growth, or new technologies. First, as a member of the regulatory Board, I fully understand the importance of maintaining the solvency of all commercial health insurers in Vermont. Second, as a physician with 34 years of practice experience in Vermont, I have not experienced an epidemic that could threaten the solvency of a health insurance plan. Third, though employers with 51-100 employees will be eligible for Vermont Health Connect in 2016,

BCBSVT did not calculate this rate filing with any expected increase in enrollees from this risk pool, unless they expect a savings in premium. If it had projected that any of these groups would enter the exchange, the rates would likely have been lower. Last, the only new technologies that BCBSVT describes as a threat to its solvency are the specialty drugs, including PCSK9 inhibitors and hepatitis C therapies. The Board and L&E agreed the proposed pharmacy trend increase of 6.5% is reasonable and appropriate and allows for the possible effects of specialty drug costs.

BCBSVT has accumulated a significant reserve fund over the past five years. In addition, the company has maintained its risk based capital (RBC) within a range that demonstrates its solvency. For these reasons I believe a reduction in the contribution to reserves from 2.0% to 1.0% is appropriate.

Adjusting the unit cost trend to 4.3% and reducing the contribution to reserve to 1.0% will reduce the overall rate increase to approximately 4.7%.

This year the Board received over 450 public comments relating to the rate increases proposed by MVP and BCBSVT. This is many more than we received last year. Similar to last year, the majority of the comments are based on a template provided to consumers by the Vermont Public Interest Research Group (VPIRG). In comparison, however, last year only 15% of the Vermonters who used the VPIRG template added a personal comment; this year over 40% took the time to add a personal note or story to the submission. Virtually all the comments focus on the fact that the rate increases and out-of-pocket costs of Vermont Health Connect are not affordable. Only a few mention specific issues of quality or plan benefit design.

The Board must rely on fact, opinion, and analysis when approving a rate increase. The most important opinion is that of Vermonters, who believe continued large rate increases in Vermont Health Connect are not affordable.

For these reasons, I respectfully dissent.

s/ Allan Ramsay

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	07/01/2015
Submitted Date	07/01/2015
Respond By Date	07/06/2015

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
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
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Sergei Mordovin, A.S.A.
Johnathan L. O'Dell, A.S.A.
Clint Prater, A.S.A.
Larry Choi, A.S.A.

L&E Actuaries & Consultants

Kansas City
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Jill J. Humes, F.S.A.
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Naomi Kloeppersmith, F.S.A.
Stephanie Crownhart, F.S.A.
Thomas L. Handley, F.S.A. (Of Counsel)

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Scott E. Morrow, F.S.A.

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

Denver
Mark Stukowski, F.S.A.

July 1, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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 the estimated impact on the 2014 CTR due to the report that CCIIO released with the actual reinsurance recoveries and risk adjustments for 2014.
2. Please discuss what impact the risk adjustment transfer should have on the 2016 premiums. Provide proposed changes, if any, to the 2016 premiums with updated exhibits.

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, 2015. 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:	*2016 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/30/2015
Submitted Date	06/30/2015
Respond By Date	07/02/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on July 2nd.

Conclusion:

Sincerely,
Jacqueline Lee

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

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

Denver
Mark Stukowski, F.S.A.

June 30, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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. Your Actuarial Memorandum states at page 9 "These groups will either have to offer QHPs or move to a self-funded alternative. We assumed that only groups that would realize lower premium by choosing QHPs would join the risk pool." Considering the risks to small employers of being self-insured and the logistics involved in setting up a self-funded plan, please explain why you assume that all of the lower cost groups would move to self-funded plans, including any support you have for this assumption. Please calculate the impact on rates if all the groups with 51-100 employees choose to offer QHPs rather than choosing a self-funded option.

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 2, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/30/2015
Submitted Date	06/30/2015
Respond By Date	07/01/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on July 1st.

Conclusion:

Sincerely,
Jacqueline Lee

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

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Scott E. Morrow, F.S.A.

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

Denver
Mark Stukowski, F.S.A.

June 30, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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 the 2014 administrative expenses on a PMPM basis were used to project the 2016 administrative expenses. Please provide quantitative support for the increased projected membership for 2016 compared to 2014, which should exclude membership that is projected to shift to QHPs from other BCBSVT products. How was the increased membership, if any, accounted for in the projected 2016 administrative expenses?
2. Confidential

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

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than July 1, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/25/2015
Submitted Date	06/25/2015
Respond By Date	06/26/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 26th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
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Sergei Mordovin, A.S.A.
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Clint Prater, A.S.A.
Larry Choi, A.S.A.

L&E Actuaries & Consultants

Kansas City
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Naomi Kloeppersmith, F.S.A.
Stephanie Crownhart, F.S.A.
Thomas L. Handley, F.S.A. (Of Counsel)

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

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

Denver
Mark Stukowski, F.S.A.

June 25, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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 the estimated impact on the 2014 CTR due to the recently released report that 2014 reinsurance recoveries will be reimbursed at 100% for individual market plans' covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000.
2. Please provide support for the projected earned premium on the "rate review detail" in SERFF of $397,744,608.
3. When available, please post a summary of the results of the risk adjustment transfers that are expected to be sent to health plans on June 30th.

4. The Market Adjusted Index Rate is required to be included in the Actuarial Memorandum and page 59 of the 2016 URRT Instructions states that: "Since the Index Rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program, risk adjustment program, and the Marketplace user fees should be on an allowed basis." Please revise the Market Adjusted Index Rate accordingly.

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 26, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/18/2015
Submitted Date	06/18/2015
Respond By Date	06/22/2015

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
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
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Sujaritha Tansen, A.S.A.
Sergei Mordovin, A.S.A.
Johnathan L. O'Dell, A.S.A.
Clint Prater, A.S.A.
Larry Choi, A.S.A.

L&E Actuaries & Consultants

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Leon L. Langlitz, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
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Christopher J. Merkel, F.S.A.
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Michael A. Brown, F.S.A.
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Stephanie Crownhart, F.S.A.
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Scott E. Morrow, F.S.A.

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

Denver
Mark Stukowski, F.S.A.

June 18, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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. You state that "Members without a pharmacy benefit were excluded" in the base period data (Page 7 of the Actuarial Memorandum):
   a. Why were these members not included since individuals not electing pharmacy would be expected to be healthier?
   b. How many member months were represented by these members?
   c. What would be the impact on the premium rates if these individuals were included with an adjustment to add the pharmacy benefit?

2. What adjustment, if any, did you make for the relative morbidity of the groups with 51-100 employees currently insured by Cigna that will purchase coverage in the exchange?

3. In the development of the pharmacy rebate adjustment why was the cost trend (12.8 percent) used for brand rather than the total trend (5.5 percent) including utilization decreases (-6.5 percent)? If you agree that the utilization decrease should have been included in the calculations please calculate the resulting impact on the premium rates.

4. Please provide administrative costs per-member-per-month from the Supplemental Health Care Exhibit for the individual market, small group market, and combined market for years 2012, 2013 and 2014.

5. Please explain any measures you have taken to control administrative costs including costs in relation to staff compensation in the past five years.

6. Please explain why the adjustments for risk adjustment and reinsurance in Exhibit 5 were not divided by the Paid to Allowed ratio as described on page 21 of the 2016 Unified Rate Review Template instructions.

7. 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 2015 session that were not included in your SERFF filing and that will affect rates. Provide details about each 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 22, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/11/2015
Submitted Date	06/11/2015
Respond By Date	06/15/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 15th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
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Steven D. Bryson, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Wesley R. Campbell, F.S.A.
Jacqueline B. Lee, F.S.A.
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Sujaritha Tansen, A.S.A.
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Xiaoxiao (Lisa) Jiang, A.S.A.
Jennifer M. Allen, A.S.A.
Sergei Mordovin, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

L&E Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
David L. Batchelder, A.S.A.
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Anthony G. Proulx, 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.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

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

June 11, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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. Were any outside sources for utilization trend considered? If so, please provide. i.e. nationwide sources.
2. The results of the regression analysis on utilization trends are influenced by seasonality in the data. In particular, the claims in the fourth quarter have been 13.9% higher on average than the claims for the first three quarters from 2011 – 2014.

The table below shows annualized trends calculated from the data in Exhibit 3B that are lower than the trends calculated using monthly regression. This is most evident by looking at the difference between the one year annualized trend of 2.3% compared to the twelve month regression of 18.8%. We note that the impact of seasonality is less evident in the longer monthly regressions, but it is not fully removed.

Please discuss the impact of seasonality on the selected trends. Were any alternate methods to calculate utilization trends considered?

	Adjusted Allowed	Member Months	PMPM
2011	$84,607,139	230,243	$367.47
2012	$134,664,221	387,494	$347.53
2013	$161,466,345	423,628	$381.15
2014	$168,285,889	431,407	$390.09

	Annual Trends[1]	Regression Analysis
1 year	2.3%	18.8%
2 year	5.9%	6.1%
3 year	2.0%	6.7%

[1] 5.9% = (390.09 / 347.53) ^ 0.5

3. Please provide the estimated impact of induced utilization for the 36 month period from 2012 – 2014, similar to Exhibit 3C.
4. Please provide additional quantitative support for the estimated impact of aging on page 16 of the Actuarial Memorandum and expand the data to include 2012.
5. In the response dated 6/4/2015, please provide quantitative support for the 2016 projected fully insured premium subject to the federal insurer fee.
6. Please elaborate on the possible impact from difficulties in enrolling through VHC on seasonal drug utilization.
7. We note that the regression for non-specialty drug utilization was selected with the period ending September 2014 due to the impact of seasonality. Please provide support for selecting the year ending November 2014 for specialty drugs.

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 15, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/01/2015
Submitted Date	06/01/2015
Respond By Date	06/04/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on June 4th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
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Sergei Mordovin, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

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D. Patrick Glenn, A.S.A., A.C.A.S.
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Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

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

June 1, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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 the expected contributions to reserves for the most recent 4 years based on the final premiums after amendments made by regulators.
2. Please provide the breakdown for the Charges for Outside Vendors by plan in Exhibit 7A for each program listed on page 29 of the Actuarial Memorandum.
3. We note that the total fees collected for the federal insurer fee will increase by 41.25% compared to 2014. Please justify increasing the fee as a percentage of premium rather than on a PMPM basis.

4. Please provide an explanation in the increase in the projected administrative costs from $25.78 in the prior filing to $28.83 in the current filing.
5. Provide quantitative support for the 0.8% increase attributed to federally-mandated changes in the individual member out-of-pocket maximums for family policies within the plans with aggregate deductibles.
6. Provide quantitative support for the 1.1% impact on premium due to leveraging.
7. Provide quantitative support for the 0.8% decrease due to plan changes implemented by BCBSVT and the State of Vermont.
8. Please confirm that the exhibit demonstrating the estimated IBNR on page 7 of the Actuarial Memorandum has estimates from 2014. If not, please provide the correct estimates.
9. Please provide further qualitative support for the $(1 + b_9)$ factor on Exhibit 5 that adjusts the experience period claims for members that did not voluntarily terminate prior to 2015.
10. Please provide additional details on the terminated plans listed on page 33 of the Actuarial Memorandum. Will any of the QHP plans be terminated?
11. Please provide further qualitative support for the induced utilization adjustment $(1 + c_1)$. Were the experience and projected period paid to allowed ratios based on the same data source? Were the paid to allowed ratios calculated using the same method described on page 25 of the Actuarial Memorandum? If not, how were they calculated?

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 4, 2015. 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: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	05/21/2015
Submitted Date	05/21/2015
Respond By Date	05/27/2015

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter and respond no later than the end of day on May 27th.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
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D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

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

May 21, 2015

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
2016 Vermont QHP Rate Filing
SERFF Tracking #: BCVT-130082559

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/15/2015. 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.

2. Provide additional support for the difference between the 6.8% FY 2015 and assumed 7.6% 2016 unit cost increases for Vermont facilities and providers impacted by the hospital budget review process of the GMCB.
3. Please provide an actual to expected comparison of the contributions to reserves for the most recent 5 years.
4. Please provide the total allowed claims and total member months for calendar year 2014 with membership categorized by the first date that coverage was provided.
5. What level of pent-up demand was included in the manual rate for pediatric dental?
6. Was there any evidence of pent-up demand in the 2014 experience for pediatric dental? i.e. higher usage in the first quarter of 2014
7. Provide additional support for the appropriateness of using a blend of experience with the manual rate for pediatric dental and vision benefits. Does the Company have a standard for full credibility for these benefits?
8. What is the estimated impact of the proposed legislation to change the blueprint program?

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 27, 2015. 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: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/08/2015
Submitted Date	07/08/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015.xlsx Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015 - Excel.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/01/2015
Submitted Date	07/01/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.30.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.30.2015.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/30/2015
Submitted Date	06/30/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.29.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.29.2015.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/26/2015
Submitted Date	06/26/2015

Dear Thomas Crompton,

Introduction:

Attached please find the response to the Inquiries dated 6/25/15.

Response 1

Comments:

Response to 6/25/15 Inquiries

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to Inquiries dated 06-25-2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015.xlsx

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: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/22/2015
Submitted Date	06/22/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.22.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.18.2015.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/15/2015
Submitted Date	06/15/2015

Dear Thomas Crompton,

Introduction:

Attached please find the response from BCBSVT on the "Objection" to the 2016 Vermont Qualified Health Plans Rate Filing.

Response 1

Comments:

Attached please find the cover letter, an Excel file and a pdf of the Excel file to the 6/11/15 inquiry.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response to BCBSVT 2016 QHP Filing Inquiries 06-11-2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.xlsx

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: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/04/2015
Submitted Date	06/04/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filings Inquiries – 06.01.2015.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: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/27/2015
Submitted Date	05/27/2015

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2016 QHP Filing.

Response 1

Comments:

Resquested documentation attached

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 05.21.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 05.21.2015.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State:	*VermontGMCB*	**Filing Company:**	*BCBSVT*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*2016 Vermont Qualified Health Plans Rate Filing*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Jude Daye on 08/18/2015 02:09 PM

Last Edited By:

Jude Daye

Submitted On:

08/18/2015 02:10 PM

Subject:

2016 Vermont Qualified Health Plans Rate Filing - Amended per GMCB Order

Comments:

Per the GMCB Order, attached please find the cover letter and supporting documents amending the 2016 Vermont Qualified Health Plans Rate Filing.

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Attachment 2016 BCBSVT QHP Filing - Exhibits - Amended per GMCB Decision.xlsx is not a PDF document and cannot be reproduced here.

Attachment Rates_Template_2016_BCBSVT_13627_Amended.xls is not a PDF document and cannot be reproduced here.

Attachment Unified_Rate_Review_Template_2016_BCBSVT_13627_Amended.xlsm is not a PDF document and cannot be reproduced here.

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

August 18, 2015

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

Subject: Blue Cross and Blue Shield of Vermont – NAIC # 53295
2016 Vermont Qualified Health Plans Rate Filing – Amended per GMCB Order
(SERFF #BCVT-130082559, GMCB-008-15-rr)

Dear Ms. Henkin:

Enclosed are amended exhibits for the Blue Cross and Blue Shield 2016 Qualified Health Plans Rate Filing. These rates have been developed in response to the Green Mountain Care Board Order dated August 13, 2015. The rates were modified as ordered, resulting in a reduction of the total projected average rate increase to 5.9 percent. To help with your review, we step through each component of the order below:

1. *Reduce its administrative cost to account for an increase in membership,*

   As described in our answer to the actuarial inquiry dated June 29, 2015, we had not accounted for the increase in membership in the calculation of the administrative charges. After accounting for this change, administrative charges were reduced by $0.40 PMPM. This is reflected on amended exhibit 7A.

2. *Recalculate the risk adjustment to account for a $2.7M payment to BCBSVT from MVP.*

   As described in our answer to the actuarial inquiry dated July 1, 2015, the most reasonable approach to projecting the 2016 transfer is to modify the actual 2014 payment of $2,670,249 by the increase in our actual average premium in 2014 to the projected average premium for 2016. The total projected risk adjustment payment expected to be received for 2016 is therefore $3,105,503 or $3.70 PMPM. This is reflected on amended exhibit 5.

3. *Modify the insurer fee as proposed and agreed by the carrier during review of the filing*

   As described in our response to the actuarial inquiry dated June 1, 2015, we modified the calculation of the federal insurer fee, reducing it to 2.64%. This is reflected on amended exhibit 7C.

4. *Reduce the allowed medical trend to 7.1%*

   As described in our answer to the actuarial inquiry dated June 29, 2015, we agreed to revise our methodology for calculating medical cost trend. The revised and agreed-upon trend was 7.2%. To comply with this order, we additionally changed the inpatient unit cost trend at one facility such that overall medical trend became 7.100%. This is reflected on amended exhibit 3J.

5. *Reduce the CTR from 2.0% to 1.0%*

   We have reduced the CTR from 2.0% to 1.0%. This is reflected on amended exhibit 7B.

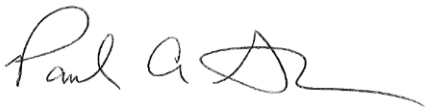
Enclosed are amended Exhibits 3J through 9, the amended Unified Rate Review Template and the amended Rate Data template.

The purpose of this amended filing is to provide the rates and a description of the modifications ordered by the Green Mountain Care Board to the rate development for the Qualified Health Plans that Blue Cross and Blue Shield of Vermont proposes to offer for the 2016 benefit year. These calculations are not intended to be used for any other purpose.

This amendment was prepared in accordance with generally accepted actuarial principals and methodologies, Actuarial Standards of Practice established by the Actuarial Standards Board, and the provisions of the Green Mountain Care Board order dated August 13, 2015.

Please let us know if you have any questions, or if we can provide additional clarity on any of the items above.

Sincerely,



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Paul Schultz, F.S.A., M.A.A.A.

MEDICAL TREND DEVELOPMENT
PROJECTION FACTOR FOR INDEX RATE CALCULATION

TREND FACTORS

Annual	Cost	Utilization	Total
Medical	5.0%	2.0%	7.100%
Pharmacy	6.0%	0.5%	6.5%

MEDICAL

Coverage Category in the Experience	Membership	CY 2014 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2016 Allowed PMPM Adjuted for Network and Small Group Definition
Catamount	28,606	$502.78	1.1024	$554.24	1.0405	$576.71
Indemnity/PPO	49,125	$363.50	1.1024	$400.71	1.0405	$416.95
Point-of-Service	4,245	$295.54	1.1024	$325.80	1.0405	$339.00
HMO	57,397	$364.19	1.1024	$401.47	1.0405	$417.74
HIX	634,346	$394.99	1.1024	$435.42	1.0405	$453.07

PHARMACY

Coverage Category in the Experience	Membership	CY 2014 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2016 Allowed PMPM Adjuted for Network and Small Group Definition
Catamount	28,606	$146.96	1.1226	$164.98	1.0105	$166.70
Indemnity/PPO	49,125	$71.20	1.1226	$79.93	1.0105	$80.77
Point-of-Service	4,245	$65.71	1.1226	$73.77	1.0105	$74.54
HMO	57,397	$81.07	1.1226	$91.01	1.0105	$91.96
HIX	634,346	$75.90	1.1226	$85.20	1.0105	$86.09

		Cost Trend (24mths)		Utilization Trend (24mths)	
Medical	$394.14	1.1024	$434.49	1.0405	$452.10
Rx	$78.55	1.1226	$88.18	1.0105	$89.11
Total	$472.70	1.1057	$522.67	1.0355	$541.21

Cost Trend Factor	$1+d_1$	1.1057
Utilization Trend Factor	$1+d_2$	1.0355

EXPECTED TRANSITIONAL REINSURANCE RECOVERIES

Product	Expected Transitional Reinsurance Recoveries (PMPM)	Projected Individual Members
Blue Rewards Gold	-$30.92	922
Blue Rewards Gold CDHP	-$30.31	0
Blue Rewards Silver	-$27.33	4,349
Blue Rewards Bronze CDHP	-$25.27	1,891
Standard Platinum	-$36.04	4,182
Standard Gold	-$31.22	2,870
Standard Silver	-$27.33	9,518
Standard Silver CDHP	-$27.80	4,414
Standard Bronze	-$24.94	1,416
Standard Bronze CDHP	-$25.24	1,465
Catastrophic	-$28.64	120
Weighted Average on Individual Members Only	-$28.70	31,147
Projected Small Group Members		38,867
Projected Total Members		70,014
Total Recoveried spread across all 70,014 members	**-$12.77**	
Uniform Reinsurance Contribution Rate of $27 per Member per Year	**$2.25**	
Market Wide Adjustment for the Transitional Reinsurance Program	**-$10.52**	

INDEX RATE CALCULATION

Index Rate : Experience Period Allowed Claims for EHB	A	$466.72
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of the Change in Small Group definition	$1+b_1$	1.0019
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	0.9911
Impact of insured formerly on Employer coverage	$1+b_4$	1.0000
Impact of new enrollment from prior high risk pool	$1+b_5$	1.0000
Impact of mandated coverage on morbidity	$1+b_6$	1.0000
Impact of Pent-up demand	$1+b_7$	1.0000
Impact of Premium Subsidy	$1+b_8$	1.0000
Changes in pool morbidity	$1+b_9$	0.9720
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	0.9947
Changes in provider networks	$1+c_2$	1.0109
Changes in demographics (age, gender, region, etc.)	$1+c_3$	1.0144
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in network delivery system	$1+c_5$	1.0000
Impact of Selection	$1+c_6$	1.0206
Adjusted Experience Period Allowed Claims for EHB		$468.98
Trend Factors		
Cost Trend	$1+d_1$	1.1057
Utilization Trend	$1+d_2$	1.0355
Projected Period Allowed Claims for Experience EHB		$536.95
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$4.66
Projected Blue Print Payments	e_2	$3.39
Projected ITS Fees	e_3	$1.39
Projected Vaccine Payments	e_4	$2.24
Projected Net cost of Reinsurance	e_5	$0.95
Additional Adjustments for Additional Mandated Benefits		
Projected Allowed Claims for Pediatric Vision	e_6	$0.37
Projected Allowed Claims for Pediatric Dental	e_7	$4.93
Projected Index Rate : Projected Period Expected Allowed Claims	$F = A\prod_{n=1}^{8}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$545.57
Market Wide Adjustments		
Risk Adjustment Payments and Fees	g_1	-$4.45
Transitional Reinsurance Payments and Recoveries	g_2	-$13.18
Vermont Exchange Fees	g_3	$0.00
Market Adjusted Index Rate	$H = F + \sum_{n=1}^{3} g_n$	**$527.94**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6A
Amended per GMCB Order

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	
Benefit Richness Adjustment	1.0157	0.9960	0.9742	0.9370	1.0825	1.0268	0.9739	0.9772	0.9381	0.9400	0.9421	
Paid to Allowed Ratio	84.00%	80.13%	75.82%	65.61%	93.84%	85.83%	75.89%	76.71%	66.10%	66.69%	68.14%	
Changes in Family Tiers	0.9427	0.9574	0.9443	0.9678	0.9920	0.9904	0.9863	0.9385	0.9786	0.9615	0.9749	
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	0.5043	
Expected Claims Cost	**$424.61**	**$403.41**	**$368.28**	**$314.09**	**$532.00**	**$460.85**	**$384.84**	**$371.40**	**$320.39**	**$318.22**	**$166.63**	**$412.13**
Administrative Charges Plan Level Adjustment	1.0706	1.0739	1.0807	1.0949	1.0560	1.0645	1.0771	1.0802	1.0927	1.0939	1.1780	
Taxes and Fees Plan Level Adjustment	1.0376	1.0376	1.0376	1.0376	1.0376	1.0377	1.0376	1.0376	1.0376	1.0376	1.0376	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$476.48**	**$454.05**	**$417.13**	**$360.43**	**$588.85**	**$514.17**	**$434.48**	**$420.49**	**$366.93**	**$364.84**	**$205.73**	**$463.16**
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Allowed Charges in Re-adjudication Model	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	
Paid Claims from Re-adjudication Model	$456.77	$438.79	$416.41	$367.52	$507.80	$466.16	$416.04	$419.73	$368.71	$372.10	$375.64	
Base Paid to Allowed Ratio	83.68%	80.39%	76.29%	67.33%	93.03%	85.40%	76.22%	76.89%	67.55%	68.17%	68.82%	
Benefit Richness Adjustment for EHB	1.1034	1.0823	1.0591	1.0200	1.1752	1.1153	1.0587	1.0623	1.0208	1.0230	1.0254	1.0866
Normalized Benefit Richness Adjustment for EHB	1.0155	0.9960	0.9747	0.9387	1.0815	1.0264	0.9743	0.9776	0.9394	0.9415	0.9437	
Projected Period Paid Claims for Experience EHB	$450.29	$431.36	$407.48	$356.00	$501.60	$459.83	$407.83	$413.44	$356.44	$360.90	$369.51	
Benefit Richness Adjustment for EHB	1.0155	0.9960	0.9747	0.9387	1.0815	1.0264	0.9743	0.9776	0.9394	0.9415	0.9437	1.0000
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	
Non-System Claims	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	
Market Wide Adjustments (paid)	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	
Total Paid Claims with Benefit Richness Adjustment	$450.42	$421.34	$389.98	$324.54	$536.31	$465.29	$390.19	$395.76	$327.39	$330.97	$338.92	
Overall Benefit Richness Adjustment	1.0157	0.9960	0.9742	0.9370	1.0825	1.0268	0.9739	0.9772	0.9381	0.9400	0.9421	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6C
Amended per GMCB Order

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Projected Period Allowed Claims for Experience EHB	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95
Paid to Allowed Ratio for EHB Portion	83.86%	80.34%	75.89%	66.30%	93.42%	85.64%	75.95%	77.00%	66.38%	67.21%	68.82%	79.82%
Projected Period Paid Claims for Experience EHB	$450.29	$431.36	$407.48	$356.00	$501.60	$459.83	$407.83	$413.44	$356.44	$360.90	$369.51	$428.58
Additional EHB Allowed Claims	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	$3.41
Non-System Claims	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32
Market Wide Adjustments	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63	-$17.63
Market Adjusted Index Rate	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94
Total Paid Claims	$443.46	$423.04	$400.31	$346.36	$495.44	$453.15	$400.66	$405.00	$348.98	$352.10	$359.74	$421.24
Paid to Allowed Ratio	84.00%	80.13%	75.82%	65.61%	93.84%	85.83%	75.89%	76.71%	66.10%	66.69%	68.14%	79.79%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 6D
Amended per GMCB Order

PLAN LEVEL ADJUSTMENT
CHANGE IN FAMILY TIER FACTOR

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	ue Rewards CDI	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Projected Period Paid Claims for Experience EHB	$450.29	$431.36	$407.48	$356.00	$501.60	$459.83	$407.83	$413.44	$356.44	$360.90	$369.51	
Family Multiplier for EHB before MOOP Changes	0.9429	0.9583	0.9319	0.9131	0.9921	0.9906	0.9865	0.9259	0.9791	0.9123	0.9161	0.9633
Adjusment to Family Multiplier for MOOP Changes	1.0007	1.0000	1.0144	1.0609	1.0000	1.0000	1.0000	1.0149	1.0000	1.0549	1.0649	1.0102
Family Multiplier for EHB after MOOP Changes	0.9436	0.9583	0.9453	0.9687	0.9921	0.9906	0.9865	0.9397	0.9791	0.9624	0.9755	0.9727
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	
Non-System Claims	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	
Market Wide Adjustments	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	-$14.07	
Total Paid Claims with Family Multiplier Adjustment	$418.04	$405.04	$378.03	$335.20	$491.47	$448.82	$395.17	$380.08	$341.53	$338.54	$350.70	
Overall Family Multiplier Adjustment	0.9427	0.9574	0.9443	0.9678	0.9920	0.9904	0.9863	0.9385	0.9786	0.9615	0.9749	

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%	$541.21	68.8%	$372.45
Individual Ages 30 or Less	92.7%	$288.21	59.9%	$172.74
Individual Ages over 30	7.3%	$644.38	70.4%	$453.88
Weighted Average		$314.06	61.5%	$193.14
Allowed Charges Adjustment		*0.5803*		
Paid to Allowed Ratio Adjustment			*0.8937*	
Plan Level Adjustment Calculation				
Projected Period Allowed Claims for Experience EHB		$536.95		
Paid to Allowed Ratio for EHB Portion		68.8%		
Benefit Richness Adjustment for EHB		0.9437		
Family Multiplier for EHB		0.9755		
Adjustment for Allowed Charges and Paid to Allowed Ratio		*0.5186*		
Projected Period Paid Claims for Experience EHB		$176.40		
Additional EHB Paid Claims		$0.98		
Non-System Claims		$3.32		
Market Wide Adjustments		-$14.07		
Expected Claims Cost		$166.63		
Market Adjusted Index Rate		$527.94		
Paid to Allowed Ratio		68.1%		
Benefit Richness Adjustment		0.9421		
Changes in Family Tiers		0.9749		
For Catastrophic Only - Impact of Eligibility		0.5043		
Expected Claims Cost		$166.63		
Total Adjustment for Catastrophic Plan			**0.5043**	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 7A
Amended per GMCB Order

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
BCBSVT Base Administrative Charges	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43	$28.43
Administrative Charges for Outside Vendors	$1.56	$1.36	$1.27	$1.36	$1.37	$1.28	$1.25	$1.35	$1.26	$1.43	$1.22	$1.33
Blue For You Reward Program	$0.00	$0.00	$0.00	$0.00							$0.00	$0.00
Total Administrative Charges PMPM	**$29.99**	**$29.79**	**$29.70**	**$29.79**	**$29.80**	**$29.71**	**$29.68**	**$29.79**	**$29.69**	**$29.87**	**$29.65**	**$29.76**
Administrative Charges Plan Level Adjustment	1.0706	1.0739	1.0807	1.0949	1.0560	1.0645	1.0771	1.0802	1.0927	1.0939	1.1780	1.0722
Administrative Charges as a percent of Premium	6.29%	6.56%	7.12%	8.27%	5.06%	5.78%	6.83%	7.08%	8.09%	8.19%	14.41%	**6.43%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

DETAILS OF CONTRIBUTION TO RESERVE

Section 1

Projected 2015 BCBSVT ACL	(A)	$22,642,905
Target RBC %	(B)	600%
Target capital	(C) = (A) x (B)	$135,857,430
Estimated Benefit Trend	(D)	7.86%
Estimated Increase in ACL	(E) = (C) x (D)	$1,780,346
Estimated Increase in Capital to Maintain Target	(F) = (B) x (E)	$10,682,076
Investment Income	(G)	$4,347,236
Tax rate	(I)	20.0%
Federal Insurer Fee	(J)	2.64%
Investment Income Net of Tax	(K) = (G) X (1-I)	$3,477,789
Additional Required	(L) = (F) - (K)	$7,204,287
Grossed up for Taxes	(M) = (L)/(1-I-J)	$9,312,677

Benefit Trend by LOB	
QHP	8.27%
LG	7.20%

	2016 Projected Premium (1)	CTR proportions (2)		Premium Portion (3) = (1) x (2)
QHP	$388,195,788	1.00		$388,195,788
Cost Plus (equiv prem)	$326,258,965	0.25		$81,564,741
Other Insured	$155,416,774	1.00		$155,416,774
Total	$869,871,527	0.72	(N)	$625,177,303
Required Insured CTR Factor to Maintain Target	= (M)/(N)	**1.49%**		

Section 2

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD Blue Rewards	Gold Blue Rewards CDHP	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	**TOTAL**
BCBSVT Contribution to Reserve	$4.76	$4.54	$4.17	$3.60	$5.89	$5.14	$4.34	$4.20	$3.67	$3.65	$2.06	$4.63
Total Contribution to Reserve PMPM	**$4.76**	**$4.54**	**$4.17**	**$3.60**	**$5.89**	**$5.14**	**$4.34**	**$4.20**	**$3.67**	**$3.65**	**$2.06**	$4.63
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101
Contribution to Reserve as a percent of Premium	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**Total**
State Assessment - HCCA	$3.47	$3.31	$3.02	$2.59	$4.33	$3.76	$3.16	$3.05	$2.64	$2.62	$1.41	$3.37
State Tax - VITL	$0.87	$0.82	$0.75	$0.65	$1.08	$0.94	$0.79	$0.76	$0.66	$0.65	$0.35	$0.84
Federal Assessment - PCORI	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19
Federal Insurer Fee	$12.58	$11.99	$11.01	$9.51	$15.55	$13.57	$11.47	$11.10	$9.69	$9.63	$5.43	$12.23
Total Taxes and Fees PMPM	**$17.11**	**$16.31**	**$14.98**	**$12.94**	**$21.15**	**$18.47**	**$15.61**	**$15.10**	**$13.18**	**$13.10**	**$7.39**	**$16.64**
Taxes and Fees Plan Level Adjustment	1.0376	1.0376	1.0376	1.0376	1.0376	1.0377	1.0376	1.0376	1.0376	1.0376	1.0376	1.0376
Taxes and Fees as a percent of Premium	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%	3.59%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Market Wide Adjusted Index Rate	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94	$527.94
Plan Level Adjusted Index Rate	$476.48	$454.05	$417.13	$360.43	$588.85	$514.17	$434.48	$420.49	$366.93	$364.84	$205.73
AV Pricing Value	90.25%	86.00%	79.01%	68.27%	111.54%	97.39%	82.30%	79.65%	69.50%	69.11%	38.97%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 8
Amended per GMCB Order

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
Expected Direct Claims PMPM	$438.69	$417.48	$382.34	$328.14	$546.08	$474.92	$398.91	$385.46	$334.46	$332.27	$180.70	$426.20
Transitional Reinsurance Recoveries PMPM	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77
Risk Adjustment Transfer Payment PMPM	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70
Adjustments for Health Care Quality PMPM*	$5.20	$5.18	$5.18	$5.18	$2.14	$2.14	$2.14	$2.14	$2.14	$2.15	$5.17	$2.71
MLR Claims	**$427.42**	**$406.20**	**$371.05**	**$316.86**	**$531.76**	**$460.59**	**$384.58**	**$371.14**	**$320.13**	**$317.96**	**$169.41**	**$412.45**
Premium PMPM	$476.48	$454.05	$417.13	$360.43	$588.85	$514.17	$434.48	$420.49	$366.93	$364.84	$205.73	$463.16
Licensing and regulatory fees	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40
Taxes & Fees PMPM	-$17.11	-$16.31	-$14.98	-$12.94	-$21.15	-$18.47	-$15.61	-$15.10	-$13.18	-$13.10	-$7.39	-$16.64
MLR Premium	**$456.97**	**$435.35**	**$399.76**	**$345.09**	**$565.30**	**$493.30**	**$416.47**	**$402.99**	**$351.36**	**$349.34**	**$195.94**	**$444.13**
Expected Loss Ratio	93.5%	93.3%	92.8%	91.8%	94.1%	93.4%	92.3%	92.1%	91.1%	91.0%	86.5%	92.9%
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

*Approximately 7.19% of current BCBSVT Administrative Charges are for health care quality plus the Blue Rewards PMPM

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 9
Amended per GMCB Decision

COMSUMER ADJUSTED PREMIUM RATES
AMENDED PER GMCB DECISION

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$476.48	$454.05	$417.13	$360.43	$588.85	$514.17	$434.48	$420.49	$366.93	$364.84	$205.73	
PMPM to Single Contract Conversion Factor	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	
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	$371,401,557.12
2015 Approved Rates												
Single Rate	$493.87		$428.14	$360.49	$624.18	$541.75	$465.61	$436.20	$395.78	$384.02	$228.24	
Couple Rate	$987.74		$856.28	$720.98	$1,248.36	$1,083.50	$931.22	$872.40	$791.56	$768.04	$456.48	
Adult and Child(ren) Rate	$953.17		$826.31	$695.75	$1,204.67	$1,045.58	$898.63	$841.87	$763.86	$741.16	$440.50	
Family Rate	$1,387.77		$1,203.07	$1,012.98	$1,753.95	$1,522.32	$1,308.36	$1,225.72	$1,112.14	$1,079.10	$641.35	$350,712,794.16
2016 Approved Rate Increases												
Single Rate	7.6%		8.6%	11.5%	5.2%	5.8%	4.1%	7.5%	3.4%	5.9%	0.5%	
Couple Rate	7.6%		8.6%	11.5%	5.2%	5.8%	4.1%	7.5%	3.4%	5.9%	0.5%	
Adult and Child(ren) Rate	7.6%		8.6%	11.5%	5.2%	5.8%	4.1%	7.5%	3.4%	5.9%	0.5%	
Family Rate	7.6%		8.6%	11.5%	5.2%	5.8%	4.1%	7.5%	3.4%	5.9%	0.5%	**5.899%**
Inforce Contracts												
Single Rate	1,091		2,819	1,376	4,470	2,898	6,665	3,511	1,253	1,709	113	
Couple Rate	286		730	352	1,634	847	2,182	1,168	359	461	0	
Adult and Child(ren) Rate	69		104	76	358	186	301	206	55	89	2	
Family Rate	297		220	299	1,330	705	1,003	997	207	435	1	

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Note To Reviewer

Created By:

Jude Daye on 06/09/2015 11:16 AM

Last Edited By:

Jude Daye

Submitted On:

06/09/2015 11:16 AM

Subject:

Updated Actuarial Dataset

Comments:

Attached please find the updated Actuarial Dataset for the 2016 Vermont Qualified Health Plans Rate Filing.

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Attachment BCBSVT 2016 QHP Filing - Actuarial Memo Dataset - New Version.xlsx is not a PDF document and cannot be reproduced here.

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Post Submission Update Request Processed On 06/29/2015

Status:	Allowed
Created By:	Jude Daye
Processed By:	Thomas Crompton
Comments:	This post submission update due to the blue print adjustment has been allowed.

Company Rate Information:

Company Name:BCBSVT

Field Name	Requested Change	Prior Value
Overall % Indicated Change	8.528%	8.378%
Overall % Rate Impact	8.528%	8.378%
Written Premium Change for this Program	$29907922	$29381671
Maximum %Change (where required)	14.544%	14.311%
Minimum %Change (where required)	5.135%	4.697%
REQUESTED RATE CHANGE INFORMATION:		
Min:	5.135	4.697
Max:	14.544	14.311
Weighted Avg.:	8.528	8.378
REQUESTED RATE:		
Projected Earned Premium:	397,825,765.000	397,744,608.000
Projected Incurred Claims:	353,935,722.000	353,052,516.000
Min:	215.190	214.290
Max:	602.300	601.770
Weighted Avg.:	474.640	473.990

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2016 Vermont Qualified Health Plans Rate Filing*
Project Name/Number: */*

Post Submission Update Request Processed On 08/19/2015

Status:	Allowed
Created By:	Jude Daye
Processed By:	Thomas Crompton
Comments:	This post submission update has been allowed.

Company Rate Information:

Company Name:BCBSVT

Field Name	Requested Change	Prior Value
Overall % Indicated Change	5.899%	8.528%
Overall % Rate Impact	5.899%	8.528%
Written Premium Change for this Program	$20688763	$29907922
Maximum %Change (where required)	11.493%	14.544%
Minimum %Change (where required)	0.513%	5.135%
REQUESTED RATE CHANGE INFORMATION:		
Min:	0.513	5.135
Max:	11.493	14.544
Weighted Avg.:	5.899	8.528
REQUESTED RATE:		
Projected Earned Premium:	388,195,788.000	397,825,765.000
Projected Incurred Claims:	348,969,663.000	353,935,722.000
Min:	205.730	215.190
Max:	588.850	602.300
Weighted Avg.:	463.160	474.640

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 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: 7.700%
Effective Date of Last Rate Revision: 01/01/2015
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	5.899%	5.899%	$20,688,763	40,864	$350,712,794	11.493%	0.513%

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		18106
BCBSVT EPO (Small Group)	13627VT032		22301
BCBSVT EPO Blue Rewards (Individual)	13627VT038		5271
BCBSVT EPO Blue Rewards (Small Group)	13627VT036		3075
BCBSVT EPO Blue Rewards CDHP (Individual)	13627VT039		1891
BCBSVT EPO Blue Rewards CDHP (Small Group)	13627VT037		1555
BCBSVT EPO CDHP (Individual)	13627VT035		5879
BCBSVT EPO CDHP (Small Group)	13627VT033		8972

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: 773,719
Benefit Change: Increase
Percent Change Requested: Min: 0.513 Max: 11.493 Avg: 5.899

PRIOR RATE:

Total Earned Premium: 350,712,794.00
Total Incurred Claims: 270,303,265.00
Annual $: Min: 202.96 Max: 555.04 Avg: 433.78

REQUESTED RATE:

Projected Earned Premium: 388,195,788.00
Projected Incurred Claims: 348,969,663.00
Annual $: Min: 205.73 Max: 588.85 Avg: 463.16

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	BCBSVT 2016 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 2016 QHP Filing - Plain Language Summary.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Filing Compliance Certification
Comments:	
Attachment(s):	BCBSVT 2016 QHP Filing - 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: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	Unified_Rate_Review_Template_2016_BCBSVT_13627.pdf Unified_Rate_Review_Template_2016_BCBSVT_13627.xlsm UnifiedRateReviewSubmission_2016_BCBSVT_13627_20150515141539.xml
Item Status:	
Status Date:	

Satisfied - Item:	Exhibits
Comments:	Excel too big for SERFF. Excel version sent in the attached Zip file.
Attachment(s):	BCBSVT 2016 QHP Filing - Exhibits.pdf BCBSVT 2016 QHP Filing - Exhibits.zip
Item Status:	
Status Date:	

Satisfied - Item:	Attachments A, B & C
Comments:	
Attachment(s):	Attachment A - Standard Plans AV Certification.pdf Attachment B - Blue Rewards AV Certification.pdf Attachment C - Pediatric Dental Manual Rates.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Data Template
Comments:	
Attachment(s):	Rates_Template_2016_BCBSVT_13627.pdf Rates_Template_2016_BCBSVT_13627.xls Rates_Template_2016_BCBSVT_13627.xml
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Data Set
Comments:	
Attachment(s):	BCBSVT 2016 QHP Filing - Actuarial Memo Dataset.pdf BCBSVT 2016 QHP Filing - Actuarial Memo Dataset.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 05.21.2015

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 05.21.2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.01.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filings Inquiries – 06.01.2015.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Response to BCBSVT 2016 QHP Filing Inquiries 06-11-2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.22.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.18.2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response to Inquiries dated 06-25-2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015 - Excel.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.29.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.29.2015.pdf
Item Status:	

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2016 Vermont Qualified Health Plans Rate Filing
Project Name/Number: /

Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.30.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 06.30.2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015
Comments:	
Attachment(s):	Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015.pdf Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015.xlsx Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015 - Excel.pdf
Item Status:	
Status Date:	

Attachment Unified_Rate_Review_Template_2016_BCBSVT_13627.xlsm is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission_2016_BCBSVT_13627_20150515141539.xml is not a PDF document and cannot be reproduced here.

Attachment BCBSVT 2016 QHP Filing - Exhibits.zip is not a PDF document and cannot be reproduced here.

Attachment Rates_Template_2016_BCBSVT_13627.xls is not a PDF document and cannot be reproduced here.

Attachment Rates_Template_2016_BCBSVT_13627.xml is not a PDF document and cannot be reproduced here.

Attachment BCBSVT 2016 QHP Filing - Actuarial Memo Dataset.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2016 QHP Filings Inquiries 06.01.2015.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2016 QHP Filing Inquiries - 06.25.2015.xlsx is not a PDF document and cannot be reproduced here.

Attachment Responses to BCBSVT 2016 QHP Filing Inquiries - 07.01.2015.xlsx is not a PDF document and cannot be reproduced here.

BLUE CROSS BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING
ACTUARIAL MEMORANDUM

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BLUE CROSS BLUE SHIELD OF VERMONT
2016 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, 2016

1.2. Company Contact Information

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

1.3. Scope and Purpose

The purpose of this rate filing is to provide the rates and a description of the rate development for the Qualified Health Plans (QHPs) that Blue Cross and Blue Shield of Vermont (BCBSVT) proposes to offer for the 2016 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 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 8.4 percent.

1.5. Reason for Rate Increase(s)

Significant health care price increases were partially offset by a very competitive pharmacy contract negotiated by BCBSVT. Actuarial assumptions, notably including favorable assumptions about the makeup of the 2016 QHP population, combined with these factors to produce a 5.3 percent increase in rates. The remainder of the 8.4 percent increase was driven by changes related to federal and state health care reforms, including a change in allowed individual Out-of-Pocket Maximums and a reduction in federal subsidies of QHP premiums through their Transitional Reinsurance Program.

An increase of 2.9 percent is driven by three items required solely because of mandated changes associated with the Affordable Care Act:

- 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 is reduced in 2016 before being eliminated entirely in 2017. Because the premium subsidy changes from an estimated four percent to an estimated two percent in 2016, it will require groups and members to pay 2.2 percent more for their coverage. This is offset by a reduction in the fee to finance the program, which reduces premiums by 0.3 percent.

- Federally-mandated changes in the individual member out-of-pocket maximums for family policies within plans with aggregate deductibles will increase the premiums by 0.8 percent.

- Some deductibles, out-of-pocket maximums and co-pays in QHPs remain unchanged from 2015 to 2016. 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 had an impact of 1.1 percent on premium, offset by a 0.8 percent decrease due to plan changes implemented by BCBSVT and the State of Vermont.

In the absence of mandated changes associated with the Affordable Care Act, a 5.3 percent increase would have been requested:

- An estimate of increases in the amounts providers are paid was included in 2015 QHP rates. Increases beyond those assumptions that have already occurred in 2015, or that are projected to occur before the end of 2015, drive a premium increase of 1.1 percent. This is primarily attributable to prescription drug price increases.

- Amounts that providers are paid are expected to increase by 6.4 percent in 2016. This includes a 1.9 premium percent increase due to increases in the wholesale price of prescription drugs and a 4.4 percent premium increase due to payments to providers of medical services. The latter increase reflects a continued cost shift from Medicare and Medicaid to commercial rates within the Vermont health care system. In the absence of this cost shift, premiums would have been lower by 1.7 percent.

- The new pharmacy contract BCBSVT has negotiated with its Pharmacy Benefit Manager reduces the premium by 1.9 percent.

- BCBSVT assumes that members who have or will enroll in our QHPs in 2016 will prove to be significantly healthier on average than those insured during calendar 2014, either in QHPs or individual and small group products. This assumption creates a premium decrease of 3.5 percent.

- Actual 2014 experience was lower than that assumed in the 2015 QHP filing, however the population underlying that favorable claims result is experiencing higher utilization trends than the population studied for the 2015 filing. The higher assumed the utilization trend increases premiums by 3.1 percent, almost fully offset by a 2.9 percent decrease for the updated experience base.

- In the absence of continued membership growth, administrative charges are increasing approximately proportionally to premium. In terms of an absolute dollar increase, these higher administrative costs raise premiums by 0.7 percent. BCBSVT administrative expenditures remain well below seven percent of premium.

- In order to maintain an adequate level of reserves as required by financial regulation, BCBSVT must increase its contribution to reserve for this filing due to rising health care costs and to protect QHP members by ensuring continued financial stability should a significant adverse event occur (see section 3.8.5.2 for details). This has the effect of increasing premiums by 1.0 percent.

- Other adjustments to the assumptions used in the 2016 rate development cumulatively have the effect of reducing the required rate increase by 1.5 percent. These include items such as:
    - The impact of plan selection (as described in section 3.4.6) increases the premium by 2.0 percent.
    - Other changes, including various modeling enhancements and a number of nearly offsetting adjustments for demographic, generate the remaining 0.5 percent decrease in premiums.

2. PROPOSED BENEFITS

2.1. Description of Benefits

BCBSVT Standard Plans: BCBSVT is providing rates for the Standard Plans with benefits as approved by the Green Mountain Care Board, which are outlined in Exhibit 1A – "State of Vermont Standard Plan Designs." The plans are on the EPO network and offer members access to a nationwide network of providers. These plans include coverage for all Essential Health Benefits (EHBs). The Form filings for these products can be found under BCVT-129970537 for Non-CDHP plans and BCVT-129970594 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-129970545 for Non-CDHP plans and BCVT-129970589 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.

2.2. AV Metal Values

BCBSVT will be offering two types (Standard and Non-Standard) of QHPs in 2016. Standard plans are designed by the State of Vermont and offered by all issuers of QHPs. Please see *Attachment A – Standard Plans AV Certification* 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*, 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 2014 experience of Blue Cross and Blue Shield of Vermont (BCBSVT) Individual, Small Group and QHP products, along with The Vermont Health Plan (TVHP) Small Group products. TVHP is a fully owned subsidiary of BCBSVT.

We combined both companies since all small group members have migrated to QHPs and Small Group products are no longer offered under TVHP. This population will be the Single Risk Pool. Members without a pharmacy benefit were excluded.

We used claims incurred January 1, 2014 through December 31, 2014 and paid through February 28, 2015. 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, 2013	$255,382,946	$343,335,184
Estimate of IBNR as of March 31, 2013 for Claims	1,767,447	1,923,401
Estimate of IBNR as of March 31, 2013 for Pharmacy Rebates	($2,205,011)	($2,205,011)
Total Claims	$255,820,510	$343,616,795
Member Months	735,603	735,603
Total Per Member Per Month (PMPM)	$347.77	$467.12

The experience period total allowed charges PMPM are $467.12.

In the experience period, the earned premium was $297,310,928. Neither BCBSVT nor TVHP will be required to pay MLR rebates for the 2014 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 $467.12.

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% 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 we don't believe that experience for these new benefits is credible and 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	$343,616,795	$467.12
Remove BlueCard Fees	($964,831)	($1.31)
Remove Pharmacy Rebates	$2,683,267	$3.65
Remove Payments to Blueprint Program	($888,620)	($1.21)
Replace Capitation with FFS equivalent	$304,482	$0.41
Remove Dental and Vision Claims	($1,432,153)	($1.95)
Line A of Exhibit 5	**$343,318,939**	**$466.72**

3.4. Projection Factors

3.4.1. Change in the Definition of Small Group

In 2016, the definition of Small Group will change to include groups with 51-100 employees. These groups will either have to offer QHPs or move to a self-funded alternative. We assumed that only groups that would realize lower premiums by choosing QHPs would join the risk pool. This represented just under half of all members in groups of 51-100 employees. We included their claims and member months in all of the factors described below.

	Single Risk Pool	Additional Small Groups	Total
Experience Period Allowed Claims	$343,318,939	$18,480,975	$361,799,914
Experience Period Member Months	735,603	38,116	773,719
PMPM	$466.72	$484.86	$467.61

The factor ($1+b_1$ on Exhibit 5) to adjust for the change in the definition of Small Group is $467.61/$466.70 = 1.0019.

3.4.2. Membership Projections

As of March 2015, BCBSVT had 67,050 members enrolled in a QHP product, either individually through Vermont Health Connect or directly as small group employees.

We used this information to project the 2016 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 total member months expected to be covered by this filing is 840,168.

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

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

3.4.3. Changes in the Morbidity of the Population Insured

Our experience period is based on calendar year 2014. 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.

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	All Other Members	Total
Experience Period Allowed	$55,797,077	$315,298,581	$365,734,212
Member Months	87,497	686,222	773,719
PMPM	$634.61	$459.47	$472.70

The factor ($1+b_9$ on Exhibit 5) to adjust for the change in pool morbidity is $459.47/$472.70 = 0.9720.

We also adjusted the experience for the new entrants. As of March, 6,508 members that were not previously enrolled with BCBSVT or TVHP had enrolled in one of our QHP Products. All that is known at this time are the members' age and gender. Using Milliman's Health Cost Guidelines (2014) age-gender factors (AGF), we compared the expected claims cost of our existing members to the expected claims cost of the new entrants.

Again, we started with the experience claims adjusted for the network and the change in the definition of Small Group, then split the continuing members into the market they joined (Individual Non-Subsidized, Individual Subsidized, Small Groups with 2-50 employees and Small Groups with 51-100 employees). We adjusted the PMPM of the new members within each market by the ratio of the resulting AGF for new and continuing members. The weighted average PMPM of new and continuing members was compared to the PMPM for existing members alone in order to derive the adjustment for new member morbidity. See Exhibit 2B for details.

3.4.4. 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 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	1.0924
Projected Period Average Utilization Factor	1.0866
Benefit Adjustment ($1+c_1$ on Exhibit 5) = 1.0866/1.0924	0.9947

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. Both of these benefits were new in 2014, and we don't believe that their experience is credible. We therefore blended claims estimates provided by outside vendors with our experience.

For the Pediatric Vision benefit, the expected allowed claims cost per child, as calculated by our vision vendor, VSP, is $3.10 per month. This translates to $0.53 PMPM based on the experience period split between adult and child. Our experience for this benefit was $0.22 PMPM. Blending these two values with equal weights, we calculate the cost to be $0.37 PMPM. 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, Milliman performed the calculation of the expected claims cost for each benefit for the 2015 QHP rate filing. Using their information, we estimated the expected allowed charges and paid claims for the new Blue Rewards CDHP Gold plan. Using the experience period split between adult and child, we calculate the overall expected allowed charges at $7.25 PMPM. Using the 5 percent trend previously used by Milliman, we trended both the expected changes and the experience period charges of $2.04 PMPM to the projection period. Then, we blended the two values with equal weights. The overall expected allowed charges per child are $4.93 per member per month. 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 new members, 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	1.2189
Projected Period Average Age-Sex Factor	1.2365
Demographic Adjustment ($1+c_3$ on Exhibit 5) = 1.2365 / 1.2189	1.0144

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 the impact of selection on allowed costs, 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 2016 QHPs are offered on our EPO Network. This was a new network as of January 1, 2014. Our experience period claims came from four different networks, BCBSVT's Non-Managed network (PPO/Indemnity), BCBSVT's Managed network (VHP/EPO), BCBSVT's Catamount network and TVHP's network. All four of these networks have different contracts with different reimbursement schedules. Using the historical contracted reimbursement schedules, we calculated network factors that represent the different contracts. Using these factors, we can adjust our projected allowed changes to represent the contract that will be effective in 2016. See details on Exhibit 2E.

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 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

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

that instead reflect actual 2014 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.

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 $3.66 PMPM. This number is estimated using our contractual rebate guarantee since we have not yet received the details underlying the rebate payment for calendar year 2014. Pharmacy rebates are expected to trend at the same rate as Brand Drugs. As shown on Exhibit 3I, the projected trend for Brand drugs is 12.8 percent, which brings projected pharmacy rebates to $4.66 PMPM.

- Blueprint Payments (e_2):
  BCBSVT participates in the Vermont Blueprint for Health[2] program. The experience period payments for this program were uncharacteristically low due to membership changes. Members are attributed to Blueprint based on their choice of Primary Care Provider or their claims. With the start of the Exchange, many members were assigned a new member number, which is how historical claims are tracked for attribution. We expect that the 2016 experience will revert back to historical levels. We therefore included the PMPM from the 2015 QHP rate filing ($2.09 PMPM) as our projection. The Blueprint program includes payments to Community Health Teams (CHT) that are set for each payer at the start of the contract year (July). Recent invoices reflect BCBSVT's increased market share. This increased allocation adds an additional $0.25 PMPM to projected Blueprint fees, for a total of $2.34 PMPM.

  Although we are aware that legislation currently contemplating changes to the Blueprint program could impact BCBSVT's cost, we have not include any estimates of those legislated changes in our rates. Neither did we anticipate an expected change to Blueprint charges that may occur should the proposed Blueprint Manual be used to determine payments.

- 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,

[2] http://hcr.vermont.gov/blueprint

we believe that the medical utilization trend is 2.0 percent and therefore these fees are expected to increase at the same rate. The experience period fees ($1.34 PMPM) are projected to grow to $1.39 PMPM in 2016.

- 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 2015 rates of $11.61 per child and $0.84 per adult to the experience period membership. The average PMPM ($2.24) for the experience period was used as the expected cost for the projection period.

- Net Cost of Reinsurance (e_5): BCBSVT uses reinsurance to protect itself against very high claims. Included in the Projected Index Rate is the net cost (reinsurance premium less expected reinsurance claims) of reinsurance. This PMPM cost was calculated in BCBSVT Large Group Rating Program Filing (BCVT-1299910512).

3.4.7. Trend Factors (cost/utilization):

The calendar year 2014 results were lower than historical results for the population included in this filing, due to the changes in membership and benefits that occurred with the start of the Exchange. Using this data without adjustment would artificially skew the regression downward and would produce unreasonable results to project future trend. To ensure that the trends selected are representative of the expected change from calendar year 2014 to calendar year 2016, we included historical information from members that were active on December 31, 2014 and had at least 2 years of enrollment when performing regressions to calculate trends. This cohort will be referenced as “continuing members” in the descriptions below.

Medical Trend Development

The source of the data is BCBSVT’s data warehouse, except where noted below. To ensure accuracy of claims information, the data used has been reconciled against internal reserving, enrollment, and other financial reports. Claims incurred between January 1, 2012 and December 31, 2014, completed through February 28, 2015, 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 expected to purchase QHPs in 2016 (as described in section 3.4.1).

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

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.

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 2014 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

Claims were normalized to the December 2014 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 2014. 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 +6.1 percent (most recent 24

months through December 2014) to +18.8 percent (most recent 12 months through December 2014).

Since we are using information from a closed block of business, further adjustments are necessary to get reasonable results. First, we adjusted the historical data for the changes in benefits. 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 2014. Second, we adjusted the result for aging. Using the Milliman Health Cost Guidelines, we calculated the average age-gender factors for the continuing population.

Calendar Year	Member Months	Average Age-Gender Factor	Aging Adjustment
2013	423,628	1.2159	
2014	431,407	1.2488	1.0270

The utilization trend selected is 2.0 percent, calculated as follows:

Utilization Trend from Unadjusted Data	6.1%
Adjustment for Benefits (= 1.048/1.061)	0.9877
Adjustment for Aging (= 1/1.027)	0.9737
Selected Utilization Trend (= 1.061 x 0.9877 x 0.9737)	2.0%

Unit Cost

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

During calendar year 2014, almost 55 percent of total claims dollars were provided by Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board (GMCB). We have assumed that the GMCB would approve hospital budgets for October 1, 2015 and October 1, 2016 that support identical commercial increases as that approved for October 1, 2014. 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.

Similarly, we assumed for other providers within the BCBSVT service area that overall 2015 and 2016 budget increases would be identical to those implemented during calendar 2014. 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 2014 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:

Annual Reimbursement Changes due to Budget Increases and Contracting Season

	Percent of Total Allowed Claims	FY 2015 Unit Cost Increases	Assumption to 2016	Total Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	53.6%	6.8%	7.6%	7.2%
Other facilities and providers	46.4%	3.1%	3.2%	3.1%
Total	100.0%	5.1%	5.6%	5.3%

Overall Medical Trend
Our selected trend assumptions are 2.0 percent for utilization (including intensity) and 5.3 percent for unit cost increases, resulting in an overall medical trend assumption of 7.4 percent.

Pharmacy Trend Development

The source of the data is BCBSVT's data warehouse, except where noted below. To ensure accuracy of claims information, the data used has been reconciled against internal reserving, enrollment, and other financial reports. Claims incurred between January 1, 2012 and December 31, 2014, completed through February 28, 2015, 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 expected to purchase QHPs in 2016 (as described in section 3.4.1).

Drug card and HSA drug experience is combined, and completion factors, based on the total drug card and HSA pharmacy experience for both companies, were applied to estimate the ultimate incurred claims. Allowed charges are used rather than claim payments, in order to mitigate the effect of benefit changes on observed trends.

ESI has been the pharmacy benefits manager for BCBSVT and TVHP since July 2009. The initial ESI contract was for a period of 3 years; a new contract became effective

July 2012. We have adjusted the historical pharmacy claims data, as well as the projected pharmacy claims, to normalize for the various guarantees within these contracts. Specifically, all historical experience has been restated to the provisions for the contract year ending in June 2015.

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 2014 for both Generic and Brand cost trend. For the utilization trend, we selected the regression for the period ending September 2014. We excluded fourth quarter due to the exaggerated seasonal pattern we have observed for the last two years, which we believe is largely influenced by the difficulties in enrolling through VHC. The initial selections of brand and generic cost trends based on historical analysis are then reduced by a factor equal to the contracted future improvement in pricing guarantees. We have a new pharmacy contract with very favorable terms that was negotiated for the three years beginning in July 2015. The impact of the new contract is reflected in the cost trends.

As described above, the use of a closed population requires adjustment 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 2014, as shown on Exhibit 3E. Our actuarial value models do not have monthly seasonal output, and comparing non-calendar year periods would skew this adjustment. We then adjusted the utilization trend for aging.

The utilization trend selected is 0.5 percent, calculated as follows:

Utilization Trend from Unadjusted Data	3.6%
Adjustment for Benefits (= 1.062/1.067)	0.9962
Adjustment for Aging (= 1/1.027)	0.9737
Selected Utilization Trend (= 1.036 x 0.9962 x 0.9737)	0.5%

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 88.7 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 2014 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 2014 is projected through six months following each generic launch date for the majority of the brands. For some brands where our PBM specifically told us that there would be no exclusivity period, we shifted the days supply to generic on the expiration date. After that time, all utilization is expected to shift to generic.

Specialty Drugs

Beginning in January 2014, a new treatment for hepatitis C was introduced to the market. Because this drug is skewing the specialty trend, we modified our approach to calculate the projected trend. First, we recalculated the specialty drug trend after excluding the new hepatitis C drugs (Sovaldi, Olysio and Harvoni). This reduced the 24 points regression on rolling 12 months data, for year ending November 2014, from 31.8 percent to 28.7 percent (as shown on Exhibit 3G). We selected the year ending November 2014 to mitigate the same phenomenon described above (skewed seasonality). These regression criteria were chosen in order to best capture the most recent history of drug costs. Rolling 12-months regression is more appropriate for Specialty Drugs because of the low-frequency, high-cost nature of these drugs. The regression results were then adjusted for the projected impact of the future contracts

with our PBM. 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
2012	387,494	1.1881	
2013	423,628	1.2159	
2014	431,407	1.2488	$= (1.2488/1.1881)^{0.5}$

In our attempt to understand why the specialty trend for this population was much higher than for the large group population, we analyzed the type of scripts and frequency by class of specialty drugs for both the large group population and the QHP continuing population. As shown on Exhibit 3H, the QHP continuing population had much higher utilization trends between 2013 and 2014 than the large group population for antineoplastic drugs and neurological therapies. We believe that these trends represent unusual events and that similar trends would not continue in the future. We adjusted the utilization trend for these two classes, which have random or near-random incidence, to match the large group population. We did not make a similar adjustment for rheumatological agents or other specialty medications because we would expect these classes of medications to be utilized more extensively by a QHP population that is older and less likely to have obtained coverage through an employer. This reduced the specialty trend by a factor of 0.9779.

Based Specialty Trend	28.7%
Discount Adjustment	0.9765
Aging Adjustment	0.9754
Utilization Adjustment	0.9779
Projected Specialty Trend	19.9%

Then, to project the expected cost of hepatitis C treatment in the rating period, we started with the actual claims for calendar year 2014, in which 17 claimants had a treatment for hepatitis C.

ESI provided projections of potential claimants for these therapies who would receive treatment in 2014, 2015 and 2016. Using their projection and applying it to experience period claimants, we projected that 26 members will receive treatment in 2016. ESI has recently entered new arrangements with the manufacturers of hepatitis C treatments. The new drug Viekira Pak, which was approved by the FDA in late December, will be the only drug ESI includes on their formularies for treatment of hepatitis C. We will assume that ESI's pricing for treatments for hepatitis C in 2016 will now refer to Viekira Pak.

The expected discounted cost for a three-month treatment of Viekira Pak is $54,000. There are two recommended treatments for Viekira Pak: a three-month regimen and a six-month regimen. We assume that the distribution of treatment duration is the same as our experience with Sovaldi. Our members' treatments on Sovaldi ended in January 2015 (the final treatments began in August 2014), so we have complete data about the duration of Sovaldi treatments. Of the 24 members who completed treatment, 16 received the drug for three months and eight received the drug for six months. Therefore the average length of treatment is four months and the projected cost of Viekira Pak is $72,000 per treatment. This produced an estimate of $1,872,000 for 2016, based on assumptions of 26 new claimants at an average cost of therapy of $72,000.

A new type of drug that treats patients with high cholesterol (hyperlipidemia) is currently under review by the FDA. This drug, known as PCSK9 inhibitors, is anticipated to be approved in August 2015. The initial indication for these drugs is to treat 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. ESI estimates that these new drugs will cost $12,000 per year per patient. Using our most recent membership counts, we estimate that 129 of our members are likely to receive this new treatment. We included this additional cost in our specialty trend calculation.

To calculate the effective specialty trend, we started with the pharmacy claims from the calendar year 2014 experience period and removed the new hepatitis C drugs. We then trended those claims at a 19.9 percent rate for 24 months, added the incremental cost of hepatitis C treatment and added the incremental cost of the hyperlipidemia specialty drugs for a total restated projected claims. Using this method, the restated effective specialty drug trend is 21.9 percent.

Pharmacy Specialty Claims in the Experience	$19,558,864
Hepatitis C Drugs in the Experience	$1,735,457
Pharmacy Specialty Claims without Hepatitis C drugs	$17,823,407
Projected Specialty Claims using a 19.9% trend for 24 months	$25,261,492
Adding incremental cost of Hepatitis C treatment for the projection period	$1,872,000
Adding incremental cost of PCSK9 treatment for the projection period	$1,548,000
Restated Projected Specialty Claims	$29,041,492
Restated Specialty Trend	21.9 %

ESI has opined that PCSK9 inhibitors have a profound impact on lowering cholesterol as compared to statins, and that the utilization of these new drugs may far exceed that attributable only to familial hypercholesterolemia. They estimate that 10 percent or more of the population currently taking statins would switch to a PCSK9

inhibitor, while an additional 3 to6 percent of the total population may currently have untreated issues with high cholesterol due to intolerance to or lack of results from statins. Using the lower end of these ranges leads to the following results:

Restated Projected Specialty Claims	$29,041,492
Added incremental cost of PCSK9 for members currently on statins switching to PCSK9	$9,412,362
Added incremental cost of PCSK9 for members not currently on statins	$20,820,000
Restated Projected Specialty Claims	$59,273,854
Restated Specialty Trend	74.1%

Due to the potentially massive impact of these drugs, we reached out to key cardiologists in the State to better understand how they are likely to prescribe the inhibitors. There appears to be a preference to wait until more clinical studies are available on these new drugs before a wholesale move away from statins is likely to take place. Furthermore, we will implement clinical programs to ensure that this very expensive treatment is used appropriately. Because of this, we have chosen not to include the full potential cost of PCSK9 inhibitors in our trend projection to 2016, but instead to only include the portion related to familial hypercholesterolemia, for which we understand the treatment is very likely to be available and prescribed in 2016.

Overall Pharmacy Trend
Exhibit 3I summarizes the trends calculates our total allowed pharmacy trend as 6.5 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 3J.

3.5. Credibility of Experience

BCBSVT's experience period had 735,603 member months and is therefore fully credible.

3.6. Credibility manual rate development

Since BCBSVT's experience is fully credible, no manual rate was needed in the development of rates for the experience period EHB. For additional EHB that BCBSVT

does not currently have in its experience, the projected claims were based on manual rates produced by consultants. See Attachment C for details.

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

3.6.2. Adjustments Made to the Data: Not Applicable

3.6.3. Inclusion of Capitation Payments: Not Applicable

3.7. Market Adjusted Index Rate

The Market Adjusted Index Rate (line H of Exhibit 5) is $536.95. This is calculated by adjusting the Projected Index Rate (line F of Exhibit 5, $547.33) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustments PMPM:

BCBSVT does not expect any risk adjustment transfer for 2016. BCBSVT covers at least 90 percent of the members enrolled in QHP products and therefore would closely track with the average risk of the market. We also have no information or experience on which to base an estimate of a risk adjustment amount.

As described in the Final Notice of Benefits and Payment Parameters for 2016 rule (80 F.R. 10750), the per capita risk adjustment user fee, used to fund the HHS-risk adjustment program, is $1.75 per enrollee per year (line g_1 of Exhibit 5).

3.7.2. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

To estimate the expected recoveries from the transitional reinsurance, BCBSVT adjusted its 2014 experience period by the network, changes in Small Group definitions and trend factors ($1+c_2$, $1+b_1$, $1+d_1$, $1+d_2$ of Exhibit 5) and then re-adjudicated claims for each of the proposed benefits to model the expected claims that would be included in the Transitional Reinsurance Program.

Because the QHP enrollment period was delayed until April 1, 2014, the calendar year 2014 data has disproportionate experience from members with exactly three months of enrollment and nine months of enrollment. To adjust for this, we excluded members with exactly three months of membership where the third month was March 2014 and excluded members with exactly nine months who were active on December 31, 2014. This adjustment didn't significantly impact the starting allowed, from $544.04 to $545.85.

While we understand that this was not a precise transformation, it had the effect of producing a sample population with an average duration that was better aligned with

both historical and expected projection period duration patterns, while having only a minimal impact on the PMPM allowed claims cost of the modeled membership.

The Final Notice of Benefits and Payment Parameters for 2016 rule (80 F.R. 10750) defined the 2016 Transitional Reinsurance Program parameters as:

- $90,000 claims attachment point
- 50 percent coinsurance
- $250,000 reinsurance cap

Using these parameters, BCBSVT estimated the expected recoveries for each QHP design. The expected recoveries were then weighted based on projected membership by plan. The recoveries only apply to members in the individual market. The projected recoveries must therefore be spread across all members, as Vermont has a combined market. The expected recoveries PMPM are $12.77. See Exhibit 4 for details.

We have assumed that the final parameters for 2016 will not be changed. Found in the preamble to this rule are the following comment and response that support this assumption.

> "Comment: Several commenters asked that HHS not change the uniform reinsurance payment parameters for 2016 finalized in this rule in subsequent rulemaking.
>
> Response: We are finalizing the 2016 uniform payment parameters as proposed, and do not intend to make any future adjustments to these parameters.
>
> Given the smaller pool of reinsurance contributions to be collected for the 2016 benefit year, we proposed that the uniform reinsurance payment parameters for the 2016 benefit year be established at an attachment point of $90,000, a reinsurance cap of $250,000, and a coinsurance rate of 50 percent. We estimated that these uniform reinsurance payment parameters will result in total requests for reinsurance payments of approximately $4 billion for the 2016 benefit year. "

The Final Notice of Benefits and Payment Parameters for 2016 rule (80 F.R. 10750) also established the Uniform Reinsurance Contribution rate at $27 annually per capita, or $2.25 PMPM.

The market-wide adjustment for the Transitional reinsurance program is therefore -$10.52 (-$12.77+$2.25), as shown on line g_2 of Exhibit 5.

3.7.3. Exchange User Fees

BCBSVT does not expect Vermont Health Connect to charge a user fee for 2016.

3.8. Plan Adjusted Index Rates

3.8.1. Plan Adjustment – Actuarial Value and Cost Sharing adjustment

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

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

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.

The experience used in this model is our calendar year 2014 data, adjusted by the network, changes in Small Group definitions and trend factors ($1+c_2$, $1+b_1$, $1+d_1$, $1+d_2$ of Exhibit 5). Because the QHP enrollment period was delayed until April 1, 2014, the calendar year 2014 data has disproportionate experience from members with exactly three months of enrollment and nine months of enrollment. To adjust for this, we excluded members with exactly three months of membership where the third month was March 2014 and excluded members with exactly nine months who were active on December 31, 2014. This adjustment didn't significantly impact the starting allowed, from $544.04 to $545.85.

While we understand that this was not a precise transformation, it had the effect of producing a sample population with an average duration that was better aligned with both historical and expected projection period duration patterns, while having only a minimal impact on the PMPM allowed claims cost of the modeled membership.

Using this adjusted experience, we re-adjudicated every plan to calculate the base 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. 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 benefit. 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.

In the URRT, the Paid to Allowed Average Factor is the weighted average Expected Claims Cost without Market Wide Adjustments ($416.97+$10.37) divided by Projected Index Rate ($547.33). As shown in Section 3 of Worksheet 1 of the URRT, the paid to allowed average factor is 78.1 percent.

3.8.1.3. Change in Family Tier

This factor represents the adjustment by plan needed to ensure that the premium produced using the state tier factors matches the premium required for the plan based on the BCBSVT tier factors, which reflect the plan benefits. These factors reflect the Vermont defined tier structures and the changes in allowed Maximum Out-of-Pocket mandated by the federal government.

In the preamble of the final 2016 Notice of Benefit and Payment Parameters (80 FR 10750), it was clarified that the self-only annual limitation on cost sharing of $6,850 applies to each individual regardless of whether the individual is enrolled in a self-only or other than self-only plan. This impacts our aggregate plans where the family out-of-pocket is greater than $6,850. For those plans, we had to adjust the projected claims paid by the plan on family tier to account for the new limit.

Vermont has defined the following tier structure:

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

These mandated tier factors do not represent the expected relationships between tiers.

Based on the experience period claims, trended to 2016 and adjusted for the changes in network and changes in the Small Group definition, we created a model to calculate the expected payments for benefits where more than one member

accumulates to a combined out-of-pocket. Using the same base, we calculated expected claims payments for children, adults, and combinations of both using a convolution model.

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

The details of these adjustments can be found on Exhibit 6D.

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

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

3.8.4. Impact of specific eligibility categories for the catastrophic plan

This plan adjustment includes two components of the impact of the specific eligibility categories for the catastrophic plan. Both of these adjustments are based on the eligible population. The eligible population includes Vermont residents that are under age 30 and residents age 30 and over who would find the lowest cost plan to be more than 8 percent of their income. 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 premiums. We project that 92 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 0.5852 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 0.8958.

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 0.5140. See Exhibit 6E for details.

3.8.5. Adjustment for distribution of the administrative costs

3.8.5.1. Administrative Expense Load:

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

- BCBSVT Base Administrative Charges
  To develop the Base Administrative Expenses PMPM, we used calendar year 2014 data.

  We combined the expenses for the members known to be in a QHP in 2015. These members are from BCBSVT QHP Products, BCBSVT Small Group, BCBSVT Nongroup, BCBSVT Safety Net, BCBSVT Catamount and TVHP Small Group. The experience period PMPM is $28.40.

  While the specific functions differ in some respects, the cost of the administrative functions associated with QHPs in 2016 is expected to be comparable to the cost of administering coverage for the eligible populations in 2014.

  We have removed one-time expenses related to the resource augmentation of certain enrollment functions during calendar 2014, as we do not expect these expenses to recur in future years. This reduced base period expenses by $0.82 PMPM.

  The remaining charges ($27.58 PMPM) are projected to 2016 using a 2.2 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 2015, over the projection period. Other operating costs are assumed to remain flat. We have calculated that 74.9 percent of our administrative costs are for salaries and benefits. We are therefore increasing our projected administrative expenses by the weighted average of 2.2 percent per annum.

		BCBSVT Totals	% of Total
Employee costs:	(A) = $a_1 + a_2$	$34,569,941	52.6%
Salaries and taxes	a_1	$25,743,854	
Benefits	a_2	$8,826,087	
Purchased services	(B)	$19,548,975	29.8%
Other operating costs	(C)	$11,585,685	17.6%
Total Administrative Expenses	(A)+(B)+(C)	$65,704,601	100.0%
BCBSVT Personnel Cost	(A)/{(A)+(C)}		74.9%

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. BCBSVT projects that membership will remain at current levels over the projection period. The projection of administrative charges is therefore assumed to not be impacted by membership changes.

- Charges for Outside Vendors
  - Vermont Collaborative Care
    This is the amount PMPM to be paid to VCC for utilization review and management of mental health and substance abuse claims.

  - CBA Dental and VSP Vision
    These benefits are being administered by third party administrators. The administrative fees are charged for eligible members only. The ratio of eligible members to total members, based on the projected 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 2015.

  - 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

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

The total of these charges adds up to 6.4 percent of premium. The details of the administrative charges are on Exhibit 7A.

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

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

As demonstrated in section 1 of Exhibit 7B, a contribution to reserves of 1.52 percent is required merely to maintain RBC levels in light of medical trend. In other words, should all other assumptions in this and subsequent filings come to fruition and medical trend hold constant at current levels, the company would eventually become insolvent due to medical trend alone with a contribution to reserves of less than 1.52 percent.

An adequate contribution to reserves should exceed the minimum required to keep pace with trend. 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 class of PCSK9 inhibitors discussed in section 3.4.7. Should the lower end of ESI's projection come to fruition rather than the projection built into our pharmacy trend, the impact would be approximately a 134 percentage-point decline in RBC ratio. Such an event would 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 percent contribution to reserve, which provides appropriate margin above the minimum needed to keep pace with trend to help ensure continued financial stability should a significant adverse event occur.

Details of Contribution to Reserve by product are on section 2 of Exhibit 7B.

3.8.5.3. Taxes and Fees:

The proposed rates include on average 3.67 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. Although we are aware of the discussion in the state legislature about an increase to HCCT, we have not included any proposed increases to this tax in the rates.

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 $2.31 per member per year, or $0.19 per member per month.

The Federal Insurer Fee is estimated at 2.73 percent of premium, which represents actual 2014 insurer fee, adjusted proportionally for total industry assessments in 2016 ($11.3 billion) versus 2014 ($8.0 billion).

2014 Annual Fee on Health Insurance, per final bill received from IRS	(A)	$7,971,576
2014 Eligible Premium (from Form 8963 submitted to the IRS)	(B)	$515,476,529
Fee as percent of Total Premium	(C) = (A) / (B)	1.55%
Anticipated Federal Income Tax rate	(D)	20.00%
2014 Required Charge as a percent of Total Premium	**(E) = {(C) / (1— (D)}**	**1.93%**
Incremental Increase of the Insurer Fee	(F)	141.25%
2016 Estimated Required Charge as a percent of Total Premium	**(G) = (E) x (F)**	**2.73%**

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

3.8.6. AV Pricing Values

As described in the 2016 Unified Rate Review Instructions dated February 21, 2015, 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 91.9 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 factors. As explained in section 3.8.1.3., 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 1.1151.

Rate Structure	Single	Couple	Adult + child(ren)	Family	Average
Exchange Tiers	1.000	2.000	1.930	2.810	1.4785
Tier weights	63.0%	19.6%	3.6%	13.8%	100.0%

Average Members per Subscriber	1.6487
Contract Conversion Factor	= 1.6487/1.4785 = 1.1151

The Consumer Adjusted Premium Rates are shown on Exhibit 9.

3.10. Small Group Plan Premium Rates

All Small Groups must renew on 1/1/2016 according to the combined market rules. BCBSVT will not file small group rates for Q2-Q4 2016.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

The following products will be terminated prior to 1/1/2016.

Product ID	Product Name	Product Type	Description	Market
13627VT001	CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT002	Vermont Freedom Plan	PPO	PPO	Small Group
13627VT003	Vermont Health Partnership	POS	Point of Service	Small Group
13627VT004	Comprehensive	Indemnity	Comprehensive	Small Group
13627VT005	Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT006	Individual HSA	PPO	PPO HDHP	Individual
13627VT007	Vermont Freedom Plan	PPO	PPO	Individual
13627VT008	Catamount Blue	PPO	PPO	Individual
13627VT009	Individual Comp	Indemnity	Comprehensive	Individual
13627VT010	CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT011	PPO	PPO	PPO	Small Group
13627VT012	POS	POS	Point of Service	Small Group
13627VT013	Comprehensive	Indemnity	Comprehensive	Small Group
13627VT014	Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT015	Individual HSA	PPO	PPO HDHP	Individual
13627VT016	Vermont Freedom Plan	PPO	PPO	Individual
13627VT017	Catamount Blue	PPO	PPO	Individual
13627VT018	Individual Comp	Indemnity	Comprehensive	Individual
13627VT019	AIVIS - CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT020	AIVIS - PPO	PPO	PPO	Small Group
13627VT021	AIVIS - POS	POS	Point of Service	Small Group
13627VT022	AIVIS - Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT023	VACE - CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT024	VACE - PPO	PPO	PPO	Small Group
13627VT025	VSAA - CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT026	VSAA - PPO	PPO	PPO	Small Group
13627VT027	VSAA - POS	POS	Point of Service	Small Group
13627VT028	VSDS - CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT029	VSDS - PPO	PPO	PPO	Small Group
13627VT030	VHSG - CDHP Comprehensive	Indemnity	Comprehensive HDHP	Small Group
13627VT031	VHSG - PPO	PPO	PPO	Small Group

4.2. Plan Type

Our plan type is EPO.

4.3. Warning Alerts

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

5. RELIANCE AND ACTUARIAL CERTIFICATION

5.1. Reliance

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

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

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

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the Qualified Health Plans that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to offer in 2016. 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 2016, the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, that the Index Rate is developed in accordance with federal regulations, and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

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

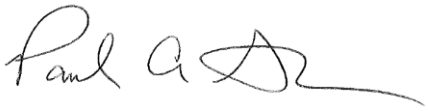
In my opinion, the projected Index Rate is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), developed in compliance with the applicable Actuarial Standards of Practice, reasonable in relation to the benefits provided and the population anticipated to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

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

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

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



Paul Schultz, F.S.A., M.A.A.A.
Actuarial Director
Blue Cross and Blue Shield of Vermont
May 15, 2015

BLUE CROSS BLUE SHIELD OF VERMONT
2016 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, 2016.

There are 40,864 contracts (67,050 members) currently enrolled in a BCBSVT QHP. BCBSVT is proposing an average rate increase of 8.4 percent across all QHPs. Increases for specific QHPs range from 4.7 percent to 14.3 percent.

Of the total 8.4 percent increase, an increase of 2.9 percent is driven by three items required solely because of mandated changes associated with the Affordable Care Act:

- 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. This QHP subsidy is reduced in 2016 before being eliminated entirely in 2017. Because the premium subsidy changes in 2016 from about four percent to about two percent, it will require groups and members to pay 1.8 percent more for their coverage.

- Federally-mandated changes to the individual member out-of-pocket maximums for family policies within plans with aggregate deductibles contributes 0.8 percent to the average increase.

- Some deductibles, out-of-pocket maximums and co-pays in Qualified Health Plans remain unchanged from 2015 to 2016. 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. The resulting premium increase is partially offset by plan changes implemented by BCBSVT and the State of Vermont, resulting in a 0.3 percent increase in premiums.

BLUE CROSS BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING
PLAIN LANGUAGE SUMMARY

In the absence of mandated changes associated with the Affordable Care Act, a 5.3 percent increase would have been requested:

- Amounts that providers are paid are expected to increase by 6.4 percent during 2016. This results in a 4.4 percent premium increase due to increased payments to providers of medical services, and an additional 1.9 percent premium increase due to increases in the wholesale price of prescription drugs.

- An estimate of increases in the amounts providers are paid was included in 2015 QHP rates. Increases beyond those assumptions that have already occurred in 2015, or that are projected to occur before the end of 2015, drive a premium increase of 1.1 percent. This is primarily attributable to prescription drug price increases.

- BCBSVT has negotiated a new pharmacy contract with its Pharmacy Benefit Manager, which has an impact of reducing the average premium by 1.9 percent.

- BCBSVT administrative expenditures for Qualified Health Plans remain well below seven percent of premium.

- In order to maintain an adequate level of reserves as required by financial regulation, BCBSVT must increase its contribution to reserve for this filing due to rising health care costs and to protect QHP members by ensuring continued financial stability should a significant adverse event occur. This has the effect of increase premiums by 1.0 percent.

- Other adjustments to the assumptions used in the 2016 rate development, including an assumption that that members who will enroll in our qualified health plans in 2016 will prove to be significantly healthier on average than those insured during calendar 2014, cumulatively have the effect of reducing the required rate increase by 1.9 percent.

BCBSVT started selling QHPs in January 2014. In its first year, this line of business represented $250 million of earned premium. Due to higher-than-expected actual claims and administrative charges, the line of business incurred a loss of 2.7 percent for calendar year 2014. 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 related to federal policy changes and increases in prices paid to providers in Vermont, we believe that there is no way to further reduce these rates without underfunding the health care coverage on which Vermonters rely.

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

Ruth Greene
Vice President, Treasurer & CFO

May 15, 2015
Date

Unified Rate Review v2.0.3

Company Legal Name:	**Blue Cross and Blue Shield of V**	State:	**VT**
HIOS Issuer ID:	**13627**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2016**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2014 to 12/31/2014

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$297,310,928	$404.17	100.00%
Incurred Claims in Experience Period	$255,820,510	347.77	86.04%
Allowed Claims:	$343,616,795	467.12	115.57%
Index Rate of Experience Period		$467.00	
Experience Period Member Months	735,603		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2016 to 12/31/2016 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	51.02	$18,848.35	$80.14	0.960	1.059	1.053	1.020	50.97	$22,145.80	$94.07	0.00	$0.00	$0.00
Outpatient Hospital	Visits	2,406.75	881.10	176.72	0.960	1.059	1.053	1.020	2,404.49	1,034.67	207.32	0.00	0.00	0.00
Professional	Visits	7,723.30	174.99	112.63	0.960	1.055	1.053	1.020	7,716.06	204.82	131.70	0.00	0.00	0.00
Other Medical	Visits	1,352.70	166.93	18.82	0.960	0.948	1.053	1.020	1,351.43	175.45	19.76	0.00	0.00	0.00
Capitation	Benefit Period	10,298.00	4.44	3.81	0.960	0.840	1.053	1.020	10,288.34	4.14	3.55	0.00	0.00	0.00
Prescription Drug	Prescriptions	13,817.91	65.15	75.02	0.960	1.113	1.060	1.005	13,406.33	81.39	90.93	0.00	0.00	0.00
Total				$467.12							$547.33			$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%	$547.33	$459,846,381
Paid to Allowed Average Factor in Projection Period			0.781	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$427.46	$359,140,023
Projected Risk Adjustments PMPM			-0.15	(126,025)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$427.61	$359,266,048
Projected ACA reinsurance recoveries, net of rein prem, PMPM			10.52	8,838,567
Projected Incurred Claims			$417.09	$350,427,481
Administrative Expense Load		6.36%	30.15	25,334,987
Profit & Risk Load		2.00%	9.48	7,966,977
Taxes & Fees		3.67%	17.40	14,619,403
Single Risk Pool Gross Premium Avg. Rate, PMPM			$474.13	$398,348,847
Index Rate for Projection Period			$547.33	
% increase over Experience Period			17.31%	
% Increase, annualized:			8.31%	
Projected Member Months				840,168

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):	**1/1/2016**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	BCBSVT EPO (Small Group)				BCBSVT EPO CDHP (Small Group)	
Product ID:	13627VT017	13627VT032				13627VT033	
Metal:	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze
AV Metal Value	0.000	0.890	0.810	0.716	0.614	0.701	0.610
AV Pricing Value	0.010	1.121	0.980	0.829	0.701	0.802	0.697
Plan Type:	PPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	Terminated Product	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):	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002
Exchange Plan?	No	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	8.10%	0.00%				0.00%	
Historical Rate Increase - Calendar Year - 1	0.00%	0.00%				0.00%	
Historical Rate Increase - Calendar Year 0	0.00%	8.25%				5.76%	
Effective Date of Proposed Rates	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016
Rate Change % (over prior filing)	0.00%	7.51%	8.24%	6.53%	5.98%	10.08%	8.61%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	7.51%	8.24%	6.53%	5.98%	10.08%	8.61%
Proj'd Per Rate Change % (over Exper. Period)	-100.00%	15.61%	18.44%	17.13%	17.15%	12.00%	10.84%
Product Threshold Rate Increase %	#DIV/0!	7.38%				9.61%	

Product	BCBSVT EPO (Individual)					BCBSVT EPO CDHP (Individual)	
Product ID:	13627VT034					13627VT035	
Metal:	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze
AV Metal Value	0.612	0.890	0.810	0.716	0.614	0.701	0.610
AV Pricing Value	0.399	1.121	0.980	0.829	0.701	0.802	0.697
Plan Type:	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	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):	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002
Exchange Plan?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	0.00%					0.00%	
Historical Rate Increase - Calendar Year - 1	0.00%					0.00%	
Historical Rate Increase - Calendar Year 0	8.62%					5.72%	
Effective Date of Proposed Rates	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016
Rate Change % (over prior filing)	4.70%	7.51%	8.24%	6.53%	5.98%	10.08%	8.61%
Cum'tive Rate Change % (over 12 mos prior)	4.70%	7.51%	8.24%	6.53%	5.98%	10.08%	8.61%
Proj'd Per Rate Change % (over Exper. Period)	7.69%	15.61%	18.44%	17.13%	17.15%	12.00%	10.84%
Product Threshold Rate Increase %	7.05%					9.74%	

Product	BCBSVT EPO Blue Rewards (Small Group)		BCBSVT EPO CDHP Blue Rewards (Small Gro		BCBSVT EPO Blue Rewards (Individual)		BSVT EPO CDHP Blue Rewards (Individu	
Product ID:	13627VT036		13627VT037		13627VT038		13627VT039	
Metal:	Gold	Silver	Gold	Bronze	Gold	Silver	Gold	Bronze
AV Metal Value	0.802	0.718	0.780	0.620	0.802	0.718	0.780	0.620
AV Pricing Value	0.908	0.796	0.866	0.688	0.908	0.796	0.866	0.688
Plan Type:	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 Bronze CDHP Plan	BCBSVT Blue Rewards Gold Plan	BCBSVT Blue Rewards Silver Plan	BCBSVT Blue Rewards Gold CDHP Plan	BCBSVT Blue Rewards Bronze CDHP Plan
Plan ID (Standard Component ID):	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390003
Exchange Plan?	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	0.00%		0.00%		0.00%		0.00%	
Historical Rate Increase - Calendar Year 0	7.56%		5.66%		8.06%		5.66%	
Effective Date of Proposed Rates	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016
Rate Change % (over prior filing)	10.08%	11.26%	0.00%	14.31%	10.08%	11.26%	0.00%	14.31%
Cum'tive Rate Change % (over 12 mos prior)	10.08%	11.26%	0.00%	14.31%	10.08%	11.26%	0.00%	14.31%
Proj'd Per Rate Change % (over Exper. Period)	13.71%	16.05%	#DIV/0!	16.32%	13.71%	16.05%	#DIV/0!	16.32%
Product Threshold Rate Increase %	10.42%		14.31%		11.02%		14.31%	

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

Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390003
Inpatient	$4.58	$0.00	$6.14	$5.83	$3.79	$2.84	$5.77	$4.19	$1.01	$6.14	$5.83	$3.79	$2.84	$5.77	$4.19	$6.60	$6.40	$0.00	$6.89	$6.60	$6.40	$0.00	$6.89
Outpatient	$10.08	$0.00	$13.52	$12.86	$8.36	$6.26	$12.71	$9.24	$2.22	$13.52	$12.86	$8.36	$6.26	$12.71	$9.24	$14.56	$14.10	$0.00	$15.19	$14.56	$14.10	$0.00	$15.19
Professional	$6.41	$0.00	$8.59	$8.17	$5.31	$3.98	$8.08	$5.87	$1.41	$8.59	$8.17	$5.31	$3.98	$8.08	$5.87	$9.25	$8.96	$0.00	$9.65	$9.25	$8.96	$0.00	$9.65
Prescription Drug	$4.42	$0.00	$5.93	$5.64	$3.67	$2.74	$5.58	$4.05	$0.97	$5.93	$5.64	$3.67	$2.74	$5.58	$4.05	$6.38	$6.18	$0.00	$6.66	$6.38	$6.18	$0.00	$6.66
Other	$0.96	$0.00	$1.29	$1.23	$0.80	$0.60	$1.21	$0.88	$0.21	$1.29	$1.23	$0.80	$0.60	$1.21	$0.88	$1.39	$1.34	$0.00	$1.45	$1.39	$1.34	$0.00	$1.45
Capitation	$0.17	$0.00	$0.23	$0.22	$0.14	$0.11	$0.22	$0.16	$0.04	$0.23	$0.22	$0.14	$0.11	$0.22	$0.16	$0.25	$0.24	$0.00	$0.26	$0.25	$0.24	$0.00	$0.26
Administration	$2.54	$0.00	$2.94	$2.95	$2.92	$2.90	$2.97	$2.99	$2.93	$2.94	$2.92	$2.90	$2.92	$2.97	$2.99	$2.92	$2.90	$0.00	$3.01	$2.92	$2.90	$0.00	$3.01
Taxes & Fees	$1.17	$0.00	$1.59	$1.49	$1.01	$0.77	$1.45	$1.08	$0.28	$1.59	$1.49	$1.01	$0.77	$1.45	$1.08	$1.65	$1.59	$0.00	$1.68	$1.65	$1.59	$0.00	$1.68
Risk & Profit Charge	$4.46	$0.00	$6.50	$5.72	$4.77	$4.02	$4.75	$4.08	$2.26	$6.50	$5.72	$4.77	$4.02	$4.75	$4.08	$5.37	$4.75	$0.00	$4.20	$5.37	$4.75	$0.00	$4.20
Total Rate Increase	$34.79	$0.00	$46.73	$44.11	$30.77	$24.21	$42.74	$32.54	$11.33	$46.73	$44.11	$30.77	$24.21	$42.74	$32.54	$48.36	$46.46	$0.00	$48.99	$48.36	$46.46	$0.00	$48.99
Member Cost Share Increase	$0.33	$0.00	$4.31	$5.00	-$2.08	-$5.94	$0.13	-$14.63	$4.45	$4.31	$5.00	-$2.08	-$5.94	$0.13	-$14.63	$7.68	$3.94	$0.00	-$2.17	$7.68	$3.94	$0.00	-$2.17
Average Current Rate PMPM	$427.66	$0.00	$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	$439.16	$380.72	$0.00	$320.56	$439.16	$380.72	$0.00	$320.56
Projected Member Months	840,168	0	125,328	65,208	72,816	19,596	73,260	39,192	1,440	50,184	34,440	114,216	16,992	52,968	17,580	26,844	13,032	11,844	19,284	11,064	52,188	0	22,692

tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390003
Plan Adjusted Index Rate	$400.61	$331.93	$520.53	$443.96	$379.77	$321.07	$384.46	$337.43	$198.99	$520.53	$443.96	$379.77	$321.07	$384.46	$337.43	$428.73	$368.09	$0.00	$317.70	$428.73	$368.09	$0.00	$317.70
Member Months	735,603	101,257	95,506	45,869	58,710	16,283	57,969	29,559	961	43,050	29,722	82,832	12,881	43,117	12,795	20,033	8,203	0	14,799	9,226	37,336	0	15,495
Total Premium (TP)	$294,686,735	$33,610,287	$49,713,965	$20,363,891	$22,296,151	$5,227,967	$22,286,706	$9,974,221	$191,231	$22,408,919	$13,195,308	$31,456,903	$4,135,690	$16,576,720	$4,317,472	$8,588,734	$3,019,476	$0	$4,701,678	$3,955,457	$13,743,161	$0	$4,922,798
EHB Percent of TP, [see instructions]	99.96%	99.97%	99.97%	99.94%	99.90%	99.97%	99.96%	99.97%	100.00%	100.00%	99.98%	99.96%	99.94%	99.96%	99.89%	99.96%	99.98%	100.00%	99.99%	99.93%	99.94%	100.00%	99.92%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.04%	0.03%	0.03%	0.06%	0.10%	0.03%	0.04%	0.03%	0.00%	0.00%	0.02%	0.04%	0.06%	0.04%	0.11%	0.04%	0.02%	0.00%	0.01%	0.07%	0.06%	0.00%	0.08%
Total Allowed Claims (TAC)	$343,616,795	$44,622,254	$55,593,482	$20,424,288	$20,296,189	$5,351,267	$21,359,244	$9,306,198	$152,378	$46,320,449	$16,217,206	$42,670,376	$3,343,477	$19,802,013	$3,906,557	$8,119,898	$2,216,100	$0	$4,064,271	$4,956,328	$12,123,710	$0	$2,771,109
EHB Percent of TAC, [see instructions]	99.96%	99.97%	99.97%	99.94%	99.90%	99.97%	99.96%	99.97%	100.00%	100.00%	99.98%	99.96%	99.94%	99.96%	99.89%	99.96%	99.98%	100.00%	99.99%	99.93%	99.94%	100.00%	99.92%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.04%	0.03%	0.03%	0.06%	0.10%	0.03%	0.04%	0.03%	0.00%	0.00%	0.02%	0.04%	0.06%	0.04%	0.11%	0.04%	0.02%	0.00%	0.01%	0.07%	0.06%	0.00%	0.08%
Allowed Claims which are not the issuer's obligation:	$87,796,285	$11,011,967	$3,841,918	$3,211,696	$5,165,651	$1,739,651	$5,534,153	$3,189,061	$66,736	$11,136,897	$4,379,112	$15,443,586	$1,607,267	$7,559,471	$1,953,458	$1,548,359	$760,449	$0	$1,707,316	$1,665,439	$4,797,820	$0	$1,476,277
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	0.00%	0.00%	0.00%	#DIV/0!	0.00%
Total Incurred claims, payable with issuer funds	$255,820,510	$33,610,287	$51,751,564	$17,212,591	$15,130,538	$3,611,617	$15,825,092	$6,117,138	$85,643	$35,183,553	$11,838,094	$27,226,790	$1,736,210	$12,242,541	$1,953,099	$6,571,539	$1,455,650	$0	$2,356,955	$3,290,889	$7,325,890	$0	$1,294,832
Net Amt of Rein	$16,803,420.48	-$531,599.25	-$501,406.50	-$240,812.25	-$308,227.50	-$85,485.75	-$304,337.25	-$155,184.75	-$5,045.25	$8,283,609.43	$1,579,281.21	$4,802,039.62	$253,786.25	$2,391,032.15	$614,153.04	-$105,173.25	-$43,065.75	$0.00	-$77,694.75	$726,805.28	$536,487.82	$0.00	-$25,742.07
Net Amt of Risk Adj	$50,747.68		$7,640.48	$3,669.52	$4,696.80	$1,302.64	$4,637.52	$2,364.72	$76.88	$3,444.00	$2,377.76	$6,626.56	$1,030.48	$3,449.36	$1,023.60	$1,602.64	$656.24	$0.00	$1,183.92	$738.08	$2,986.88	$0.00	$1,239.60
Incurred Claims PMPM	$347.77	$331.93	$541.87	$375.26	$257.72	$221.80	$272.99	$206.95	$89.12	$817.27	$398.29	$328.70	$134.79	$283.94	$152.65	$328.04	$177.45	#DIV/0!	$159.26	$356.70	$196.22	#DIV/0!	$83.56
Allowed Claims PMPM	$467.12	$440.68	$582.09	$445.27	$345.70	$328.64	$368.46	$314.83	$158.56	$1,075.97	$545.63	$515.14	$259.57	$459.26	$305.32	$405.33	$270.16	#DIV/0!	$274.63	$537.21	$324.72	#DIV/0!	$178.84
EHB portion of Allowed Claims, PMPM	$466.95	$440.54	$581.91	$445.00	$345.37	$328.55	$368.32	$314.75	$158.56	$1,075.95	$545.50	$514.94	$259.41	$459.06	$305.00	$405.18	$270.12	#DIV/0!	$274.61	$536.82	$324.54	#DIV/0!	$178.69

tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390003
Plan Adjusted Index Rate	$473.99	$0.00	$601.77	$525.84	$444.82	$376.14	$430.60	$374.02	$214.29	$601.77	$525.84	$444.82	$376.14	$430.60	$374.02	$487.52	$427.18	$464.73	$369.54	$487.52	$427.18	$464.73	$369.54
Member Months	840,168	-	125,328	65,208	72,816	19,596	73,260	39,192	1,440	50,184	34,440	114,216	16,992	52,968	17,580	26,844	13,032	11,844	19,284	11,064	52,188	-	22,692
Total Premium (TP)	$398,228,769	$0	$75,418,339	$34,289,207	$32,389,863	$7,370,885	$31,546,083	$14,658,608	$308,573	$30,199,109	$18,110,052	$50,805,326	$6,391,410	$22,808,257	$6,575,279	$13,087,018	$5,567,047	$5,504,218	$7,126,177	$5,393,934	$22,293,821	$0	$8,385,563
EHB Percent of TP, [see instructions]	99.97%	100.00%	99.98%	99.97%	99.97%	99.96%	99.97%	99.96%	99.93%	99.98%	99.97%	99.97%	99.96%	99.97%	99.96%	99.97%	99.97%	99.97%	99.96%	99.97%	99.97%	99.97%	99.96%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.03%	0.00%	0.02%	0.03%	0.03%	0.04%	0.03%	0.04%	0.07%	0.02%	0.03%	0.03%	0.04%	0.03%	0.04%	0.03%	0.03%	0.03%	0.04%	0.03%	0.03%	0.03%	0.04%
Total Allowed Claims (TAC)	$459,846,381	$0	$68,595,361	$35,690,080	$39,854,141	$10,725,414	$40,097,154	$21,450,828	-$788,150	$27,467,043	$18,849,932	$62,513,467	$9,300,175	$28,990,801	$9,622,003	$14,692,438	$7,132,762	$6,482,537	$10,554,648	$6,055,623	$28,563,886	$0	$12,419,938
EHB Percent of TAC, [see instructions]	99.97%	100.00%	99.98%	99.97%	99.97%	99.96%	99.97%	99.96%	99.93%	99.98%	99.97%	99.97%	99.96%	99.97%	99.96%	99.97%	99.97%	99.97%	99.96%	99.97%	99.97%	99.97%	99.96%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.03%	0.00%	0.02%	0.03%	0.03%	0.04%	0.03%	0.04%	0.07%	0.02%	0.03%	0.03%	0.04%	0.03%	0.04%	0.03%	0.03%	0.03%	0.04%	0.03%	0.03%	0.03%	0.04%
Allowed Claims which are not the issuer's obligation	$111,531,779	$0	-$64,113	$4,630,790	$10,734,217	$4,158,314	$11,789,348	$8,401,960	$566,607	$1,782,800	$3,521,071	$19,959,094	$4,029,546	$9,996,438	$4,212,435	$2,884,104	$2,138,177	$1,524,858	$4,214,183	$1,530,849	$9,988,757	$0	$5,532,343
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0																						
Portion of above payable by HHS on behalf of insured person, as %	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	0.00%
Total Incurred claims, payable with issuer funds	$348,314,602	$0	$68,659,474	$31,059,289	$29,119,925	$6,567,100	$28,307,807	$13,048,868	$221,544	$25,684,243	$15,328,861	$42,554,373	$5,270,629	$18,994,363	$5,409,568	$11,808,334	$4,994,585	$4,957,679	$6,340,465	$4,524,773	$18,575,129	$0	$6,887,594
Net Amt of Rein	$8,838,264		-$281,988	-$146,718	-$163,836	-$44,091	-$164,835	-$88,182	$37,996	$1,695,559	$997,801	$2,864,884	$385,575	$1,353,398	-$404,089	-$60,399	-$29,322	-$26,649	-$43,389	$317,246	$1,308,783	$0	$522,344
Net Amt of Risk Adj	-$122,525		-$18,277	-$9,510	-$10,619	-$2,858	-$10,684	-$5,716	-$210	-$7,319	-$5,023	-$16,657	-$2,478	-$7,725	-$2,564	-$3,915	-$1,901	-$1,727	-$2,812	-$1,614	-$7,611	$0	-$3,309
Incurred Claims PMPM	$414.58	#DIV/0!	$547.84	$476.31	$399.91	$335.12	$386.40	$332.95	$153.85	$511.80	$445.09	$372.58	$310.18	$358.60	$307.71	$439.89	$383.26	$418.58	$328.79	$408.96	$355.93	#DIV/0!	$303.53
Allowed Claims PMPM	$547.33	#DIV/0!	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	$547.33	#DIV/0!	$547.33
EHB portion of Allowed Claims, PMPM	$547.15	#DIV/0!	$547.19	$547.17	$547.15	$547.11	$547.14	$547.11	$546.95	$547.19	$547.17	$547.15	$547.11	$547.14	$547.11	$547.16	$547.14	$547.15	$547.11	$547.16	$547.14	#DIV/0!	$547.11

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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	$150	$750	$2,000	$1,425	$4,000	$4,100
Rx Ded	$0	$50	$150	Combined	$500	Combined
Integrated Ded	No	No	No	Yes	No	Yes
Medical OOPM	$1,250	$4,250	$5,600	$5,750	$6,850	$6,500
Rx OOPM	$1,250	$1,250	$1,250	$1,300	$1,250	$1,300
Integrated OOPM	No	No	No	Yes	Yes	Yes
Family Deductible / OOP	Stacked	Stacked	Stacked	Aggregate, Embedded Individual OOPM of $6,850	Stacked	Aggregate, Embedded Individual OOPM of $6,850
Medical Deductible waived for:	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Dental Class I, Vision	Preventive Care	Preventive Care, Dental Class I	Preventive Care
Drug Deductible waived for:	N/A	Generic Scripts	Generic Scripts	Wellness Scripts	N/A	Wellness Scripts
Service Category						
Preventive	$0	$0	$0	0%	$0	0%
PCP Office Visit	$10	$15	$25	10%	$35	50%
MH/SA Office Visit	$10	$15	$25	10%	$35	50%
Specialist Office Visit	$20	$25	$50	25%	$85	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	$40	$40	$60	$40	$80	40%
Rx Non-Preferred Brand	50%	50%	50%	50%	60%	60%
Pediatric Vision (Exam and Materials)	$20	$25	$50	25%	$85	50%
Pediatric Dental Class I	0%	0%	0%	0%	0%	0%
Pediatric Dental Class II	30%	30%	30%	30%	30%	30%
Pediatric Dental Class III	50%	50%	50%	50%	50%	50%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

BLUE REWARDS (NON-STANDARD) PLAN DESIGNS

	GOLD	GOLD	SILVER	BRONZE	CATASTROPHIC
	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards
Deductible/OOP Max	Deductible	CDHP	Deductible	CDHP	Deductible
Medical Ded	$1,250	$2,500	$2,000	$6,550	$6,850
Rx Ded	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$2,500	$6,850	$6,550	$6,850
Rx OOPM	$1,250	$1,300	$1,250	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate, Embedded Individual OOPM of $6,850	Aggregate, Embedded Individual OOPM of $6,850	Aggregate, Embedded Individual OOPM of $6,850	Aggregate, Embedded Individual OOPM of $6,850	Aggregate, Embedded Individual OOPM of $6,850
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, 3 PCP/MH Office Visits
Drug Deductible waived for:	N/A	Wellness Scripts	N/A	Wellness Scripts	N/A
Service Category					
Preventive	$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%	3 visits per member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit		0%		0%	
Specialist Office Visit	$30	0%	$50	0%	0%
Urgent Care	$30	0%	$50	0%	0%
Ambulance	$30	0%	$50	0%	0%
DME	$30	0%	$50	0%	0%
ER	$250	0%	$250	0%	0%
Radiology (MRI, CT, PET)	$500	0%	$1,750	0%	0%
Outpatient	$500	0%	$1,750	0%	0%
Inpatient	$500	0%	$1,750	0%	0%
Rx Generic	$5	$5	$5	$25	0%
Rx Preferred Brand	40%	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	60%	0%
Pediatric Vision (Exam and Materials)	$30	0%	$50	0%	0%
Pediatric Dental Class I	0%	0%	0%	0%	0%
Pediatric Dental Class II	30%	0%	30%	0%	0%
Pediatric Dental Class III	50%	0%	50%	0%	0%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

PROJECTED MEMBERSHIP BY PLAN AND MARKET

Product	Individual Market	Small Group Market	TOTAL
Blue Rewards Gold	922	2,237	3,159
Blue Rewards Gold CDHP	0	987	987
Blue Rewards Silver	4,349	1,086	5,435
Blue Rewards Bronze CDHP	1,891	1,607	3,498
Standard Platinum	4,182	10,444	14,626
Standard Gold	2,870	5,434	8,304
Standard Silver	9,518	6,068	15,586
Standard Silver CDHP	4,414	6,105	10,519
Standard Bronze	1,416	1,633	3,049
Standard Bronze CDHP	1,465	3,266	4,731
Catastrophic	120	0	120
Total	**31,147**	**38,867**	**70,014**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

ADJUSTMENT FOR IMPACT OF THE HEALTH STATUS OF NEWLY INSURED

	Continuing				New Entrants			
	Individual Non-Subsidized	Individual Subsidized	Small Group (2-50) Employees	Small Group (51-100) Employees	Individual Non-Subsidized	Individual Subsidized	Small Group (2-50) Employees	Small Group (51-100) Employees
Projected Membership	10,431	17,240	33,024	2,811	1,049	2,427	2,879	153
AGF Factors	1.3842	1.3155	1.1312	1.1658	1.2895	1.1426	0.9985	0.9907
PMPM	$524.08	$538.95	$418.54	$478.83	=1.2895 / 1.3842 x $524.08 = $488.24	=1.1426 / 1.3155 x $538.95 = $468.12	=0.9985 / 1.1312 x $418.54 = $369.43	=0.9907 / 1.1658 x $478.83 = $406.92
Average PMPM				$471.23				$426.26

Weighted Average of Continuing Members and New Entrants	$467.05
Impact of New Entrants (Line 1+b3 on Exhibit 5) = $467.05 / $471.23	**0.9911**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

PEDIATRIC DENTAL

Membership Distribution	
Adult	82.9%
Child	17.1%
Actuals Pediatric Dental Experienc	$2.04
Trended Pediatric Dental	$2.25

Product	Projected Membership	Based on Milliman Data Projected Allowed Charges per Child	Projected Allowed Charges PMPM	Credibility Adjusted Allowed PMPM	
Blue Rewards Gold	3,159	$45.66	$7.79		
Blue Rewards Gold CDHP	987	$42.55	$7.26		
Blue Rewards Silver	5,435	$44.81	$7.65		
Blue Rewards Bronze CDHP	3,498	$37.46	$6.40		
Standard Platinum	14,626	$47.29	$8.07		
Standard Gold	8,304	$46.36	$7.91		
Standard Silver	15,586	$45.19	$7.71		
Standard Silver CDHP	10,519	$42.29	$7.22		
Standard Bronze	3,049	$43.75	$7.47		
Standard Bronze CDHP	4,731	$41.58	$7.10		
Catastrophic	120	$35.40	$6.04		
Total	70,014		$7.61	**$4.93**	(line e_7 of Exhibit 5)

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

DEMOGRAPHIC ADJUSTMENT

		Experience Period		Projected Period - Excluding New Members	
Gender	Age Group	Member Months	Average Age	Members	Average Age
F	0-1	3,335	0.48	241	0.61
F	2-6	9,282	4.06	733	4.07
F	7-18	36,982	13.09	2,941	13.12
F	19-22	20,400	20.49	1,622	20.56
F	23-24	9,704	23.50	773	23.48
F	25-29	24,487	26.99	1,965	27.02
F	30-34	25,793	32.03	2,106	32.08
F	35-39	25,625	36.99	2,181	36.97
F	40-44	31,195	42.17	2,471	42.15
F	45-49	40,342	47.07	3,318	47.02
F	50-54	50,650	52.09	4,180	52.05
F	55-59	56,143	56.96	4,659	57.05
F	60-64	57,319	62.03	4,835	62.02
F	65+	5,334	68.21	576	67.45
M	0-1	3,672	0.50	230	0.60
M	2-6	9,867	4.16	762	4.09
M	7-18	37,659	13.08	2,970	13.05
M	19-22	20,885	20.50	1,661	20.58
M	23-24	10,545	23.51	841	23.51
M	25-29	23,965	26.94	1,968	26.99
M	30-34	24,015	32.03	1,968	32.05
M	35-39	25,737	36.98	2,150	37.00
M	40-44	30,353	42.14	2,442	42.17
M	45-49	36,228	47.07	2,951	47.03
M	50-54	46,171	52.15	3,772	52.10
M	55-59	50,947	56.91	4,255	57.00
M	60-64	50,219	61.98	4,216	61.98
M	65+	6,865	68.39	719	67.75
Total		773,719	41.39	63,506	41.87
		Age/Gender Factor	1.2189		1.2365

Demographic Adjustment (Line 1+c3 on Exhibit 5) = 1.2365 / 1.2189 **1.0144**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

IMPACT OF THE CHANGE IN PROVIDER NETWORK

MEDICAL CLAIMS

Coverage Category in the Experience	CY 2014 Allowed Claims	Experience Membership	CY 2014 Allowed PMPM	Network Adjustment	CY 2014 Allowed PMPM Adjuted for Network
Catamount	$10,333,313	28,606	$361.23	1.3919	$502.78
Indemnity/PPO	$18,283,952	49,125	$372.19	0.9766	$363.50
Point-of-Service	$1,254,577	4,245	$295.54	1.0000	$295.54
HMO	$20,591,099	57,397	$358.75	1.0152	$364.19
Qualified Health Plans	$250,559,018	634,346	$394.99	1.0000	$394.99
Weighted Average PMPM			$389.06	1.0131	$394.14

PHARMACY CLAIMS

Coverage Category in the Experience	CY 2014 Allowed Claims	Experience Membership	CY 2014 Allowed PMPM	Network Adjustment	CY 2014 Allowed PMPM Adjuted for Network
Catamount	$4,203,872	28,606	$146.96	1.0000	$146.96
Indemnity/PPO	$3,497,887	49,125	$71.20	1.0000	$71.20
Point-of-Service	$278,953	4,245	$65.71	1.0000	$65.71
HMO	$4,653,002	57,397	$81.07	1.0000	$81.07
Qualified Health Plans	$48,144,242	634,346	$75.90	1.0000	$75.90
Weighted Average PMPM			$78.55	1.0000	$78.55
Total Average PMPM			**$467.61**		**$472.70**

Impact of Change in Provider Network (Line 1+c2 on Exhibit 5) = $472.7 / $467.61 **1.0109**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

IMPACT OF SELECTION

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD Blue Rewards	Gold Blue Rewards CDHP	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	Weighted Average
Projected Paid Claims												
Using HHS Induced Utilization Factors												
2016 Projected FFS Allowed Charges - Without Selection	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	
Benefit Richness Adjustment	1.0155	0.9960	0.9747	0.9387	1.0815	1.0264	0.9743	0.9776	0.9394	0.9415	0.9437	
Pricing Actuarial Value	83.86%	80.34%	75.89%	66.30%	93.42%	85.64%	75.95%	77.00%	66.38%	67.21%	68.82%	
Family Multiplier	0.9436	0.9583	0.9453	0.9687	0.9921	0.9906	0.9865	0.9397	0.9791	0.9624	0.9755	
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	0.5242	
Projected Paid Claims	$422.70	$403.37	$367.82	$317.14	$527.25	$458.04	$384.06	$372.12	$321.20	$320.37	$174.69	$410.97
Projected Paid Claims												
Using BCBSVT Actual Utilization Factors												
2016 Projected FFS Allowed Charges - Without Selection	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	$526.06	
Benefit Richness Adjustment	1.0081	1.0081	0.8764	0.6011	1.5672	1.0081	0.8764	0.8764	0.6011	0.6011	0.9989	
Pricing Actuarial Value	83.79%	80.50%	74.23%	58.74%	94.98%	85.48%	74.38%	75.66%	58.78%	59.80%	68.82%	
Family Multiplier	0.9436	0.9583	0.9453	0.9687	0.9921	0.9906	0.9865	0.9397	0.9791	0.9624	0.9755	
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	0.5242	
Projected Paid Claims	$419.25	$409.07	$323.52	$179.93	$776.87	$449.03	$338.30	$327.79	$181.99	$182.00	$184.92	$419.43
Selection Impact											line 1+c6 on Exhibit 5	**1.0206**
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

MEDICAL TREND DEVELOPMENT
ILLUSTRATION OF CONTRACT NORMALIZATION

Month	Contract Increase	Normalization Factor	Experience Claims	Normalized Claims
Jan-11		1.1699	$1,000,000	$1,169,859
Feb-11		1.1699	$1,000,000	$1,169,859
Mar-11		1.1699	$1,000,000	$1,169,859
Apr-11		1.1699	$1,000,000	$1,169,859
May-11		1.1699	$1,000,000	$1,169,859
Jun-11		1.1699	$1,000,000	$1,169,859
Jul-11		1.1699	$1,000,000	$1,169,859
Aug-11		1.1699	$1,000,000	$1,169,859
Sep-11		1.1699	$1,000,000	$1,169,859
Oct-11	1.0400	1.1249	$1,000,000	$1,124,864
Nov-11		1.1249	$1,000,000	$1,124,864
Dec-11		1.1249	$1,000,000	$1,124,864
Jan-12		1.1249	$1,000,000	$1,124,864
Feb-12		1.1249	$1,000,000	$1,124,864
Mar-12		1.1249	$1,000,000	$1,124,864
Apr-12		1.1249	$1,000,000	$1,124,864
May-12		1.1249	$1,000,000	$1,124,864
Jun-12		1.1249	$1,000,000	$1,124,864
Jul-12		1.1249	$1,000,000	$1,124,864
Aug-12		1.1249	$1,000,000	$1,124,864
Sep-12		1.1249	$1,000,000	$1,124,864
Oct-12	1.0400	1.0816	$1,000,000	$1,081,600
Nov-12		1.0816	$1,000,000	$1,081,600
Dec-12		1.0816	$1,000,000	$1,081,600
Jan-13		1.0816	$1,000,000	$1,081,600
Feb-13		1.0816	$1,000,000	$1,081,600
Mar-13		1.0816	$1,000,000	$1,081,600
Apr-13		1.0816	$1,000,000	$1,081,600
May-13		1.0816	$1,000,000	$1,081,600
Jun-13		1.0816	$1,000,000	$1,081,600
Jul-13		1.0816	$1,000,000	$1,081,600
Aug-13		1.0816	$1,000,000	$1,081,600
Sep-13		1.0816	$1,000,000	$1,081,600
Oct-13	1.0400	1.0400	$1,000,000	$1,040,000
Nov-13		1.0400	$1,000,000	$1,040,000
Dec-13		1.0400	$1,000,000	$1,040,000
Jan-14		1.0400	$1,000,000	$1,040,000
Feb-14		1.0400	$1,000,000	$1,040,000
Mar-14		1.0400	$1,000,000	$1,040,000
Apr-14		1.0400	$1,000,000	$1,040,000
May-14		1.0400	$1,000,000	$1,040,000
Jun-14		1.0400	$1,000,000	$1,040,000
Jul-14		1.0400	$1,000,000	$1,040,000
Aug-14		1.0400	$1,000,000	$1,040,000
Sep-14		1.0400	$1,000,000	$1,040,000
Oct-14	1.0400	1.0000	$1,000,000	$1,000,000
Nov-14		1.0000	$1,000,000	$1,000,000
Dec-14		1.0000	$1,000,000	$1,000,000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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 - 12 Months
Jan-11	17,792	$5,245,455	$294.82	$6,311,998	$354.77	$316.88	$322.64	$214.19
Feb-11	18,078	$4,640,120	$256.67	$5,589,813	$309.21	$318.62	$324.27	$217.35
Mar-11	18,314	$5,990,744	$327.11	$7,208,138	$393.59	$320.20	$325.74	$220.24
Apr-11	18,498	$5,654,874	$305.70	$6,743,976	$364.58	$321.95	$327.38	$223.49
May-11	18,712	$5,373,426	$287.16	$6,405,223	$342.31	$323.66	$328.97	$226.68
Jun-11	18,921	$6,235,143	$329.54	$7,415,678	$391.93	$325.44	$330.63	$230.02
Jul-11	19,278	$5,332,093	$276.59	$6,317,701	$327.72	$327.17	$332.24	$233.30
Aug-11	19,654	$5,806,085	$295.41	$6,884,141	$350.27	$328.96	$333.91	$236.74
Sep-11	19,921	$6,407,145	$321.63	$7,627,417	$382.88	$330.77	$335.59	$240.23
Oct-11	20,174	$6,450,125	$319.72	$7,484,081	$370.98	$332.52	$337.22	$243.66
Nov-11	20,351	$6,723,423	$330.37	$7,629,522	$374.90	$334.35	$338.92	$247.25
Dec-11	20,550	$7,914,981	$385.16	$8,989,452	$437.44	$336.12	$340.57	$250.78
Jan-12	30,617	$9,063,490	$296.03	$10,235,183	$334.30	$337.97	$342.28	$254.47
Feb-12	30,831	$10,143,874	$329.02	$11,484,116	$372.49	$339.82	$344.00	$258.22
Mar-12	31,211	$10,183,501	$326.28	$11,444,062	$366.67	$341.56	$345.62	$261.78
Apr-12	31,477	$9,361,020	$297.39	$10,541,984	$334.91	$343.44	$347.36	$265.64
May-12	31,763	$10,141,300	$319.28	$11,400,368	$358.92	$345.26	$349.05	$269.43
Jun-12	32,073	$9,423,742	$293.82	$10,570,585	$329.58	$347.15	$350.81	$273.40
Jul-12	32,408	$9,272,460	$286.12	$10,359,973	$319.67	$349.00	$352.52	$277.30
Aug-12	32,733	$9,703,585	$296.45	$10,788,099	$329.58	$350.91	$354.29	$281.39
Sep-12	33,111	$8,951,985	$270.36	$9,941,818	$300.26	$352.84	$356.07	$285.54
Oct-12	33,427	$11,189,657	$334.75	$12,356,784	$369.66	$354.71	$357.81	$289.61
Nov-12	33,770	$11,643,660	$344.79	$12,826,984	$379.83	$356.66	$359.61	$293.88
Dec-12	34,073	$11,996,034	$352.07	$12,714,266	$373.15	$358.55	$361.36	$298.08
Jan-13	34,913	$11,901,970	$340.90	$12,575,252	$360.19	$360.52	$363.17	$302.47
Feb-13	35,143	$11,707,776	$333.15	$12,380,809	$352.30	$362.49	$365.00	$306.93
Mar-13	35,395	$12,622,617	$356.62	$13,319,805	$376.32	$364.29	$366.66	$311.01
Apr-13	35,405	$12,742,292	$359.90	$13,418,782	$379.01	$366.29	$368.50	$315.60
May-13	35,390	$13,259,972	$374.68	$13,997,660	$395.53	$368.23	$370.30	$320.10
Jun-13	35,384	$12,046,683	$340.46	$12,672,929	$358.15	$370.25	$372.16	$324.82
Jul-13	35,404	$11,820,991	$333.89	$12,397,163	$350.16	$372.22	$373.97	$329.45
Aug-13	35,424	$11,664,737	$329.29	$12,204,075	$344.51	$374.26	$375.86	$334.31
Sep-13	35,353	$12,650,194	$357.83	$13,204,675	$373.51	$376.31	$377.75	$339.24
Oct-13	35,314	$15,334,516	$434.23	$15,965,762	$452.11	$378.31	$379.59	$344.08
Nov-13	35,332	$13,767,813	$389.67	$14,296,018	$404.62	$380.39	$381.50	$349.15
Dec-13	35,171	$14,496,292	$412.17	$15,033,413	$427.44	$382.40	$383.35	$354.13
Jan-14	35,342	$13,850,266	$391.89	$14,218,588	$402.31	$384.50	$385.28	$359.35
Feb-14	35,411	$12,168,353	$343.63	$12,488,942	$352.69	$386.61	$387.22	$364.65
Mar-14	35,492	$12,920,443	$364.04	$13,226,797	$372.67	$388.53	$388.98	$369.50
Apr-14	35,371	$12,580,124	$355.66	$12,854,001	$363.41	$390.66	$390.94	$374.95
May-14	35,928	$13,178,421	$366.80	$13,432,921	$373.88	$392.73	$392.84	$380.29
Jun-14	36,050	$13,532,471	$375.38	$13,790,002	$382.52	$394.89	$394.82	$385.90
Jul-14	36,146	$13,234,647	$366.14	$13,402,523	$370.79	$396.98	$396.74	$391.40
Aug-14	36,276	$13,019,824	$358.91	$13,168,028	$363.00	$399.16	$398.73	$397.18
Sep-14	36,308	$14,226,032	$391.82	$14,377,482	$395.99	$401.35	$400.74	$403.03
Oct-14	36,360	$16,022,787	$440.67	$16,069,659	$441.96	$403.48	$402.69	$408.78
Nov-14	36,392	$14,585,580	$400.79	$14,605,064	$401.33	$405.69	$404.72	$414.81
Dec-14	36,331	$16,651,882	$458.34	$16,651,882	$458.34	$407.85	$406.69	$420.72
				Annual Increase		6.7%	6.1%	18.8%

Regressions

Regression on Adjusted PMPM - 36 Months		Regression on Adjusted PMPM - 24 Months		Regression on Adjusted PMPM - 12 Months	
1.000	0.247	1.000	0.455	1.000	0.000
0.000	1.625	0.000	3.033	0.000	7.371
0.373	0.074	0.183	0.075	0.418	0.064
20.259	34.000	4.936	22.000	7.169	10.000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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 - 24 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
Jan-13	34,913	$12,575,252	$360.19	$363.17	0.8966	1.0166	$12,784,266	$366.17	$370.66
Feb-13	35,143	$12,380,809	$352.30	$365.00	0.8963	1.0169	$12,590,271	$358.26	$372.12
Mar-13	35,395	$13,319,805	$376.32	$366.66	0.8963	1.0170	$13,545,858	$382.71	$373.45
Apr-13	35,405	$13,418,782	$379.01	$368.50	0.8963	1.0170	$13,646,417	$385.44	$374.93
May-13	35,390	$13,997,660	$395.53	$370.30	0.8963	1.0170	$14,235,050	$402.23	$376.37
Jun-13	35,384	$12,672,929	$358.15	$372.16	0.8963	1.0169	$12,887,427	$364.22	$377.86
Jul-13	35,404	$12,397,163	$350.16	$373.97	0.8963	1.0170	$12,607,771	$356.11	$379.31
Aug-13	35,424	$12,204,075	$344.51	$375.86	0.8963	1.0170	$12,411,577	$350.37	$380.81
Sep-13	35,353	$13,204,675	$373.51	$377.75	0.8959	1.0174	$13,434,407	$380.01	$382.32
Oct-13	35,314	$15,965,762	$452.11	$379.59	0.8961	1.0172	$16,240,413	$459.89	$383.78
Nov-13	35,332	$14,296,018	$404.62	$381.50	0.8962	1.0171	$14,539,856	$411.52	$385.30
Dec-13	35,171	$15,033,413	$427.44	$383.35	0.8962	1.0171	$15,290,992	$434.76	$386.78
Jan-14	35,342	$14,218,588	$402.31	$385.28	0.9116	0.9999	$14,216,750	$402.26	$388.31
Feb-14	35,411	$12,488,942	$352.69	$387.22	0.9125	0.9990	$12,475,904	$352.32	$389.85
Mar-14	35,492	$13,226,797	$372.67	$388.98	0.9132	0.9981	$13,201,778	$371.96	$391.24
Apr-14	35,371	$12,854,001	$363.41	$390.94	0.9112	1.0004	$12,858,543	$363.53	$392.79
May-14	35,928	$13,432,921	$373.88	$392.84	0.9111	1.0004	$13,438,415	$374.04	$394.30
Jun-14	36,050	$13,790,002	$382.52	$394.82	0.9115	1.0000	$13,789,765	$382.52	$395.86
Jul-14	36,146	$13,402,523	$370.79	$396.74	0.9114	1.0002	$13,404,614	$370.85	$397.37
Aug-14	36,276	$13,168,028	$363.00	$398.73	0.9113	1.0003	$13,171,521	$363.09	$398.95
Sep-14	36,308	$14,377,482	$395.99	$400.74	0.9113	1.0003	$14,381,378	$396.09	$400.53
Oct-14	36,360	$16,069,659	$441.96	$402.69	0.9114	1.0001	$16,071,213	$442.00	$402.06
Nov-14	36,392	$14,605,064	$401.33	$404.72	0.9113	1.0002	$14,608,478	$401.42	$403.65
Dec-14	36,331	$16,651,882	$458.34	$406.69	0.9115	1.0000	$16,651,882	$458.34	$405.20
		Annual Increase		6.1%					4.8%

Regressions

	Adjusted PMPM - 24
1.00016	0.4552
0.00007	3.0331
18.32%	0.0752
4.93578	22

	Adjusted PMPM - 24
1.00013	1.9228
0.00008	3.1300
11.55%	0.0776
2.87376	22

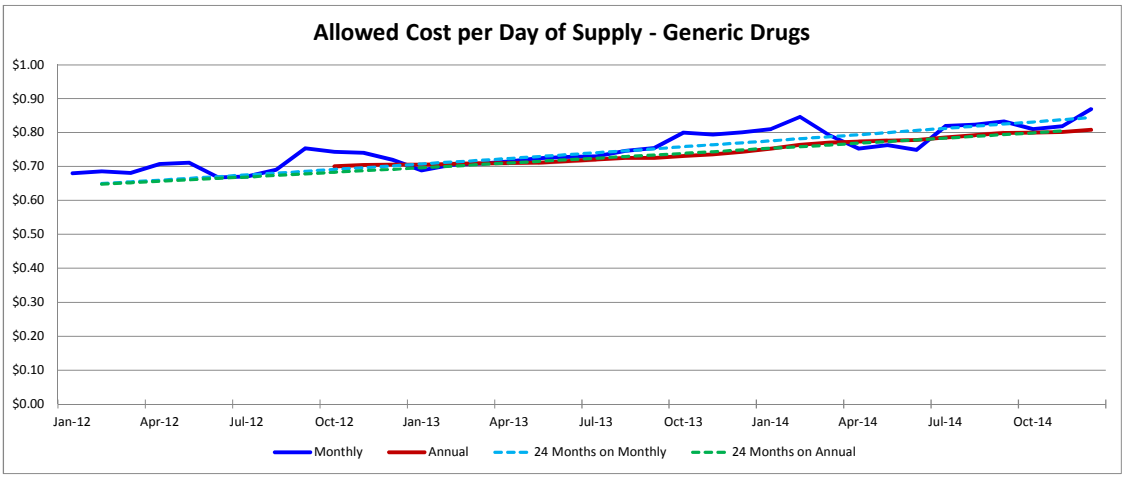
Impact of Benefit Chages **-1.25%**

PHARMACY TREND DEVELOPMENT

GENERIC DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Adjusted Allowed Charge	Cost/ Supply	Monthly Cost Trend	Supply	Adjusted Allowed Charge	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Jan-12	640,563	$436,099	$0.68							
Feb-12	646,774	$443,553	$0.69						$0.65	$0.65
Mar-12	712,000	$485,222	$0.68						$0.65	$0.65
Apr-12	687,617	$486,666	$0.71						$0.66	$0.66
May-12	733,083	$521,475	$0.71						$0.67	$0.66
Jun-12	736,484	$492,191	$0.67						$0.67	$0.67
Jul-12	751,558	$504,693	$0.67						$0.68	$0.67
Aug-12	791,957	$547,355	$0.69						$0.68	$0.67
Sep-12	739,577	$557,796	$0.75						$0.69	$0.68
Oct-12	867,500	$645,317	$0.74		7,307,113	$5,120,367	$0.70		$0.69	$0.68
Nov-12	829,031	$614,105	$0.74		8,136,143	$5,734,471	$0.70		$0.70	$0.69
Dec-12	890,165	$641,014	$0.72		9,026,308	$6,375,485	$0.71		$0.70	$0.69
Jan-13	877,653	$604,570	$0.69	1.2%	9,263,398	$6,543,957	$0.71		$0.71	$0.70
Feb-13	801,607	$565,076	$0.70	2.8%	9,418,231	$6,665,480	$0.71		$0.71	$0.70
Mar-13	874,350	$619,876	$0.71	4.0%	9,580,581	$6,800,134	$0.71		$0.72	$0.71
Apr-13	912,540	$653,037	$0.72	1.1%	9,805,504	$6,966,505	$0.71		$0.72	$0.71
May-13	915,644	$663,873	$0.73	1.9%	9,988,065	$7,108,903	$0.71		$0.73	$0.72
Jun-13	872,065	$635,464	$0.73	9.0%	10,123,646	$7,252,176	$0.72		$0.74	$0.72
Jul-13	929,901	$679,240	$0.73	8.8%	10,301,989	$7,426,722	$0.72		$0.74	$0.72
Aug-13	935,748	$699,007	$0.75	8.1%	10,445,781	$7,578,375	$0.73		$0.75	$0.73
Sep-13	925,216	$698,342	$0.75	0.1%	10,631,420	$7,718,921	$0.73		$0.75	$0.73
Oct-13	986,062	$789,227	$0.80	7.6%	10,749,982	$7,862,831	$0.73		$0.76	$0.74
Nov-13	916,614	$728,815	$0.80	7.3%	10,837,566	$7,977,541	$0.74	4.4%	$0.76	$0.74
Dec-13	1,092,166	$875,235	$0.80	11.3%	11,039,567	$8,211,762	$0.74	5.3%	$0.77	$0.75
Jan-14	877,589	$711,564	$0.81	17.7%	11,039,503	$8,318,756	$0.75	6.7%	$0.78	$0.75
Feb-14	850,995	$720,725	$0.85	20.1%	11,088,891	$8,474,405	$0.76	8.0%	$0.78	$0.76
Mar-14	1,000,194	$792,519	$0.79	11.8%	11,214,735	$8,647,047	$0.77	8.6%	$0.79	$0.76
Apr-14	926,786	$698,103	$0.75	5.3%	11,228,982	$8,692,113	$0.77	9.0%	$0.79	$0.77
May-14	963,156	$735,315	$0.76	5.3%	11,276,494	$8,763,555	$0.78	9.2%	$0.80	$0.77
Jun-14	977,047	$732,119	$0.75	2.8%	11,381,475	$8,860,210	$0.78	8.7%	$0.81	$0.78
Jul-14	1,008,264	$826,739	$0.82	12.3%	11,459,838	$9,007,710	$0.79	9.0%	$0.81	$0.78
Aug-14	989,486	$815,392	$0.82	10.3%	11,513,575	$9,124,095	$0.79	9.2%	$0.82	$0.79
Sep-14	1,017,066	$847,483	$0.83	10.4%	11,605,425	$9,273,236	$0.80	10.1%	$0.83	$0.79
Oct-14	1,046,960	$848,834	$0.81	1.3%	11,666,323	$9,332,843	$0.80	9.4%	$0.83	$0.80
Nov-14	980,397	$802,980	$0.82	3.0%	11,730,106	$9,407,008	$0.80	8.9%	$0.84	$0.81
Dec-14	1,147,888	$997,911	$0.87	8.5%	11,785,828	$9,529,683	$0.81	8.7%	$0.84	$0.81

Exponential Trend:	9.7%	8.2%
Adjustment for Future ESI Contract Terms:	0.7844	0.7844
Adjusted Trend:	-14.0%	-15.1%



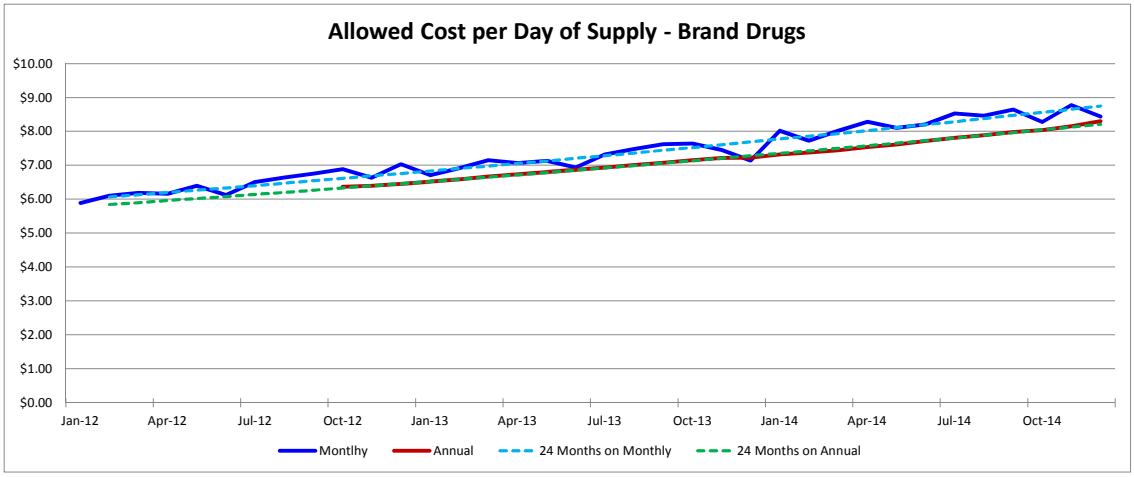
Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.000	1.000	0.000
	0.000	1.450	0.000	0.283
	0.706	0.036	0.979	0.007
	52.881	22.000	1007.963	22.000

PHARMACY TREND DEVELOPMENT

BRAND DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Adjusted Allowed Charge	Cost/ Supply	Monthly Cost Trend	Supply	Adjusted Allowed Charge	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Jan-12	146,715	$864,285	$5.89							
Feb-12	149,981	$915,810	$6.11						$6.07	$5.85
Mar-12	160,702	$995,125	$6.19						$6.13	$5.90
Apr-12	150,005	$925,162	$6.17						$6.20	$5.96
May-12	159,623	$1,021,276	$6.40						$6.27	$6.02
Jun-12	143,691	$879,989	$6.12						$6.34	$6.08
Jul-12	146,646	$954,818	$6.51						$6.40	$6.14
Aug-12	148,284	$985,558	$6.65						$6.48	$6.21
Sep-12	145,814	$985,362	$6.76						$6.55	$6.27
Oct-12	162,895	$1,121,782	$6.89		1,514,356	$9,649,168	$6.37		$6.62	$6.33
Nov-12	156,025	$1,035,553	$6.64		1,670,381	$10,684,721	$6.40		$6.69	$6.40
Dec-12	175,880	$1,236,476	$7.03		1,846,261	$11,921,197	$6.46		$6.76	$6.46
Jan-13	155,310	$1,042,344	$6.71	13.9%	1,854,856	$12,099,256	$6.52		$6.84	$6.53
Feb-13	138,489	$958,813	$6.92	13.4%	1,843,364	$12,142,258	$6.59		$6.91	$6.59
Mar-13	156,867	$1,121,693	$7.15	15.5%	1,839,529	$12,268,827	$6.67		$6.98	$6.65
Apr-13	158,906	$1,122,922	$7.07	14.6%	1,848,430	$12,466,587	$6.74		$7.06	$6.72
May-13	161,541	$1,153,360	$7.14	11.6%	1,850,348	$12,598,671	$6.81		$7.13	$6.79
Jun-13	152,797	$1,060,670	$6.94	13.3%	1,859,454	$12,779,352	$6.87		$7.21	$6.86
Jul-13	162,762	$1,191,904	$7.32	12.5%	1,875,570	$13,016,437	$6.94		$7.29	$6.93
Aug-13	169,685	$1,269,988	$7.48	12.6%	1,896,971	$13,300,867	$7.01		$7.37	$7.00
Sep-13	164,122	$1,252,289	$7.63	12.9%	1,915,279	$13,567,794	$7.08		$7.45	$7.07
Oct-13	180,653	$1,381,032	$7.64	11.0%	1,933,037	$13,827,044	$7.15		$7.53	$7.14
Nov-13	167,574	$1,249,678	$7.46	12.4%	1,944,585	$14,041,169	$7.22	12.9%	$7.61	$7.21
Dec-13	203,516	$1,454,616	$7.15	1.7%	1,972,222	$14,259,309	$7.23	12.0%	$7.69	$7.28
Jan-14	133,122	$1,067,917	$8.02	19.5%	1,950,034	$14,284,882	$7.33	12.3%	$7.78	$7.36
Feb-14	136,378	$1,054,657	$7.73	11.7%	1,947,923	$14,380,726	$7.38	12.1%	$7.86	$7.43
Mar-14	150,691	$1,209,514	$8.03	12.2%	1,941,747	$14,468,547	$7.45	11.7%	$7.94	$7.50
Apr-14	136,167	$1,128,710	$8.29	17.3%	1,919,008	$14,474,335	$7.54	11.8%	$8.03	$7.58
May-14	140,811	$1,141,874	$8.11	13.6%	1,898,278	$14,462,850	$7.62	11.9%	$8.11	$7.65
Jun-14	143,554	$1,178,413	$8.21	18.3%	1,889,035	$14,580,593	$7.72	12.3%	$8.20	$7.73
Jul-14	143,566	$1,224,585	$8.53	16.5%	1,869,839	$14,613,274	$7.82	12.6%	$8.29	$7.81
Aug-14	140,096	$1,186,567	$8.47	13.2%	1,840,249	$14,529,853	$7.90	12.6%	$8.38	$7.89
Sep-14	153,413	$1,326,155	$8.64	13.3%	1,829,541	$14,603,719	$7.98	12.7%	$8.47	$7.97
Oct-14	164,569	$1,362,820	$8.28	8.3%	1,813,457	$14,585,507	$8.04	12.4%	$8.56	$8.05
Nov-14	147,011	$1,290,509	$8.78	17.7%	1,792,894	$14,626,339	$8.16	13.0%	$8.66	$8.13
Dec-14	184,671	$1,558,445	$8.44	18.1%	1,774,049	$14,730,168	$8.30	14.8%	$8.75	$8.21

Exponential Trend:	13.8%	12.7%
Adjustment for Future ESI Contract Terms:	0.9915	0.9915
Adjusted Trend:	12.8%	11.8%

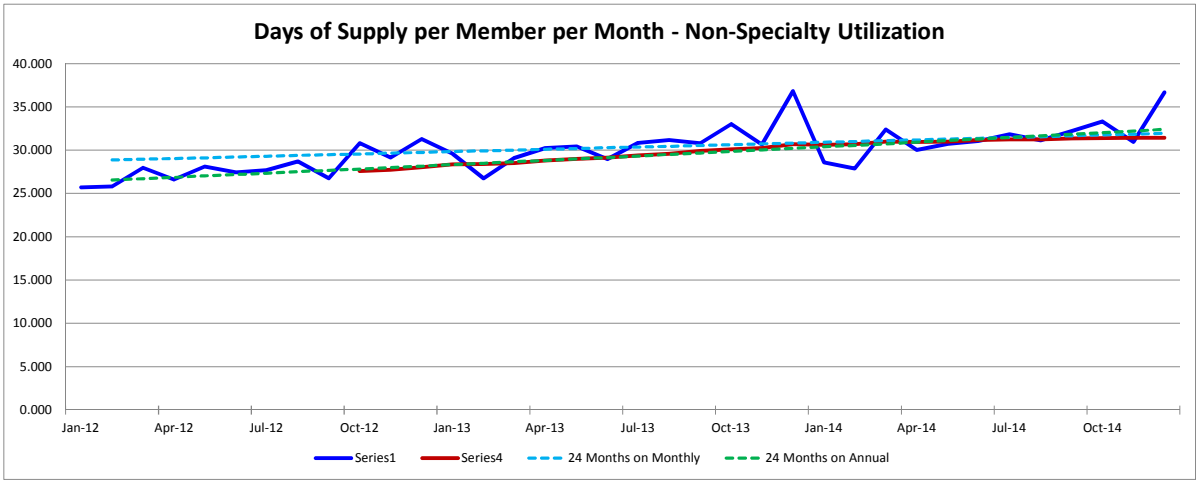


Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.000	1.000	0.000
	0.000	1.074	0.000	0.172
	0.895	0.027	0.997	0.004
	187.516	22.000	6315.206	22.000

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-12	30,617	787,278	25.714							
Feb-12	30,831	796,755	25.843						28.880	26.571
Mar-12	31,211	872,702	27.961						28.962	26.719
Apr-12	31,477	837,622	26.611						29.050	26.879
May-12	31,763	892,706	28.105						29.135	27.034
Jun-12	32,073	880,175	27.443						29.223	27.196
Jul-12	32,408	898,204	27.716						29.309	27.353
Aug-12	32,733	940,241	28.725						29.398	27.516
Sep-12	33,111	885,391	26.740						29.487	27.681
Oct-12	33,427	1,030,395	30.825		319,651	8,821,469	27.597		29.574	27.841
Nov-12	33,770	985,056	29.170		353,421	9,806,525	27.747		29.664	28.007
Dec-12	34,073	1,066,045	31.287		387,494	10,872,570	28.059		29.751	28.169
Jan-13	34,913	1,032,963	29.587	15.1%	391,790	11,118,255	28.378		29.841	28.337
Feb-13	35,143	940,096	26.751	3.5%	396,102	11,261,596	28.431		29.932	28.507
Mar-13	35,395	1,031,217	29.135	4.2%	400,286	11,420,111	28.530		30.014	28.660
Apr-13	35,405	1,071,446	30.263	13.7%	404,214	11,653,935	28.831		30.105	28.831
May-13	35,390	1,077,185	30.438	8.3%	407,841	11,838,414	29.027		30.194	28.998
Jun-13	35,384	1,024,862	28.964	5.5%	411,152	11,983,101	29.145		30.285	29.171
Jul-13	35,404	1,092,663	30.863	11.4%	414,148	12,177,559	29.404		30.374	29.340
Aug-13	35,424	1,105,434	31.206	8.6%	416,839	12,342,752	29.610		30.467	29.515
Sep-13	35,353	1,089,338	30.813	15.2%	419,081	12,546,699	29.939		30.559	29.692
Oct-13	35,314	1,166,715	33.038	7.2%	420,968	12,683,019	30.128		30.649	29.863
Nov-13	35,332	1,084,188	30.686	5.2%	422,530	12,782,151	30.251	9.0%	30.742	30.042
Dec-13	35,171	1,295,682	36.840	17.7%	423,628	13,011,789	30.715	9.5%	30.832	30.215
Jan-14	35,342	1,010,711	28.598	-3.3%	424,057	12,989,537	30.632	7.9%	30.926	30.396
Feb-14	35,411	987,373	27.883	4.2%	424,325	13,036,814	30.724	8.1%	31.020	30.577
Mar-14	35,492	1,150,885	32.427	11.3%	424,422	13,156,482	30.999	8.7%	31.105	30.742
Apr-14	35,371	1,062,954	30.052	-0.7%	424,388	13,147,989	30.981	7.5%	31.199	30.926
May-14	35,928	1,103,967	30.727	1.0%	424,926	13,174,772	31.005	6.8%	31.291	31.105
Jun-14	36,050	1,120,600	31.085	7.3%	425,592	13,270,510	31.181	7.0%	31.386	31.290
Jul-14	36,146	1,151,829	31.866	3.3%	426,334	13,329,676	31.266	6.3%	31.478	31.471
Aug-14	36,276	1,129,582	31.139	-0.2%	427,186	13,353,825	31.260	5.6%	31.574	31.659
Sep-14	36,308	1,170,479	32.237	4.6%	428,141	13,434,966	31.380	4.8%	31.670	31.848
Oct-14	36,360	1,211,529	33.320	0.9%	429,187	13,479,780	31.408	4.2%	31.763	32.033
Nov-14	36,392	1,127,408	30.980	1.0%	430,247	13,523,000	31.431	3.9%	31.859	32.224
Dec-14	36,331	1,332,559	36.678	-0.4%	431,407	13,559,877	31.432	2.3%	31.953	32.410
								Exponential Trend:	3.6%	7.3%



Regressions	24 Months on Monthly		24 Months on Annual	
	1.000	0.527	1.000	0.010
	0.000	2.431	0.000	0.309
	0.113	0.060	0.968	0.008
	2.790	22.000	668.137	22.000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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 - 24 Months	Average Induced Utilization Factor	Normalization Factor for Induced Utilization	Adjusted Claims - Normalized for Induced Utilization Factor	Adjusted PMPM	Regression on Adjusted PMPM - 24 Months
Jan-13	34,913	1,032,963	29.59	29.13	0.8756	1.0080	1,041,249	29.82	29.27
Feb-13	35,143	940,096	26.75	29.29	0.8766	1.0069	946,593	26.94	29.42
Mar-13	35,395	1,031,217	29.13	29.44	0.8776	1.0058	1,037,180	29.30	29.56
Apr-13	35,405	1,071,446	30.26	29.60	0.8779	1.0054	1,077,230	30.43	29.71
May-13	35,390	1,077,185	30.44	29.76	0.8784	1.0049	1,082,429	30.59	29.86
Jun-13	35,384	1,024,862	28.96	29.92	0.8788	1.0043	1,029,273	29.09	30.01
Jul-13	35,404	1,092,663	30.86	30.08	0.8812	1.0017	1,094,477	30.91	30.16
Aug-13	35,424	1,105,434	31.21	30.24	0.8817	1.0011	1,106,625	31.24	30.32
Sep-13	35,353	1,089,338	30.81	30.41	0.8822	1.0004	1,089,803	30.83	30.48
Oct-13	35,314	1,166,715	33.04	30.57	0.8822	1.0005	1,167,271	33.05	30.63
Nov-13	35,332	1,084,188	30.69	30.74	0.8824	1.0003	1,084,495	30.69	30.79
Dec-13	35,171	1,295,682	36.84	30.90	0.8823	1.0004	1,296,196	36.85	30.94
Jan-14	35,342	1,010,711	28.60	31.07	0.8868	0.9953	1,005,963	28.46	31.10
Feb-14	35,411	987,373	27.88	31.24	0.8871	0.9950	982,435	27.74	31.26
Mar-14	35,492	1,150,885	32.43	31.40	0.8871	0.9949	1,145,031	32.26	31.41
Apr-14	35,371	1,062,954	30.05	31.57	0.8820	1.0008	1,063,769	30.07	31.57
May-14	35,928	1,103,967	30.73	31.74	0.8822	1.0005	1,104,464	30.74	31.73
Jun-14	36,050	1,120,600	31.08	31.91	0.8825	1.0002	1,120,775	31.09	31.89
Jul-14	36,146	1,151,829	31.87	32.08	0.8826	1.0001	1,151,910	31.87	32.05
Aug-14	36,276	1,129,582	31.14	32.26	0.8826	1.0000	1,129,586	31.14	32.21
Sep-14	36,308	1,170,479	32.24	32.43	0.8826	1.0000	1,170,456	32.24	32.38
Oct-14	36,360	1,211,529	33.32	32.61	0.8828	0.9998	1,211,333	33.31	32.54
Nov-14	36,392	1,127,408	30.98	32.78	0.8827	0.9999	1,127,298	30.98	32.71
Dec-14	36,331	1,332,559	36.68	32.96	0.8826	1.0000	1,332,559	36.68	32.87
		Annual Increase		6.7%					6.2%

Regressions

	Adjusted PMPM - 24
1.00018	0.0200
0.00006	2.5929
26.72%	0.0643
8.02137	22

	Adjusted PMPM - 24
1.00017	0.0310
0.00006	2.6081
24.18%	0.0646
7.01648	22

Impact of Benefit Chages **-0.38%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 3F

PHARMACY TREND DEVELOPMENT
GENERIC DISPENSING RATE

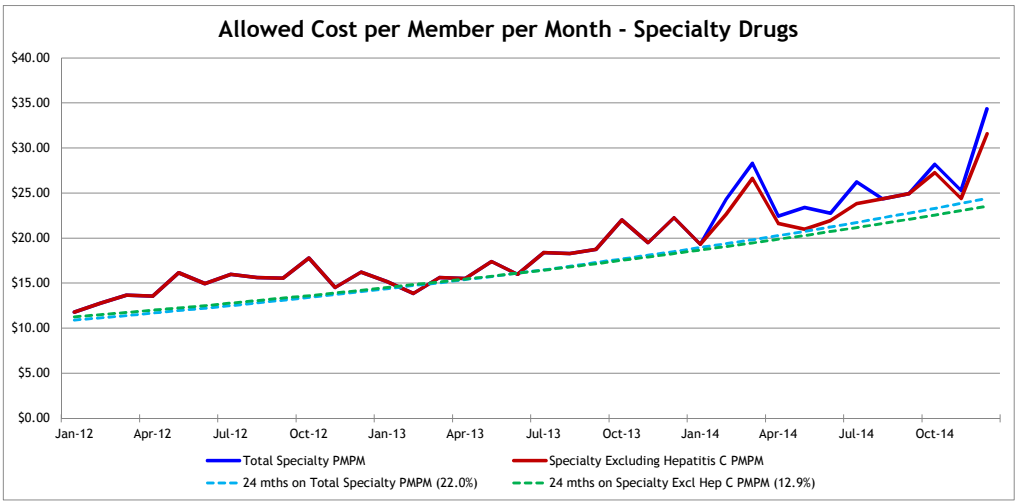
					Generic Dispensing Rate	
Month	Generic	Brands Losing Exclusivity	Brand	Total Non-Specialty	Monthly	Rolling 12
Jan-14	1,543,077		240,201	1,783,278	86.5%	
Feb-14	1,478,244		235,665	1,713,908	86.2%	
Mar-14	1,667,213		260,094	1,927,307	86.5%	
Apr-14	1,562,819		225,339	1,788,158	87.4%	
May-14	1,625,991		236,860	1,862,851	87.3%	
Jun-14	1,618,132		234,575	1,852,708	87.3%	
Jul-14	1,690,687		238,019	1,928,706	87.7%	
Aug-14	1,678,155		234,864	1,913,019	87.7%	
Sep-14	1,709,744		253,645	1,963,389	87.1%	
Oct-14	1,764,168		273,193	2,037,361	86.6%	
Nov-14	1,620,811		242,138	1,862,949	87.0%	
Dec-14	1,877,440		299,834	2,177,275	86.2%	87.0%
Jan-15	1,543,077	7,470	232,731	1,783,278	86.9%	87.0%
Feb-15	1,478,244	11,258	224,407	1,713,908	86.9%	87.0%
Mar-15	1,667,213	11,240	248,854	1,927,307	87.1%	87.1%
Apr-15	1,562,819	11,285	214,055	1,788,158	88.0%	87.1%
May-15	1,625,991	10,384	226,476	1,862,851	87.8%	87.2%
Jun-15	1,618,132	15,034	219,541	1,852,708	88.2%	87.3%
Jul-15	1,690,687	13,518	224,501	1,928,706	88.4%	87.3%
Aug-15	1,678,155	14,234	220,630	1,913,019	88.5%	87.4%
Sep-15	1,709,744	14,403	239,242	1,963,389	87.8%	87.4%
Oct-15	1,764,168	14,345	258,849	2,037,361	87.3%	87.5%
Nov-15	1,620,811	14,354	227,783	1,862,949	87.8%	87.6%
Dec-15	1,877,440	13,662	286,173	2,177,275	86.9%	87.6%
Jan-16	1,550,547	13,808	218,923	1,783,278	87.7%	87.7%
Feb-16	1,489,501	11,959	212,448	1,713,908	87.6%	87.7%
Mar-16	1,678,453	11,911	236,943	1,927,307	87.7%	87.8%
Apr-16	1,574,103	9,620	204,435	1,788,158	88.6%	87.8%
May-16	1,636,375	22,841	203,634	1,862,851	89.1%	87.9%
Jun-16	1,633,166	19,512	200,030	1,852,708	89.2%	88.0%
Jul-16	1,704,205	23,180	201,321	1,928,706	89.6%	88.1%
Aug-16	1,692,389	23,092	197,538	1,913,019	89.7%	88.2%
Sep-16	1,724,146	22,674	216,569	1,963,389	89.0%	88.3%
Oct-16	1,778,513	23,992	234,856	2,037,361	88.5%	88.4%
Nov-16	1,635,166	21,705	206,079	1,862,949	88.9%	88.5%
Dec-16	1,891,102	44,395	241,777	2,177,275	88.9%	88.7%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

PHARMACY TREND DEVELOPMENT
SPECIALTY TREND CALCULATIONS

	MONTHLY DATA				PMPM		Rolling 12 PMPM		EXPONENTIAL FIT	
Incurred Date	Members	Specialty Drug Allowed Charges Excluding Hepatitis C	Hepatitis C Allowed Charges	Total Specialty Drug Allowed Charges	Total Specialty PMPM	Specialty Excluding Hepatitis C PMPM	Total Specialty PMPM	Specialty Excluding Hepatitis C PMPM	Total Specialty	Specialty Excluding Hepatitis C
Jan-12	30,617	$ 360,816	$ -	$ 360,816	$11.78	$11.78			$10.89	$11.26
Feb-12	30,831	$ 394,144	$ -	$ 394,144	$12.78	$12.78			$11.15	$11.50
Mar-12	31,211	$ 426,516	$ -	$ 426,516	$13.67	$13.67			$11.40	$11.74
Apr-12	31,477	$ 426,958	$ -	$ 426,958	$13.56	$13.56			$11.67	$11.99
May-12	31,763	$ 513,031	$ -	$ 513,031	$16.15	$16.15			$11.94	$12.24
Jun-12	32,073	$ 479,190	$ -	$ 479,190	$14.94	$14.94			$12.22	$12.51
Jul-12	32,408	$ 517,370	$ -	$ 517,370	$15.96	$15.96			$12.50	$12.77
Aug-12	32,733	$ 511,035	$ -	$ 511,035	$15.61	$15.61			$12.80	$13.05
Sep-12	33,111	$ 514,669	$ -	$ 514,669	$15.54	$15.54			$13.10	$13.33
Oct-12	33,427	$ 594,642	$ -	$ 594,642	$17.79	$17.79			$13.41	$13.61
Nov-12	33,770	$ 489,687	$ -	$ 489,687	$14.50	$14.50			$13.72	$13.90
Dec-12	34,073	$ 552,738	$ -	$ 552,738	$16.22	$16.22	$14.92	$14.92	$14.04	$14.19
Jan-13	34,913	$ 529,314	$ -	$ 529,314	$15.16	$15.16	$15.18	$15.18	$14.37	$14.50
Feb-13	35,143	$ 486,303	$ -	$ 486,303	$13.84	$13.84	$15.25	$15.25	$14.71	$14.82
Mar-13	35,395	$ 552,803	$ -	$ 552,803	$15.62	$15.62	$15.41	$15.41	$15.03	$15.11
Apr-13	35,405	$ 548,844	$ -	$ 548,844	$15.50	$15.50	$15.56	$15.56	$15.39	$15.43
May-13	35,390	$ 615,962	$ -	$ 615,962	$17.40	$17.40	$15.67	$15.67	$15.74	$15.76
Jun-13	35,384	$ 564,711	$ -	$ 564,711	$15.96	$15.96	$15.76	$15.76	$16.11	$16.10
Jul-13	35,404	$ 650,838	$ -	$ 650,838	$18.38	$18.38	$15.96	$15.96	$16.48	$16.44
Aug-13	35,424	$ 647,811	$ -	$ 647,811	$18.29	$18.29	$16.19	$16.19	$16.87	$16.79
Sep-13	35,353	$ 662,192	$ -	$ 662,192	$18.73	$18.73	$16.45	$16.45	$17.28	$17.16
Oct-13	35,314	$ 776,931	$ -	$ 776,931	$22.00	$22.00	$16.81	$16.81	$17.67	$17.52
Nov-13	35,332	$ 688,064	$ -	$ 688,064	$19.47	$19.47	$17.22	$17.22	$18.09	$17.90
Dec-13	35,171	$ 782,633	$ -	$ 782,633	$22.25	$22.25	$17.72	$17.72	$18.51	$18.27
Jan-14	35,342	$ 682,023	$ -	$ 682,023	$19.30	$19.30	$18.06	$18.06	$18.95	$18.67
Feb-14	35,411	$ 801,734	$ 59,494	$ 861,228	$24.32	$22.64	$18.93	$18.79	$19.40	$19.07
Mar-14	35,492	$ 944,957	$ 58,827	$ 1,003,784	$28.28	$26.62	$19.99	$19.71	$19.81	$19.45
Apr-14	35,371	$ 765,059	$ 29,076	$ 794,135	$22.45	$21.63	$20.57	$20.22	$20.28	$19.87
May-14	35,928	$ 753,145	$ 87,245	$ 840,390	$23.39	$20.96	$21.07	$20.52	$20.75	$20.28
Jun-14	36,050	$ 791,362	$ 29,086	$ 820,448	$22.76	$21.95	$21.64	$21.02	$21.24	$20.72
Jul-14	36,146	$ 861,001	$ 87,268	$ 948,269	$26.23	$23.82	$22.30	$21.48	$21.73	$21.16
Aug-14	36,276	$ 883,678	$ -	$ 883,678	$24.36	$24.36	$22.81	$21.99	$22.24	$21.62
Sep-14	36,308	$ 904,400	$ -	$ 904,400	$24.91	$24.91	$23.32	$22.50	$22.77	$22.08
Oct-14	36,360	$ 991,212	$ 33,502	$ 1,024,714	$28.18	$27.26	$23.84	$22.95	$23.30	$22.55
Nov-14	36,392	$ 887,058	$ 33,505	$ 920,564	$25.30	$24.38	$24.33	$23.35	$23.85	$23.04
Dec-14	36,331	$ 1,147,479	$ 100,678	$ 1,248,157	$34.36	$31.58	$25.34	$24.14	$24.40	$23.52

Exponential Trend:	31.8%	28.7%
Adjustment for Future ESI Contract Terms:	0.9765	0.9765
Adjusted Trend:	28.7%	25.7%



Regressions	24 Months on Monthly		24 Months on Annual	
	1.0007573	3.86973E-13	1.000692	5.7776E-12
	3.44276E-05	1.431984245	2.768E-05	1.1514775
	95.65%	0.035507289	96.60%	0.02855188
	483.4981824	22	624.3555	22

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 3H

PHARMACY TREND DEVELOPMENT
UTILIZATION ADJUSTMENT FOR SPECIALTY TREND

	Qualified Health Plan Continuing Population				
Total Days Supply for Specialty Drugs	CY 2013	CY 2014	Annual Trend	CY 2016 Projection	Projected Trend
MISCELLANEOUS ANTINEOPLASTIC DRUGS	8.27	11.26	36.2%	20.88	
MISCELLANEOUS NEUROLOGICAL THERAPY	28.13	33.42	18.8%	47.17	
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	68.23	78.26	14.7%	102.94	
ALL OTHER	39.18	44.08	12.5%	55.78	
TOTAL	143.81	167.02		226.78	16.5%

	Large Group Population		
Total Days Supply for Specialty Drugs	CY 2013	CY 2014	Annual Trend
MISCELLANEOUS ANTINEOPLASTIC DRUGS	10.35	11.27	8.9%
MISCELLANEOUS NEUROLOGICAL THERAPY	27.21	31.51	15.8%
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	54.82	59.02	7.7%
ALL OTHER	50.06	51.14	2.2%
TOTAL	142.44	152.94	7.4%

Adjustment for Utilization	Qualified Health Plan Continuing Population			
Total Days Supply for Specialty Drugs	CY 2014	Annual Trend	CY 2016 Projection	Projected Trend
MISCELLANEOUS ANTINEOPLASTIC DRUGS	11.26	8.9%	13.35	
MISCELLANEOUS NEUROLOGICAL THERAPY	33.42	15.8%	44.80	
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	78.26	14.7%	102.94	
ALL OTHER	44.08	12.5%	55.78	
TOTAL	167.02		216.88	14.0%

Adjustment Factor	**0.9779**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXHIBIT 3I

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 2014							
Member Months						773,719	
# Days Supply	a	19,836,481	2,974,428	22,810,908	125,488	22,936,397	
Allowed Charge per Supply	b	$0.86	$8.12				
Total Allowed Charges	c=a*b	$17,063,878	$24,155,213	$41,219,091	$19,558,864	$60,777,955	$78.55
Utilization Trends							
Trend from the Regression Calculation (Exh 3D)	d1			**3.6%**			
Aging Adjustment	d2			**0.9737**			
Adjustment for Benefits	d3			**0.9962**			
Projected Utitlization Trend	e=d1*d2*d3-1			**0.52%**			
Projected # Days Supply (1 yr)	$f=a*(1+e)^2$			23,049,969			
Projected Rolling-12 dispensing rate (Generic and Brand split)	g=e*f	**88.7%**	**11.3%**				
Non-Specialty Projected # Days Supply: Generic and Brand	h=f*g	20,448,435	2,601,534				
Utilization Trends: Generic and Brand	i=h/a-1	**1.5%**	**-6.5%**				
Cost Trends							
Calculated Annual Trend	*j*	*9.7%*	*13.8%*				
Contract Change for FY 2015	*k*	*0.7844*	*0.9915*				
Adjusted Annual Trend	*l=(1+j)*k-1*	*-14.0%*	*12.8%*				
Projected Allowed Charge per Supply	$m=b*(1+l)^2$	$0.6368	$10.33				
Projected Total Allowed Charges	n=m*h	$13,021,293	$26,881,850	*$39,903,142*	$29,041,492	$68,944,634	$89.11
Annual Trend	$o=(n/c)^{0.5}$	**-12.6%**	**5.5%**	**-1.6%**	**21.9%**	**6.5%**	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

MEDICAL TREND DEVELOPMENT
PROJECTION FACTOR FOR INDEX RATE CALCULATION

TREND FACTORS

Annual	Cost	Utilization	Total
Medical	5.3%	2.0%	7.4%
Pharmacy	6.0%	0.5%	6.5%

MEDICAL

Coverage Category in the Experience	Membership	CY 2014 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2016 Allowed PMPM Adjuted for Network and Small Group Definition
Catamount	28,606	$502.78	1.1093	$557.71	1.0405	$580.32
Indemnity/PPO	49,125	$363.50	1.1093	$403.22	1.0405	$419.56
Point-of-Service	4,245	$295.54	1.1093	$327.84	1.0405	$341.12
HMO	57,397	$364.19	1.1093	$403.98	1.0405	$420.35
HIX	634,346	$394.99	1.1093	$438.15	1.0405	$455.90

PHARMACY

Coverage Category in the Experience	Membership	CY 2014 Allowed PMPM Adjuted for Network and Small Group Definition	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2016 Allowed PMPM Adjuted for Network and Small Group Definition
Catamount	28,606	$146.96	1.1226	$164.98	1.0105	$166.70
Indemnity/PPO	49,125	$71.20	1.1226	$79.93	1.0105	$80.77
Point-of-Service	4,245	$65.71	1.1226	$73.77	1.0105	$74.54
HMO	57,397	$81.07	1.1226	$91.01	1.0105	$91.96
HIX	634,346	$75.90	1.1226	$85.20	1.0105	$86.09

		Cost Trend (24mths)		Utilization Trend (24mths)	
Medical	$394.14	1.1093	$437.21	1.0405	$454.93
Rx	$78.55	1.1226	$88.18	1.0105	$89.11
Total	$472.70	1.1115	$525.39	1.0355	$544.04

Cost Trend Factor	$1+d_1$	1.1115
Utilization Trend Factor	$1+d_2$	1.0355

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

EXPECTED TRANSITIONAL REINSURANCE RECOVERIES

Product	Expected Transitional Reinsurance Recoveries (PMPM)	Projected Individual Members
Blue Rewards Gold	-$30.92	922
Blue Rewards Gold CDHP	-$30.31	0
Blue Rewards Silver	-$27.33	4,349
Blue Rewards Bronze CDHP	-$25.27	1,891
Standard Platinum	-$36.04	4,182
Standard Gold	-$31.22	2,870
Standard Silver	-$27.33	9,518
Standard Silver CDHP	-$27.80	4,414
Standard Bronze	-$24.94	1,416
Standard Bronze CDHP	-$25.24	1,465
Catastrophic	-$28.64	120
Weighted Average on Individual Members Only	-$28.70	31,147
Projected Small Group Members		38,867
Projected Total Members		70,014
Total Recoveried spread across all 70,014 members	**-$12.77**	
Uniform Reinsurance Contribution Rate of $27 per Member per Year	**$2.25**	
Market Wide Adjustment for the Transitional Reinsurance Program	**-$10.52**	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

Exhibit 5

INDEX RATE CALCULATION

Index Rate : Experience Period Allowed Claims for EHB	A	$466.72
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of the Change in Small Group definition	$1+b_1$	1.0019
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	0.9911
Impact of insured formerly on Employer coverage	$1+b_4$	1.0000
Impact of new enrollment from prior high risk pool	$1+b_5$	1.0000
Impact of mandated coverage on morbidity	$1+b_6$	1.0000
Impact of Pent-up demand	$1+b_7$	1.0000
Impact of Premium Subsidy	$1+b_8$	1.0000
Changes in pool morbidity	$1+b_9$	0.9720
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	0.9947
Changes in provider networks	$1+c_2$	1.0109
Changes in demographics (age, gender, region, etc.)	$1+c_3$	1.0144
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in network delivery system	$1+c_5$	1.0000
Impact of Selection	$1+c_6$	1.0206
Adjusted Experience Period Allowed Claims for EHB		$468.98
Trend Factors		
Cost Trend	$1+d_1$	1.1115
Utilization Trend	$1+d_2$	1.0355
Projected Period Allowed Claims for Experience EHB		$539.76
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$4.66
Projected Blue Print Payments	e_2	$2.34
Projected ITS Fees	e_3	$1.39
Projected Vaccine Payments	e_4	$2.24
Projected Net cost of Reinsurance	e_5	$0.95
Additional Adjustments for Additional Mandated Benefits		
Projected Allowed Claims for Pediatric Vision	e_6	$0.37
Projected Allowed Claims for Pediatric Dental	e_7	$4.93
Projected Index Rate : Projected Period Expected Allowed Claims	$F = A\prod_{n=1}^{8}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$547.33
Market Wide Adjustments		
Risk Adjustment Payments and Fees	g_1	$0.15
Transitional Reinsurance Payments and Recoveries	g_2	-$10.52
Vermont Exchange Fees	g_3	$0.00
Market Adjusted Index Rate	$H = F + \sum_{n=1}^{3} g_n$	**$536.95**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	
Benefit Richness Adjustment	1.0156	0.9960	0.9744	0.9375	1.0820	1.0266	0.9741	0.9773	0.9386	0.9404	0.9426	
Paid to Allowed Ratio	83.52%	79.70%	75.44%	65.34%	93.25%	85.33%	75.51%	76.32%	65.83%	66.42%	67.85%	
Changes in Family Tiers	0.9430	0.9577	0.9447	0.9680	0.9920	0.9905	0.9864	0.9389	0.9788	0.9618	0.9750	
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	0.5140	
Expected Claims Cost	**$429.51**	**$408.21**	**$372.88**	**$318.42**	**$537.46**	**$465.94**	**$389.54**	**$376.03**	**$324.75**	**$322.57**	**$172.11**	**$416.97**
Administrative Charges Plan Level Adjustment	1.0708	1.0740	1.0807	1.0948	1.0562	1.0646	1.0772	1.0803	1.0927	1.0938	1.1746	
Taxes and Fees Plan Level Adjustment	1.0389	1.0389	1.0388	1.0388	1.0389	1.0389	1.0388	1.0388	1.0388	1.0388	1.0388	
Contribution to Reserve Plan Level Adjustment	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	
Plan Level Adjusted Index Rate	**$487.52**	**$464.73**	**$427.18**	**$369.54**	**$601.77**	**$525.84**	**$444.82**	**$430.60**	**$376.14**	**$374.02**	**$214.29**	**$473.99**
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Allowed Charges in Re-adjudication Model	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	$545.85	
Paid Claims from Re-adjudication Model	$456.77	$438.79	$416.41	$367.52	$507.80	$466.16	$416.04	$419.73	$368.71	$372.10	$375.64	
Base Paid to Allowed Ratio	83.68%	80.39%	76.29%	67.33%	93.03%	85.40%	76.22%	76.89%	67.55%	68.17%	68.82%	
Benefit Richness Adjustment for EHB	1.1034	1.0823	1.0591	1.0200	1.1752	1.1153	1.0587	1.0623	1.0208	1.0230	1.0254	1.0866
Normalized Benefit Richness Adjustment for EHB	1.0155	0.9960	0.9747	0.9387	1.0815	1.0264	0.9743	0.9776	0.9394	0.9415	0.9437	
Projected Period Paid Claims for Experience EHB	$452.64	$433.61	$409.61	$357.86	$504.22	$462.23	$409.96	$415.60	$358.31	$362.79	$371.45	
Benefit Richness Adjustment for EHB	1.0155	0.9960	0.9747	0.9387	1.0815	1.0264	0.9743	0.9776	0.9394	0.9415	0.9437	1.0000
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	
Non-System Claims	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	
Market Wide Adjustments	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	
Total Paid Claims with Benefit Richness Adjustment	$455.46	$426.23	$394.70	$328.93	$541.79	$470.40	$394.92	$400.51	$331.78	$335.40	$343.39	
Overall Benefit Richness Adjustment	1.0156	0.9960	0.9744	0.9375	1.0820	1.0266	0.9741	0.9773	0.9386	0.9404	0.9426	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Projected Period Allowed Claims for Experience EHB	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76
Paid to Allowed Ratio for EHB Portion	83.86%	80.34%	75.89%	66.30%	93.42%	85.64%	75.95%	77.00%	66.38%	67.21%	68.82%	
Projected Period Paid Claims for Experience EHB	$452.64	$433.61	$409.61	$357.86	$504.22	$462.23	$409.96	$415.60	$358.31	$362.79	$371.45	$430.83
Additional EHB Allowed Claims	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	$3.41
Non-System Claims	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27
Market Wide Adjustments	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37
Market Adjusted Index Rate	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95
Total Paid Claims	$448.46	$427.94	$405.08	$350.87	$500.71	$458.20	$405.44	$409.81	$353.49	$356.64	$364.32	$426.13
Paid to Allowed Ratio	83.52%	79.70%	75.44%	65.34%	93.25%	85.33%	75.51%	76.32%	65.83%	66.42%	67.85%	79.36%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

PLAN LEVEL ADJUSTMENT
CHANGE IN FAMILY TIER FACTOR

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	ue Rewards CDI	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Projected Period Paid Claims for Experience EHB	$452.64	$433.61	$409.61	$357.86	$504.22	$462.23	$409.96	$415.60	$358.31	$362.79	$371.45	
Family Multiplier for EHB before MOOP Changes	0.9429	0.9583	0.9319	0.9131	0.9921	0.9906	0.9865	0.9259	0.9791	0.9123	0.9161	0.9633
Adjusment to Family Multiplier for MOOP Changes	1.0007	1.0000	1.0144	1.0609	1.0000	1.0000	1.0000	1.0149	1.0000	1.0549	1.0649	1.0102
Family Multiplier for EHB after MOOP Changes	0.9436	0.9583	0.9453	0.9687	0.9921	0.9906	0.9865	0.9397	0.9791	0.9624	0.9755	0.9727
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	
Non-System Claims	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	$2.27	
Market Wide Adjustments	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	-$10.37	
Total Paid Claims with Family Multiplier Adjustment	$422.91	$409.85	$382.69	$339.65	$496.72	$453.85	$399.92	$384.75	$346.00	$343.00	$355.23	
Overall Family Multiplier Adjustment	0.9430	0.9577	0.9447	0.9680	0.9920	0.9905	0.9864	0.9389	0.9788	0.9618	0.9750	

BLUE CROSS AND BLUE SHIELD OF VERMONT **Exhibit 6E**
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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%	$544.04	68.8%	$374.39
Individual Ages 30 or Less	92.0%	$289.72	59.9%	$173.64
Individual Ages over 30	8.0%	$647.74	70.4%	$456.25
Weighted Average		$318.36	61.6%	$196.25
Allowed Charges Adjustment		*0.5852*		
Paid to Allowed Ratio Adjustment			*0.8958*	
Plan Level Adjustment Calculation				
Projected Period Allowed Claims for Experience EHB		$539.76		
Paid to Allowed Ratio for EHB Portion		68.8%		
Benefit Richness Adjustment for EHB		0.9437		
Family Multiplier for EHB		0.9755		
Adjustment for Allowed Charges and Paid to Allowed Ratio		*0.5242*		
Projected Period Paid Claims for Experience EHB		$179.24		
Additional EHB Paid Claims		$0.98		
Non-System Claims		$2.27		
Market Wide Adjustments		-$10.37		
Expected Claims Cost		$172.11		
Market Adjusted Index Rate		$536.95		
Paid to Allowed Ratio		67.8%		
Benefit Richness Adjustment		0.9426		
Changes in Family Tiers		0.9750		
For Catastrophic Only - Impact of Eligibility		0.5140		
Expected Claims Cost		$172.11		
Total Adjustment for Catastrophic Plan			**0.5140**	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

DETAILS OF ADMINISTRATIVE CHARGES

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD Blue Rewards	Gold Blue Rewards CDHP	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	**TOTAL**
BCBSVT Base Administrative Charges	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83	$28.83
Administrative Charges for Outside Vendors	$1.56	$1.36	$1.27	$1.36	$1.37	$1.28	$1.25	$1.35	$1.26	$1.43	$1.22	$1.33
Blue For You Reward Program	$0.00	$0.00	$0.00	$0.00							$0.00	$0.00
Total Administrative Charges PMPM	**$30.39**	**$30.19**	**$30.10**	**$30.19**	**$30.20**	**$30.11**	**$30.08**	**$30.19**	**$30.09**	**$30.27**	**$30.05**	**$30.16**
Administrative Charges Plan Level Adjustment	1.0708	1.0740	1.0807	1.0948	1.0562	1.0646	1.0772	1.0803	1.0927	1.0938	1.1746	1.0723
Administrative Charges as a percent of Premium	6.23%	6.50%	7.05%	8.17%	5.02%	5.73%	6.76%	7.01%	8.00%	8.09%	14.02%	**6.36%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

DETAILS OF CONTRIBUTION TO RESERVE

Section 1

Projected 2015 BCBSVT ACL	(A)	$22,642,905
Target RBC %	(B)	600%
Target capital	(C) = (A) x (B)	$135,857,430
Estimated Benefit Trend	(D)	8.05%
Estimated Increase in ACL	(E) = (C) x (D)	$1,821,756
Estimated Increase in Capital to Maintain Target	(F) = (B) x (E)	$10,930,535
Investment Income	(G)	$4,347,236
Tax rate	(I)	20.0%
Federal Insurer Fee	(J)	2.73%
Investment Income Net of Tax	(K) = (G) X (1-I)	$3,477,789
Additional Required	(L) = (F) - (K)	$7,452,746
Grossed up for Taxes	(M) = (L)/(1-I-J)	$9,645,071

Benefit Trend by LOB	
QHP	8.55%
LG	7.20%

	2016 Projected Premium	CTR proportions		Premium Portion
	(1)	(2)		(3) = (1) x (2)
Exchange	$397,277,296	1.00		$397,277,296
Cost Plus (equiv prem)	$326,258,965	0.25		$81,564,741
Other Insured	$155,416,774	1.00		$155,416,774
Total	$878,953,035	0.72	(N)	$634,258,811
Required Insured CTR Factor to Maintain Target	= (M)/(N)	**1.52%**		

Section 2

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD Blue Rewards	Gold Blue Rewards CDHP	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	**TOTAL**
BCBSVT Contribution to Reserve	$9.75	$9.29	$8.54	$7.39	$12.04	$10.52	$8.90	$8.61	$7.52	$7.48	$4.29	$9.48
Total Contribution to Reserve PMPM	**$9.75**	**$9.29**	**$8.54**	**$7.39**	**$12.04**	**$10.52**	**$8.90**	**$8.61**	**$7.52**	**$7.48**	**$4.29**	$9.48
Contribution to Reserve Plan Level Adjustment	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0388
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%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**Total**
State Assessment - HCCA	$3.49	$3.32	$3.04	$2.60	$4.36	$3.78	$3.17	$3.06	$2.65	$2.64	$1.43	$3.39
State Tax - VITL	$0.87	$0.83	$0.76	$0.65	$1.09	$0.94	$0.79	$0.76	$0.66	$0.66	$0.36	$0.85
Federal Assessment - PCORI	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19
Federal Insurer Fee	$13.31	$12.69	$11.66	$10.09	$16.43	$14.36	$12.15	$11.76	$10.27	$10.21	$5.85	$12.94
Total Taxes and Fees PMPM	**$17.87**	**$17.03**	**$15.65**	**$13.54**	**$22.07**	**$19.28**	**$16.30**	**$15.78**	**$13.78**	**$13.70**	**$7.84**	**$17.37**
Taxes and Fees Plan Level Adjustment	1.0389	1.0389	1.0388	1.0388	1.0389	1.0389	1.0388	1.0388	1.0388	1.0388	1.0388	1.0389
Taxes and Fees as a percent of Premium	3.66%	3.66%	3.66%	3.66%	3.67%	3.67%	3.66%	3.66%	3.66%	3.66%	3.66%	3.67%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT QUALIFIED HEALTH PLANS RATE FILING

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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Market Wide Adjusted Index Rate	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95
Plan Level Adjusted Index Rate	$487.52	$464.73	$427.18	$369.54	$601.77	$525.84	$444.82	$430.60	$376.14	$374.02	$214.29
AV Pricing Value	90.79%	86.55%	79.56%	68.82%	112.07%	97.93%	82.84%	80.19%	70.05%	69.66%	39.91%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
Expected Direct Claims PMPM	$439.89	$418.58	$383.25	$328.78	$547.84	$476.31	$399.91	$386.39	$335.12	$332.93	$182.49	$427.34
Transitional Reinsurance Recoveries PMPM	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77
Adjustments for Health Care Quality PMPM*	$5.23	$5.21	$5.21	$5.21	$2.17	$2.17	$2.16	$2.17	$2.16	$2.18	$5.20	$2.74
MLR Claims	**$432.35**	**$411.02**	**$375.69**	**$321.22**	**$537.24**	**$465.71**	**$389.30**	**$375.80**	**$324.51**	**$322.34**	**$174.92**	**$417.32**
Premium PMPM	$487.52	$464.73	$427.18	$369.54	$601.77	$525.84	$444.82	$430.60	$376.14	$374.02	$214.29	$473.99
Licensing and regulatory fees	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40
Taxes & Fees PMPM	-$17.87	-$17.03	-$15.65	-$13.54	-$22.07	-$19.28	-$16.30	-$15.78	-$13.78	-$13.70	-$7.84	-$17.37
MLR Premium	**$467.26**	**$445.30**	**$409.13**	**$353.61**	**$577.31**	**$504.17**	**$426.12**	**$412.43**	**$359.97**	**$357.93**	**$204.06**	**$454.22**
Expected Loss Ratio	92.5%	92.3%	91.8%	90.8%	93.1%	92.4%	91.4%	91.1%	90.2%	90.1%	85.7%	91.9%
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

*Approximately 7.19% of current BCBSVT Administrative Charges are for health care quality plus the Blue Rewards PMPM

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$487.52	$464.73	$427.18	$369.54	$601.77	$525.84	$444.82	$430.60	$376.14	$374.02	$214.29	
PMPM to Single Contract Conversion Factor	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	
2016 Proposed Rates												
Single Rate	$543.64	$518.23	$476.36	$412.08	$671.04	$586.38	$496.03	$480.18	$419.44	$417.08	$238.96	
Couple Rate	$1,087.28	$1,036.46	$952.72	$824.16	$1,342.08	$1,172.76	$992.06	$960.36	$838.88	$834.16	$477.92	
Adult and Child(ren) Rate	$1,049.23	$1,000.18	$919.37	$795.31	$1,295.11	$1,131.71	$957.34	$926.75	$809.52	$804.96	$461.19	
Family Rate	$1,527.63	$1,456.23	$1,338.57	$1,157.94	$1,885.62	$1,647.73	$1,393.84	$1,349.31	$1,178.63	$1,171.99	$671.48	$380,094,464.76
2015 Approved Rates												
Single Rate	$493.87		$428.14	$360.49	$624.18	$541.75	$465.61	$436.20	$395.78	$384.02	$228.24	
Couple Rate	$987.74		$856.28	$720.98	$1,248.36	$1,083.50	$931.22	$872.40	$791.56	$768.04	$456.48	
Adult and Child(ren) Rate	$953.17		$826.31	$695.75	$1,204.67	$1,045.58	$898.63	$841.87	$763.86	$741.16	$440.50	
Family Rate	$1,387.77		$1,203.07	$1,012.98	$1,753.95	$1,522.32	$1,308.36	$1,225.72	$1,112.14	$1,079.10	$641.35	$350,712,794.16
2015 Proposed Rate Increases												
Single Rate	10.1%		11.3%	14.3%	7.5%	8.2%	6.5%	10.1%	6.0%	8.6%	4.7%	
Couple Rate	10.1%		11.3%	14.3%	7.5%	8.2%	6.5%	10.1%	6.0%	8.6%	4.7%	
Adult and Child(ren) Rate	10.1%		11.3%	14.3%	7.5%	8.2%	6.5%	10.1%	6.0%	8.6%	4.7%	
Family Rate	10.1%		11.3%	14.3%	7.5%	8.2%	6.5%	10.1%	6.0%	8.6%	4.7%	**8.4%**
Inforce Contracts												
Single Rate	1,091		2,819	1,376	4,470	2,898	6,665	3,511	1,253	1,709	113	
Couple Rate	286		730	352	1,634	847	2,182	1,168	359	461	0	
Adult and Child(ren) Rate	69		104	76	358	186	301	206	55	89	2	
Family Rate	297		220	299	1,330	705	1,003	997	207	435	1	

March 23, 2015

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 2016 Standard Plan Designs

Dear Dana:

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 2016 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), 79% (Proposed, Vermont specific), 83% (Proposed, Vermont specific), 87% (federal) and 94% (federal) AV levels. The actual AVs and the corresponding FPLs for Vermont's CSR plans will not be final until after the state legislative session, likely in May. The State is requesting issuers file all potential CSR variations (six in total), including the two new proposed AV levels (79% and 83%).

The federal HDHP minimum deductible and Maximum Out of Pocket (MOOP) limits are not yet released for 2016. The 2015 minimum single deductible and MOOP are $1,300 and $6,450, respectively. The deductible increases $50 every two to three years and the MOOP increases around $100 a year on average. Should the plan designs need to change once these limits are released or as a result of the state legislative session regarding the CSR plans, the Department of Vermont Health Access (DVHA) will present the updated designs to Green Mountain Care Board (GMCB) for their information and approval, if needed.

[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 2015 standard plan designs is in Appendix B. At a high level the changes for each base standard plan are:

- Platinum – no changes
- Gold – no changes
- Silver Deductible – changes made to the medical deductible, drug deductible, medical MOOP, and specialist, generic drug, and preferred brand drug copays
- Bronze Deductible – changes made to the medical deductible, drug deductible, medical MOOP, and specialist copay
- Silver HDHP – changes made to the medical deductible, medical MOOP, and general coinsurance
- Bronze HDHP – changes made to the medical deductible and medical MOOP

For the Silver and Bronze HDHP plans, there are also now two options from which the issuers may choose one at each level. The 2016 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). 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 the new regulation can be done by adjusting the family MOOP in two ways. The first option has an aggregate family medical MOOP with an embedded $6,850 individual maximum. The second option has a stacked family medical MOOP. Both options comply with the new 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, the State of Vermont is also 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. An example of this plan design is in Appendix C.

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

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

EXECUTIVE SUMMARY

A summary of Vermont's standard plan designs is in Appendix E. 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

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

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 if the family MOOP is more than the single limit of $6,850, the MOOP must either be stacked or there must be an embedded individual MOOP of $6,850. 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 2015; 2016 amounts are not yet known). 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 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] 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.

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 F 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 drugs 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 G 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.

The IRS has yet to release the minimum deductible amount for HDHPs for 2016. The drug deductibles and MOOPs for HDHPs may need to change if the IRS changes the minimum deductible from the 2015 amount of $1,300. The current plan designs use the 2015 amounts.

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 (original model used 2010 data)
- 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.

	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 $6,850.

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

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

1. Same as for HDHPs, as much of the plan design as possible was entered into the AVC. This is the unadjusted AV. The Bronze Deductible plan then needs 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 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 H includes screen shots from the AVC and the HDHP model for each plan design with an adjusted actuarial value. Also included is a summary of the AVs and in the instance of the Bronze Deductible plan, a calculation of the adjustment.

RELIANCES

We have relied on others for information used in the actuarial value adjustments. For the original AV, the final 2016 federal AVC model was relied on. While reasonability tests have shown some errors in the calculations and there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and we make no warranties for the accuracy of the AVs that result from the AVC.

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

DISCLOSURES AND LIMITATIONS

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

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

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

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

Sincerely,

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

APPENDIX A

Actuarial Certification
State of Vermont
Actuarial Value of Standard Plan Designs
Effective January 1, 2016

I, Julie A. Peper, am associated with the firm of Wakely Consulting Group, Inc. (Wakely), am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by the State of Vermont to provide a certification of the actuarial value of the state's standard plan designs that are effective January 1, 2016 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 2016 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
- Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
- The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
- The actuarial values meet the requirements of § 156.135(b).

The assumptions and methodology used to development the actuarial values have been documented in my correspondence with the State of Vermont. The actuarial values associated with this certification are for standard plan designs (Silver HDHP, Bronze HDHP, Bronze Deductible, Silver HDHP CSR 73%, Silver HDHP CSR 77%, Silver HDHP CSR 79%, Silver HDHP CSR 83%, Silver HDHP CSR 87% and Silver HDHP CSR 94%) that will be effective as of January 1, 2016 on Vermont Health Connect.

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

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

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

Julie A. Peper, FSA, MAAA
March 20, 2015

APPENDIX B

Summary of Plan Design Changes from 2015 designs

	Deductible Plans			
Plan	**Platinum**	**Gold**	**Silver**	**Bronze**
Changes	No Change	No Change	Increase Medical Deductible from $1,900 to $2,000	Increase Medical Deductible from $3,500 to $4,000
			Increase Rx Deductible from $100 to $150	Increase Rx Deductible from $300 to $500
			Increase Medical MOOP from $5,100 to $5,600	Increase Medical MOOP from $6,350 to $6,850
			Increase Specialist office visit copay from $45 to $50	Increase Specialist office visit copay from $80 to $85
			Increase Rx Generic copay from $12 to $15	
			Increase Rx Preferred Brand copay from $50 to $60	

	Cost Sharing Reduction Plan Designs - Deductible Plans			
Plan	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Changes	Increase Medical Deductible from $1,900 to $2,000	Increase Medical Deductible from $1,500 to $1,600	No Change	No Change
	Increase Rx Deductible from $100 to $150	Increase Rx Deductible from $100 to $150		
	Increase Medical MOOP from $4,000 to $4,500	Increase Medical MOOP from $3,000 to $3,400		
	Increase Specialist office visit copay from $45 to $50	Increase Rx Preferred Brand copay from $50 to $60		
	Increase Rx Preferred Brand copay from $50 to $60			

	HDHPs - Embedded MOOP	
Plan	**Silver**	**Bronze**
Changes	Reduce Medical Deductible from $1,500 to $1,425	Increase Medical Deductible from $2,000 to $4,100
	Aggregate family Medical MOOP has embedded $6,850 individual maximum	Increase Medical MOOP from $6,250 to $6,500
	Increase General Coinsurance from 20% to 25%	Aggregate family Medical MOOP has embedded $6,850 individual maximum

	Cost Sharing Reduction Plan Designs - HDHPs Embedded MOOP			
Plan	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Changes	Increase Medical Deductible from $1,400 to $1,425	Increase Medical MOOP from $2,500 to $2,700	Increase Medical Deductible from $1,000 to $1,150	Increase Medical Deductible from $450 to $500
	Increase Medical MOOP from $3,400 to $3,800	Increase General Coinsurance to 25% from 20%	Increase Medical MOOP from $1,000 to $1,150	Increase Medical MOOP from $450 to $500
	Aggregate family Medical MOOP has embedded $6,850 individual maximum	Increase Rx Generic copay from $5 to $10		
	Increase General Coinsurance to 25% from 20%	Increase Rx Preferred Brand copay from $30 to $40		

	HDHPs - Stacked MOOP	
Plan	**Silver**	**Bronze**
Changes	Family Medical MOOP is stacked instead of aggregate	Increase Medical Deductible from $2,000 to $4,400
	Increase General Coinsurance from 20% to 25%	Increase Medical MOOP from $6,250 to $6,500
		Family Medical MOOP is stacked instead of aggregate

	Cost Sharing Reduction Plan Designs - HDHPs Stacked MOOP			
Plan	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Changes	Increase Medical Deductible from $1,400 to $1,550	Increase Medical Deductible from $1,300 to $1,400	Increase Medical Deductible from $1,000 to $1,200	Increase Medical Deductible from $450 to $500
	Increase Medical MOOP from $3,400 to $4,250	Increase Medical MOOP from $2,500 to $3,100	Increase Medical MOOP from $1,000 to $1,200	Increase Medical MOOP from $450 to $500
	Family Medical MOOP is stacked instead of aggregate	Family Medical MOOP is stacked instead of aggregate	Family Medical MOOP is stacked instead of aggregate	Family Medical MOOP is stacked instead of aggregate
	Increase General Coinsurance from 20% to 25%	Increase General Coinsurance from 20% to 25%		
		Increase Rx Generic copay from $5 to $10		
		Increase Rx Preferred Brand copay from $30 to $40		

Changes for both options of HDHP plans in 2016 are compared to the HDHP standard plan offered in 2015

Appendix C

Non-Standard Gold Plan – Example Plan Design

	Non-Standard Plans
Deductible/OOP Max	**Gold**
Type of Plan	HSA Q/HDHP
Medical Ded	$2,000
Rx Ded	$1,300
Integrated Ded	Yes
Medical OOPM	$2,000
Rx OOPM	$1,300
Integrated OOPM	Rx -No, Medical - Yes
Family Deductible / OOP	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive
Drug Deductible waived for:	Wellness scripts
Service Category	**Copay / Coinsurance**
Inpatient [1]	0%
Outpatient [2]	0%
ER [3]	0%
Radiology (MRI, CT, PET)	0%
Preventive	0%
PCP Office Visit	0%
MH/SA Office Visit	0%
Specialist Office Visit [4]	0%
Urgent Care	0%
Ambulance	0%
Rx Generic	$0
Rx Preferred Brand	$0
Rx Non-Preferred Brand	0%
Actuarial Value	
2016 Final Federal AVC, Adjusted if Necessary	79.5%

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

APPENDIX D

Comments Relative to Applicable ASOPs

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

• ASOP No. 23, *Data Quality*;

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

• ASOP No. 41, *Actuarial Communications*.

ASOP 23: Data Quality

3.1 Overview – VHCURES data was used as the basis for the HDHP model and this data source was deemed reasonable for the analysis discussed in the management report.
3.2 Selection of Data - The data was considered reasonable for our analysis subject to the following considerations -

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

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

APPENDIX E

Standard Plan Designs –Deductible Plans

	Deductible Plans			
Deductible/OOP Max	**Platinum Same as 2015 Plan Design**	**Gold Same as 2015 Plan Design**	**Silver 2016 Proposed Design**	**Bronze 2016 Proposed Design**
Type of Plan	Deductible	Deductible	Deductible	Deductible
Medical Ded	$150	$750	$2,000	$4,000
Rx Ded	$0	$50	$150	$500
Integrated Ded	No	No	No	No
Medical OOPM	$1,250	$4,250	$5,600	$6,850
Rx OOPM	$1,250	$1,250	$1,250	$1,250
Integrated OOPM	No	No	No	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]	$20	$25	$50	$85
Urgent Care	$40	$45	$60	$100
Ambulance	$50	$50	$100	$100
Rx Generic	$5	$5	$15	$20
Rx Preferred Brand	$40	$40	$60	$80
Rx Non-Preferred Brand	50%	50%	50%	60%
Actuarial Value				
2016 Final Federal AVC, Adjusted if Necessary	89.0%	81.0%	71.6%	61.4%

* Federal HDHP MOOP limits are not yet released for 2016. The 2015 minimum single deductible and MOOP are $1,300 and $6,450, respectively. The deductible increases $50 every two to three years and the MOOP increases around $100 a year on average.

** Income levels for Cost Sharing Reduction (CSR) plans are based on the income assignment in 2015

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

Standard Plan Designs – Cost Sharing Reduction Plans (Deductibles)

	Deductible Plans					
Deductible/OOP Max	**250-300% FPL (73% AV CSR) 2016 Proposed Plan Design**	**200-250% FPL (77% AV CSR) 2016 Proposed Plan Design**	**79% AV CSR (New in 2016)**	**83% AV CSR (New in 2016)**	**150-200% FPL (87% AV CSR) Same as 2015 Plan Design**	**133-150% FPL (94% AV CSR) Same as 2015 Plan Design**
Type of Plan	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Medical Ded	$2,000	$1,600	$1,250	$1,000	$600	$100
Rx Ded	$150	$150	$100	$100	$100	$0
Integrated Ded	No	No	No	No	No	No
Medical OOPM	$4,500	$3,400	$2,900	$2,250	$1,250	$500
Rx OOPM	$1,200	$1,000	$1,000	$500	$400	$200
Integrated OOPM	No	No	No	No	No	No
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb
Drug Deductible waived for:	Generic scripts	Generic scripts	Generic scripts	Generic scripts	Generic scripts	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	40%	40%	40%	40%	40%	10%
Outpatient [2]	40%	40%	40%	40%	40%	10%
ER [3]	$250	$250	$250	$250	$250	$75
Radiology (MRI, CT, PET)	40%	40%	40%	40%	40%	10%
Preventive	$0	$0	$0	$0	$0	$0
PCP Office Visit	$25	$20	$20	$15	$10	$5
MH/SA Office Visit	$25	$20	$20	$15	$10	$5
Specialist Office Visit [4]	$50	$40	$40	$30	$30	$15
Urgent Care	$60	$60	$60	$60	$50	$35
Ambulance	$100	$100	$100	$100	$100	$50
Rx Generic	$12	$12	$12	$12	$10	$5
Rx Preferred Brand	$60	$60	$60	$50	$50	$20
Rx Non-Preferred Brand	50%	50%	50%	50%	50%	30%
Actuarial Value						
2016 Final Federal AVC, Adjusted if Necessary	73.7%	77.0%	78.7%	82.8%	87.4%	94.3%

* Federal HDHP MOOP limits are not yet released for 2016. The 2015 single limit is $6,450 and on average increases around $100 a year.
** Income levels for Cost Sharing Reduction (CSR) plans are based on the income assignment in 2015

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

Standard Plan Designs – HDHP Plans

	HDHPs Option 1: Embedded MOOP		HDHPs Option 2: Stacked MOOP	
Deductible/OOP Max	**Silver 2016 Proposed Design Option 1**	**Bronze 2016 Proposed Design Option 1**	**Silver 2016 Proposed Design Option 2**	**Bronze 2016 Proposed Design Option 2**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$1,425	$4,100	$1,550	$4,400
Rx Ded	$1,300	$1,300	$1,300	$1,300
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$5,750	$6,500	$5,750	$6,500
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 $6,850 Single MOOP; 2x Individual	Aggregate with Combined Medical/Rx embedded $6,850 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				
2016 Final Federal AVC, Adjusted if Necessary	70.1%	61.0%	70.1%	61.0%

* Federal HDHP MOOP limits are not yet re

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

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

	HDHPs Option 1: Embedded MOOP					
Deductible/OOP Max	**250-300% FPL (73% AV CSR) 2016 Proposed Plan Design Option 1**	**200-250% FPL (77% AV CSR) 2016 Proposed Plan Design Option 1**	**79% AV CSR (New in 2016) Option 1**	**83% AV CSR (New in 2016) Option 1**	**150-200% FPL (87% AV CSR) 2016 Proposed Plan Design Option 1**	**133-150% FPL (94% AV CSR) 2016 Proposed Plan Design Option 1**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,425	$1,300	$1,300	$1,300	$1,150	$500
Rx Ded	$1,300	N/A	N/A	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$3,800	$2,700	$2,400	$1,650	$1,150	$500
Rx OOPM	$1,300	$1,300	$1,300	$1,300	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate with Combined Medical/Rx embedded $6,850 Single MOOP; 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	25%	25%	20%	10%	0%	0%
Outpatient [2]	25%	25%	20%	10%	0%	0%
ER [3]	25%	25%	20%	10%	0%	0%
Radiology (MRI, CT, PET)	25%	25%	20%	10%	0%	0%
Preventive	0%	0%	0%	0%	0%	0%
PCP Office Visit	10%	10%	5%	0%	0%	0%
MH/SA Office Visit	10%	10%	5%	0%	0%	0%
Specialist Office Visit [4]	25%	25%	20%	10%	0%	0%
Urgent Care	25%	25%	20%	10%	0%	0%
Ambulance	25%	25%	20%	10%	0%	0%
Rx Generic	$10	$10	$5	$5	$0	$0
Rx Preferred Brand	$40	$40	$15	$10	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	10%	0%	0%
Actuarial Value						
2016 Final Federal AVC, Adjusted if Necessary	72.9%	76.8%	78.8%	82.7%	87.0%	94.0%

* Federal HDHP MOOP limits are not yet re
** Income levels for Cost Sharing Reduction (CSR) plans are based on the income assignment in 2015

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

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

	HDHPs Option 2: Stacked MOOP					
Deductible/OOP Max	**250-300% FPL (73% AV CSR) 2016 Proposed Plan Design Option 2**	**200-250% FPL (77% AV CSR) 2016 Proposed Plan Design Option 2**	**79% AV CSR (New in 2016) Option 2**	**83% AV CSR (New in 2016) Option 2**	**150-200% FPL (87% AV CSR) 2016 Proposed Plan Design Option 2**	**133-150% FPL (94% AV CSR) 2016 Proposed Plan Design Option 2**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,550	$1,400	$1,300	$1,300	$1,200	$500
Rx Ded	$1,300	$1,300	N/A	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$3,100	$2,900	$2,000	$1,200	$500
Rx OOPM	$1,300	$1,300	$1,300	$1,300	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	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	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	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	25%	25%	20%	10%	0%	0%
Outpatient [2]	25%	25%	20%	10%	0%	0%
ER [3]	25%	25%	20%	10%	0%	0%
Radiology (MRI, CT, PET)	25%	25%	20%	10%	0%	0%
Preventive	0%	0%	0%	0%	0%	0%
PCP Office Visit	10%	10%	5%	0%	0%	0%
MH/SA Office Visit	10%	10%	5%	0%	0%	0%
Specialist Office Visit [4]	25%	25%	20%	10%	0%	0%
Urgent Care	25%	25%	20%	10%	0%	0%
Ambulance	25%	25%	20%	10%	0%	0%
Rx Generic	$10	$10	$5	$5	$0	$0
Rx Preferred Brand	$40	$40	$15	$10	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	10%	0%	0%
Actuarial Value						
2016 Final Federal AVC, Adjusted if Necessary	72.9%	76.7%	78.8%	82.8%	86.9%	94.1%

* Federal HDHP MOOP limits are not yet re
** Income levels for Cost Sharing Reduction (CSR) plans are based on the income assignment in 2015

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

APPENDIX F

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 G

Summary of Adjustments Considered and Final Adjusted AVs

Adjustments Considered	Aggregate Ded	Aggregate MOOP, Embedded $6,850	Stacked MOOP	Drug Regulation	Preventive Drugs	Pediatric Dental	AV from AVC	Final Adjusted AV
Silver HDHP – Embedded $6,850 Individual MOOP	Yes	Yes	No	Yes	Yes	Yes	72.5%	70.1%
Bronze HDHP– Embedded $6,850 Individual MOOP	Yes	Yes	No	Yes	Yes	Yes	61.4%	61.0%
Silver HDHP – Stacked MOOP	Yes	No	Yes	Yes	Yes	Yes	71.9%	70.1%
Bronze HDHP– Stacked MOOP	Yes	No	Yes	Yes	Yes	Yes	61.2%	61.0%
Bronze Deductible	No	No	No	Yes	No	Yes	60.4%	61.4%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 73%	Yes	Yes	No	Yes	Yes	Yes	75.4%	72.9%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 77%	Yes	Yes	No	Yes	Yes	Yes	79.0%	76.8%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 79%	Yes	Yes	No	No	Yes	Yes	80.8%	78.8%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 83%	Yes	Yes	No	No	Yes	Yes	84.1%	82.7%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 87%	Yes	Yes	No	No	Yes	Yes	87.5%	87.0%
Silver HDHP - Embedded $6,850 Individual MOOP CSR 94%	Yes	Yes	No	No	Yes	Yes	94.0%	94.0%
Silver HDHP - Stacked MOOP CSR 73%	Yes	No	Yes	Yes	Yes	Yes	74.0%	72.9%
Silver HDHP - Stacked MOOP CSR 77%	Yes	No	Yes	Yes	Yes	Yes	77.4%	76.7%
Silver HDHP - Stacked MOOP CSR 79%	Yes	No	Yes	No	Yes	Yes	79.5%	78.8%
Silver HDHP - Stacked MOOP CSR 83%	Yes	No	Yes	No	Yes	Yes	83.1%	82.8%
Silver HDHP - Stacked MOOP CSR 87%	Yes	No	Yes	No	Yes	Yes	87.0%	86.9%
Silver HDHP - Stacked MOOP CSR 94%	Yes	No	Yes	No	Yes	Yes	94.0%	94.1%

APPENDIX H

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. Bronze Deductible Plan
6. Silver HDHP – Embedded MOOP CSR – 73%
7. Silver HDHP – Embedded MOOP CSR – 77%
8. Silver HDHP – Embedded MOOP CSR – 79%
9. Silver HDHP – Embedded MOOP CSR – 83%
10. Silver HDHP – Embedded MOOP CSR – 87%
11. Silver HDHP – Embedded MOOP CSR – 94%
12. Silver HDHP – Stacked MOOP CSR – 73%
13. Silver HDHP – Stacked MOOP CSR – 77%
14. Silver HDHP – Stacked MOOP CSR – 79%
15. Silver HDHP – Stacked MOOP CSR – 83%
16. Silver HDHP – Stacked MOOP CSR – 87%
17. Silver HDHP – Stacked MOOP CSR – 94%

1. **Silver HDHP – Embedded MOOP**

AV from AVC = 72.5%
Adjusted AV = 70.1%

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 ($)			$1,425.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	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:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	72.51%
Metal Tier:	

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	1,425	1,425
Family Deductible	2,850	2,850
Individual Out-of-Pocket	5,750	5,750
Family Out-of-Pocket	11,500	11,500
Coinsurance (50% or Less)	23%	30%

	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	$238.33	$37.14	$275.48
Plan PMPM	$177.90	$21.85	$199.75
Actuarial Value	74.6%	58.8%	72.5%

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	1,425	1,300
Family Deductible	2,850	2,600
Individual Out-of-Pocket	5,750	1,300
Family Out-of-Pocket	11,500	2,600
Coinsurance (50% or Less)	23%	30%

	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	$238.33	$37.14	$275.48
Plan PMPM	$169.90	$23.26	$193.16
Actuarial Value	71.3%	62.6%	70.1%

2. Bronze HDHP – Embedded MOOP

AV from AVC = 61.4%
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		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 ($)			$4,100.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

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	☑	☐		$12.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	40%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.43%
Metal Tier:	Bronze

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	4,100	4,100
Family Deductible	8,200	8,200
Individual Out-of-Pocket	6,500	6,500
Family Out-of-Pocket	13,000	13,000
Coinsurance (50% or Less)	48%	44%

	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	$289.21	$45.07	$334.29
Plan PMPM	$184.19	$21.12	$205.31
Actuarial Value	63.7%	46.9%	61.4%

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	4,100	1,300
Family Deductible	8,200	2,600
Individual Out-of-Pocket	6,500	1,300
Family Out-of-Pocket	13,000	2,600
Coinsurance (50% or Less)	48%	44%

	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	$289.21	$45.07	$334.29
Plan PMPM	$177.40	$26.43	$203.83
Actuarial Value	61.3%	58.6%	60.98%

3. Silver HDHP – Stacked MOOP

AV from AVC = 71.9%
Adjusted AV = 70.1%

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 ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	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:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.86%
Metal Tier:	Silver

4. 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	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	5,750	5,750
Family Out-of-Pocket	11,500	11,500
Coinsurance (50% or Less)	23%	30%

	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	$243.69	$37.98	$281.67
Plan PMPM	$180.52	$22.06	$202.59
Actuarial Value	74.1%	58.1%	71.9%

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	1,550	1,300
Family Deductible	3,100	2,600
Individual Out-of-Pocket	5,750	1,300
Family Out-of-Pocket	11,500	2,600
Coinsurance (50% or Less)	23%	30%

	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	$243.69	$37.98	$281.67
Plan PMPM	$173.80	$23.74	$197.55
Actuarial Value	71.3%	62.5%	70.1%

4. Bronze HDHP – Stacked MOOP

AV from AVC = 61.2%
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		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 ($)			$4,400.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,500.00			
OOP Maximum if Separate ($)						

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	☑	☐		$12.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☑	60%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	40%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.17%
Metal Tier:	Bronze

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	4,400	4,400
Family Deductible	8,800	8,800
Individual Out-of-Pocket	6,500	6,500
Family Out-of-Pocket	13,000	13,000
Coinsurance (50% or Less)	48%	44%

	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	$185.29	$21.23	$206.52
Actuarial Value	63.5%	46.7%	61.2%

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	4,400	1,300
Family Deductible	8,800	2,600
Individual Out-of-Pocket	6,500	1,300
Family Out-of-Pocket	13,000	2,600
Coinsurance (50% or Less)	48%	44%

	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	$179.18	$26.55	$205.74
Actuarial Value	61.4%	58.4%	60.98%

5. **Bronze Deductible**

AV from AVC = 60.4%
Adjustments

- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 63.1%/62.1% = 1.016 x .604 = 61.4%

Adjusted AV = 61.4%

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: 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 ($)	$4,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
OOP Maximum ($)	$6,850.00					
OOP Maximum if Separate ($)						

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	☑	☐		$85.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☐		$85.00	☑	☑			☑	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$85.00	☑	☑			☑	☐
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	☑	☐		$80.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.38%
Metal Tier:	Bronze

5. 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	4,000	500
Family Deductible	8,000	1,000
Individual Out-of-Pocket	6,850	6,850
Family Out-of-Pocket	13,700	13,700
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	$290.55	$45.28	$335.83
Plan PMPM	$182.43	$26.27	$208.70
Actuarial Value	62.8%	58.0%	62.1%

5. **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	4,000	500
Family Deductible	8,000	1,000
Individual Out-of-Pocket	6,850	1,250
Family Out-of-Pocket	13,700	2,500
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	$290.55	$45.28	$335.83
Plan PMPM	$180.70	$31.26	$211.96
Actuarial Value	62.2%	69.0%	63.1%

6. Silver HDHP – Embedded MOOP CSR – 73%

AV from AVC = 75.4%
Adjusted AV = 72.9%

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	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 ($)			$1,425.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$3,800.00			
OOP Maximum if Separate ($)						

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)	☑	☑	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:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	75.44%
Metal Tier:	

6. 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	1,425	1,425
Family Deductible	2,850	2,850
Individual Out-of-Pocket	3,800	3,800
Family Out-of-Pocket	7,600	7,600
Coinsurance (50% or Less)	23%	30%

	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	$262.43	$40.90	$303.33
Plan PMPM	$203.31	$25.43	$228.74
Actuarial Value	77.5%	62.2%	75.4%

6. 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	1,425	1,300
Family Deductible	2,850	2,600
Individual Out-of-Pocket	3,800	1,300
Family Out-of-Pocket	7,600	2,600
Coinsurance (50% or Less)	23%	30%

	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	$262.43	$40.90	$303.33
Plan PMPM	$194.77	$26.30	$221.07
Actuarial Value	74.2%	64.3%	72.9%

7. Silver HDHP – Embedded MOOP CSR – 77%

AV from AVC = 79.0%
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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$2,700.00			
OOP Maximum if Separate ($)						

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:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	78.98%
Metal Tier:	

7. 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	2,700	2,700
Family Out-of-Pocket	5,400	5,400
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	$281.18	$43.82	$325.00
Plan PMPM	$227.68	$29.22	$256.89
Actuarial Value	81.0%	66.7%	79.0%

7. 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	2,700	1,300
Family Out-of-Pocket	5,400	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	$281.18	$43.82	$325.00
Plan PMPM	$220.51	$28.98	$249.50
Actuarial Value	78.4%	66.1%	76.8%

8. Silver HDHP – Embedded MOOP CSR – 79%

AV from AVC = 80.8%
Adjusted AV = 78.8%

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,400.00			
OOP Maximum if Separate ($)						

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)	☑	☑	95%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	95%		☑	☑			☐	☐
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	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$15.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 80.84%
Metal Tier:

8. **Silver HDHP – Embedded MOOP CSR – 79%, Continued**

HDHP Model – Normalization:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,400	2,400
Family Out-of-Pocket	4,800	4,800
Coinsurance (50% or Less)	18%	19%

	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	$289.21	$45.07	$334.29
Plan PMPM	$238.23	$31.83	$270.07
Actuarial Value	82.4%	70.6%	80.8%

8. **Silver HDHP – Embedded MOOP CSR – 79%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,400	1,300
Family Out-of-Pocket	4,800	2,600
Coinsurance (50% or Less)	18%	19%

	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	$289.21	$45.07	$334.29
Plan PMPM	$232.30	$31.16	$263.46
Actuarial Value	80.3%	69.1%	78.8%

9. Silver HDHP – Embedded MOOP CSR – 83%

AV from AVC = 84.1%
Adjusted AV = 82.7%

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$1,650.00			
OOP Maximum if Separate ($)						

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)	☑	☑	100%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☑	☑			☐	☐
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	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$10.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	84.15%
Metal Tier:	

9. Silver HDHP – Embedded MOOP CSR – 83%, 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	1,650	1,650
Family Out-of-Pocket	3,300	3,300
Coinsurance (50% or Less)	9%	8%

	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	$297.25	$46.33	$343.57
Plan PMPM	$254.00	$34.91	$288.91
Actuarial Value	85.4%	75.4%	84.1%

9. Silver HDHP – Embedded MOOP CSR – 83%, 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	1,650	1,300
Family Out-of-Pocket	3,300	2,600
Coinsurance (50% or Less)	9%	8%

	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	$297.25	$46.33	$343.57
Plan PMPM	$250.48	$33.61	$284.09
Actuarial Value	84.3%	72.6%	82.7%

10. Silver HDHP – Embedded MOOP CSR – 87%

AV from AVC = 87.5%
Adjusted AV = 87.0%

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	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	Medical	Drug	Combined
Deductible ($)			$1,150.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$1,150.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

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):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.46%
Metal Tier:	Gold

10. **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	1,150	1,150
Family Deductible	2,300	2,300
Individual Out-of-Pocket	1,150	1,150
Family Out-of-Pocket	2,300	2,300
Coinsurance (50% or Less)	0%	0%

	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	$310.64	$48.41	$359.05
Plan PMPM	$275.42	$38.69	$314.11
Actuarial Value	88.7%	79.9%	87.5%

10. **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	1,150	1,150
Family Deductible	2,300	2,300
Individual Out-of-Pocket	1,150	1,150
Family Out-of-Pocket	2,300	2,300
Coinsurance (50% or Less)	0%	0%

	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	$310.64	$48.41	$359.05
Plan PMPM	$273.89	$38.47	$312.36
Actuarial Value	88.2%	79.5%	87.0%

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

AV from AVC = 94.0%
Adjusted AV = 94.0%

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: 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 ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

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):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 93.96%
Metal Tier: Platinum

11. 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	500	500
Family Deductible	1,000	1,000
Individual Out-of-Pocket	500	500
Family Out-of-Pocket	1,000	1,000
Coinsurance (50% or Less)	0%	0%

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

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$328.04	$51.12	$379.17
Plan PMPM	$310.69	$45.85	$356.55
Actuarial Value	94.7%	89.7%	94.0%

11. **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	500	500
Family Deductible	1,000	1,000
Individual Out-of-Pocket	500	500
Family Out-of-Pocket	1,000	1,000
Coinsurance (50% or Less)	0%	0%

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

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$328.04	$51.12	$379.17
Plan PMPM	$310.73	$45.80	$356.53
Actuarial Value	94.7%	89.6%	94.0%

12. Silver HDHP – Stacked MOOP CSR – 73%

AV from AVC = 74.0%
Adjusted AV = 72.9%

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	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 ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

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)	☑	☑	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:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	74.04%
Metal Tier:	

12. **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	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	4,250	4,250
Family Out-of-Pocket	8,500	8,500
Coinsurance (50% or Less)	23%	30%

	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	$261.10	$40.69	$301.79
Plan PMPM	$198.78	$24.62	$223.40
Actuarial Value	76.1%	60.5%	74.0%

12. **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	1,550	1,300
Family Deductible	3,100	2,600
Individual Out-of-Pocket	4,250	1,300
Family Out-of-Pocket	8,500	2,600
Coinsurance (50% or Less)	23%	30%

	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	$261.10	$40.69	$301.79
Plan PMPM	$194.01	$25.94	$219.95
Actuarial Value	74.3%	63.7%	72.9%

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

AV from AVC = 77.4%
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 ($)			$1,400.00			
Coinsurance (%, Insurer's Cost Share)			75.00%			
OOP Maximum ($)			$3,100.00			
OOP Maximum if Separate ($)						

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:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	77.42%
Metal Tier:	

13. 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	3,100	3,100
Family Out-of-Pocket	6,200	6,200
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	$277.16	$43.20	$320.36
Plan PMPM	$220.15	$27.95	$248.10
Actuarial Value	79.4%	64.7%	77.4%

13. **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	3,100	1,300
Family Out-of-Pocket	6,200	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	$277.16	$43.20	$320.36
Plan PMPM	$217.36	$28.31	$245.67
Actuarial Value	78.4%	65.5%	76.7%

14. Silver HDHP – Stacked MOOP CSR – 79%

AV from AVC = 79.5%
Adjusted AV = 78.8%

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,900.00			
OOP Maximum if Separate ($)						

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	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	95%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	95%		☑	☑			☐	☐
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	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$15.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 79.54%
Metal Tier:

14. **Silver HDHP – Stacked MOOP CSR – 79%, Continued**

HDHP Model – Normalization:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,900	2,900
Family Out-of-Pocket	5,800	5,800
Coinsurance (50% or Less)	18%	19%

	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	$282.52	$44.03	$326.55
Plan PMPM	$229.20	$30.48	$259.68
Actuarial Value	81.1%	69.2%	79.5%

14. **Silver HDHP – Stacked MOOP CSR – 79%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,900	1,300
Family Out-of-Pocket	5,800	2,600
Coinsurance (50% or Less)	18%	19%

	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	$282.52	$44.03	$326.55
Plan PMPM	$226.97	$30.32	$257.29
Actuarial Value	80.3%	68.9%	78.8%

15. **Silver HDHP – Stacked MOOP CSR – 83%**

AV from AVC = 83.1%
Adjusted AV = 82.8%

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 ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$2,000.00			
OOP Maximum if Separate ($)						

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)	☑	☑	100%		☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☑	☑			☐	☐
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	☑	☐		$5.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$10.00	☑	☑			☑	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

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

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	83.06%
Metal Tier:	

15. Silver HDHP – Stacked MOOP CSR – 83%, Continued

HDHP Model – Normalization:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,000	2,000
Family Out-of-Pocket	4,000	4,000
Coinsurance (50% or Less)	9%	8%

	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	$248.82	$34.11	$282.93
Actuarial Value	84.5%	74.3%	83.1%

15. **Silver HDHP – Stacked MOOP CSR – 83%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

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

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,000	1,300
Family Out-of-Pocket	4,000	2,600
Coinsurance (50% or Less)	9%	8%

	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	$248.89	$32.93	$281.81
Actuarial Value	84.5%	71.7%	82.8%

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

AV from AVC = 87.0%
Adjusted AV = 86.9%

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: Gold

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

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if 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):	

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 87.01%
Metal Tier: Gold

16. 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	1,200	1,200
Family Deductible	2,400	2,400
Individual Out-of-Pocket	1,200	1,200
Family Out-of-Pocket	2,400	2,400
Coinsurance (50% or Less)	0%	0%

	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	$309.30	$48.20	$357.50
Plan PMPM	$272.89	$38.20	$311.09
Actuarial Value	88.2%	79.2%	87.0%

16. **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	1,200	1,200
Family Deductible	2,400	2,400
Individual Out-of-Pocket	1,200	1,200
Family Out-of-Pocket	2,400	2,400
Coinsurance (50% or Less)	0%	0%

	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	$309.30	$48.20	$357.50
Plan PMPM	$274.18	$36.48	$310.66
Actuarial Value	88.6%	75.7%	86.9%

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

AV from AVC = 94.0%
Adjusted AV = 94.1%

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 ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$500.00			
OOP Maximum if Separate ($)						

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):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.96%
Metal Tier:	Platinum

17. 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	500	500
Family Deductible	1,000	1,000
Individual Out-of-Pocket	500	500
Family Out-of-Pocket	1,000	1,000
Coinsurance (50% or Less)	0%	0%

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

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$328.04	$51.12	$379.17
Plan PMPM	$310.69	$45.85	$356.55
Actuarial Value	94.7%	89.7%	94.0%

17. **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	500	500
Family Deductible	1,000	1,000
Individual Out-of-Pocket	500	500
Family Out-of-Pocket	1,000	1,000
Coinsurance (50% or Less)	0%	0%

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

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$328.04	$51.12	$379.17
Plan PMPM	$311.94	$45.00	$356.95
Actuarial Value	95.1%	88.0%	94.1%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Introduction

On January 16, 2015, CMS released the final methodology on the Actuarial Value and the final Actuarial Value Calculator (AVC) for 2016. CMS made several changes in the 2016 AVC. Most notably, they trended the underlying claims to calendar year 2016 and added functionality to address copayments applied after the deductible is met.

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 then compared the results of the BAVM with the results of the AVC for various benefit plans for which results could be obtained from both. This was done separately for blocks of plans within each of the AVC's metallic range categories. We observed that the results of the two were highly correlated. This allowed us to normalize the results of the BAVM to those of the AVC.

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

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 Exchange in 2016 are included in the analysis. Claims have been adjusted to reflect the network used for BCBSVT QHPs. Calendar year 2013 claims, trended to 2016 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 member/ service 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.

A total of 794,822 member months were used for this analysis. Because of the normalization adjustment described below, it is appropriate to use this large, credible data set as a proxy for the HHS data underlying the AV model. Non-permitted factors such as projected demographic changes were not considered in the analysis.

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

For each Metal tier and CSR tier, we observed a correlation between the outputs of the AVC and BAVM for various integrated deductible plans with similar designs after the deductible as the plan tested. From these we calculated the appropriate linear regression function to normalize the results of the BAVM to approximate those of the AVC.

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

The adjustment is calculated as:

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

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

[1] BCBSVT used the same trend that CMS used in the 2016 Final AV Calculator (see page 8 of http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-Methodology.pdf)
[2] m*BAVM(x)-b is the normalized value of the BAVM result for plan x {normalized to approximate the AVC(x)}.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Methodology change per Regulatory review

In its SERFF objecion dated April 29, 2015, the Vermont Department of Financial Regulation reviweing actuary requested that we modify our calculation to simply apply the direct relationship between the AVC and BCBSVT's Model for all plans exept the Blue Rewards CDHP Gold plan.

Actuarial Opinion

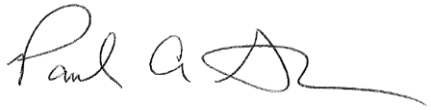
The purpose of this calculation is to comply with the requirements of 45 CFR 156.135(b)(3). The Actuarial Values were determined based on the plans' benefits and coverage data, the standard population, utilization and continuance tables published by HHS for purposes of valuation of Actuarial Value. These 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 2016.

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

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



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

Blue Rewards CDHP Plans

Gold Designs

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$2,000	0%	$2,000	82.36%	80.63%
$1,500	0%	$1,500	85.54%	84.47%
$1,750	0%	$1,750	83.89%	82.50%
$2,250	0%	$2,250	80.95%	78.88%
$2,500	0%	$2,500	79.62%	77.22%
$1,300	0%	$1,300	86.96%	86.14%
$1,400	0%	$1,400	86.24%	85.30%
$1,800	0%	$1,800	83.58%	82.11%
$2,100	0%	$2,100	81.79%	79.91%
$2,300	0%	$2,300	80.67%	78.53%
$2,400	0%	$2,400	80.14%	77.87%

Linear Regression Output		
m	b	r^2
1.21684	-0.19625	99.99%

Plan : Blue Rewards (Non-Standard) CDHP Plan - Bronze			
Items supported by the AV Calculator	Deductible	$2,500	
	Coinsurance	0%	
	OOPM	$2,500	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	77.22%
BCBSVT Model Output for items supported by the AVC		(b)	79.62%
BCBSVT Model Output for complete benefit design		(c)	80.28%
Adjustment to the AVC	Difference	(d)=(c)-(b)	0.66%
	m	(e)	1.21684
	adjustment	(f)=(d)*(e)	0.80%
	Estimated AVC value	(g)=(a)+(f)	**78.0%**

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.

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

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W33

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
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):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

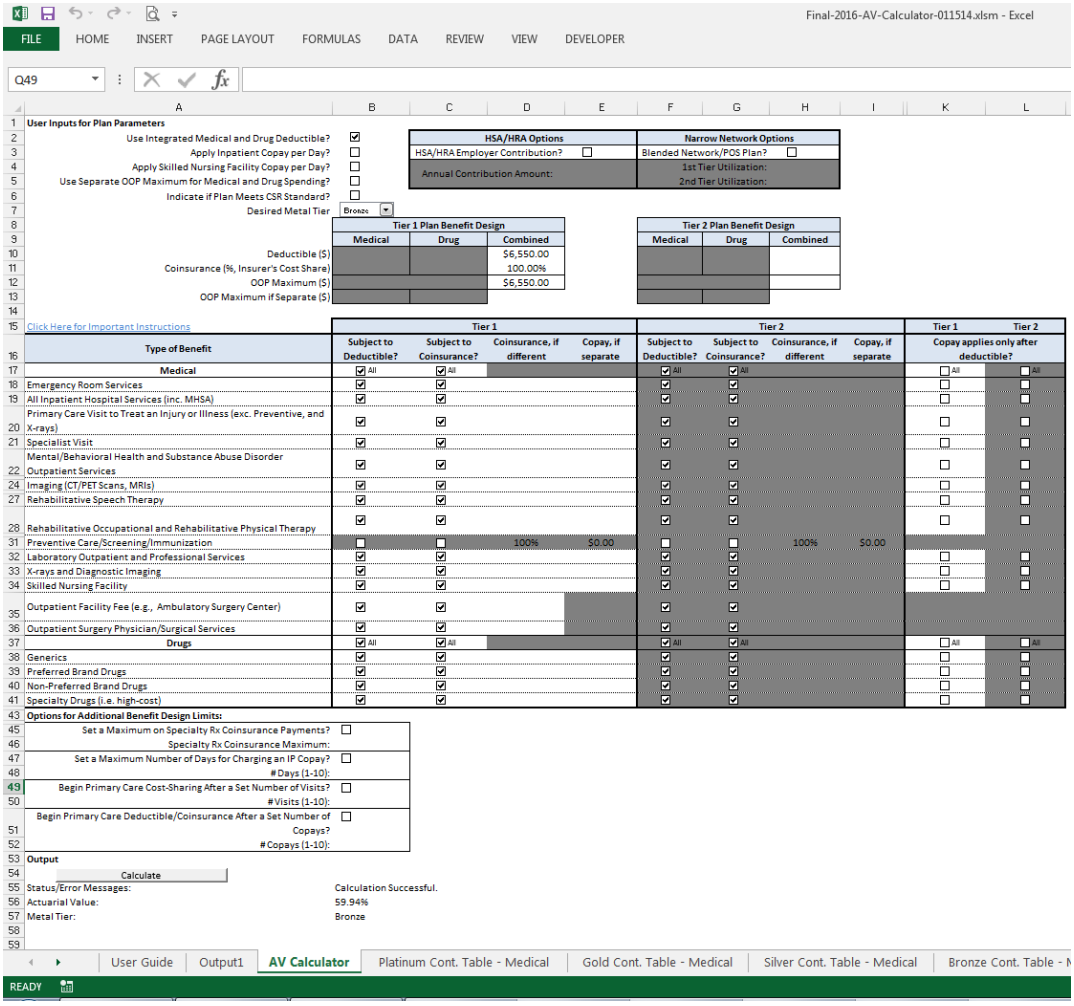
Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	77.22%
Metal Tier:	

User Guide | Output1 | Output2 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Medical | Silver Cont. Table - Medical | Bronze Co

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan : Blue Rewards (Non-Standard) CDHP Plan - Bronze			
Items supported by the AV Calculator	Deductible	$6,550	
	Coinsurance	0%	
	OOPM	$6,550	
	Rx Cost Sharing After Deductible	N/A	
AVC Output for items supported by the AVC		(a)	59.94%
BCBSVT Model Output for items supported by the AVC		(b)	64.86%
BCBSVT Model Output for complete benefit design		(c)	67.08%
Adjustment to the AVC	Estimated AVC value	(d)=(c)/(b)*(a)	**62.0%**

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.



Blue Rewards Copayment Plans

One of the new features of the 2016 AVC accommodates for plans with copayments after the deductible. Items not supported by the AV Calculator for these plans are

- Pharmacy MOOP of $1,250
- 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
2016 VERMONT EXCHANGE PRODUCTS
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	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	78.36%
BCBSVT Model Output for items supported by the AVC		(b)	81.52%
BCBSVT Model Output for complete benefit design		(c)	83.43%
Estimated AVC value		(d)=(c)/(b)*(a)	**80.2%**

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P58

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
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 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)	☑	☐		$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	☑	☐		$30.00	☑	☑			☑	☐
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):

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.36%
Metal Tier: Gold

User Guide | Output1 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Medical | Silver Cont. Table - Medical | Bronze ...

READY

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver

Items supported by the AV Calculator	Deductible	$2,000	
	Coinsurance	0%	
	OOPM	$6,850	
	Copayments after the deductible	See print below	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	69.89%
BCBSVT Model Output for items supported by the AVC		(b)	74.11%
BCBSVT Model Output for complete benefit design		(c)	76.12%
Estimated AVC value		(d)=(c)/(b)*(a)	**71.8%**

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P58

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:	

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$2,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,850.00
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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)	☑	☐		$1,750.00	☑	☑			☑	☐
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)	☑	☐		$1,750.00	☑	☑			☑	☐
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	☑	☐		$50.00	☑	☑			☑	☐
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):

Output

Calculate

Status/Error Messages: Calculation Successful.
Actuarial Value: 69.89%
Metal Tier: Silver

User Guide | Output1 | Output2 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Medical | Silver Cont. Table - Medical ...

Select destination and press ENTER or choose Paste

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 73%

Items supported by the AV Calculator	Deductible	$1,800	
	Coinsurance	0%	
	OOPM	$5,450	
	Copayments after the deductible	See print below	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	72.24%
BCBSVT Model Output for items supported by the AVC		(b)	75.79%
BCBSVT Model Output for complete benefit design		(c)	77.58%
Estimated AVC value		(d)=(c)/(b)*(a)	**73.9%**

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P58

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:	

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$1,800.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$5,450.00
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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)	☑	☐		$1,750.00	☑	☑			☑	☐
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)	☑	☐		$1,750.00	☑	☑			☑	☐
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	☑	☐		$50.00	☑	☑			☑	☐
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):

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 72.24%
Metal Tier: Silver

User Guide | Output1 | Output2 | Output3 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Medical | Silver Cont. Tat ...

READY

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 77%

Items supported by the AV Calculator	Deductible	$1,000	
	Coinsurance	0%	
	OOPM	$5,200	
	Copayments after the deductible	See print below	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	76.34%
BCBSVT Model Output for items supported by the AVC		(b)	79.95%
BCBSVT Model Output for complete benefit design		(c)	80.93%
Estimated AVC value		(d)=(c)/(b)*(a)	**77.3%**

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User Inputs for Plan Parameters

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

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

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

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$1,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$5,200.00
OOP Maximum if Separate ($)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined

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)	☑	☐		$1,750.00	☑	☑			☑	☐
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)	☑	☐		$1,750.00	☑	☑			☑	☐
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	☑	☐		$50.00	☑	☑			☑	☐
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):

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 76.34%
Metal Tier:

User Guide | Output1 | Output2 | Output3 | Output4 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Medical | Sil ...

READY

BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
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	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	86.45%
BCBSVT Model Output for items supported by the AVC		(b)	89.52%
BCBSVT Model Output for complete benefit design		(c)	89.70%
Estimated AVC value		(d)=(c)/(b)*(a)	**86.6%**

Final-2016-AV-Calculator-011514.xlsm [Read-Only] - Excel

FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW DEVELOPER

P58

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☐
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 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)	☑	☐		$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	☑	☐		$50.00	☑	☑			☑	☐
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):

Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value: 86.45%
Metal Tier: Gold

User Guide | Output1 | Output2 | Output3 | Output4 | Output5 | AV Calculator | Platinum Cont. Table - Medical | Gold Cont. Table - Me ...

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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[3] and the addition of copays on Urgent Care, Emergency Medical Transportation, DME services and Home Health Care is also immaterial; therefore we are using the AVC directly for this plan.

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FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW DEVELOPER

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	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 ($)			$0.00							
11	Coinsurance (%, Insurer's Cost Share)			100.00%							
12	OOP Maximum ($)			$850.00							
13	OOP Maximum if Separate ($)										
14											
15	Click Here for Important Instructions										

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

	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?
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	☑	☐		$35.00	☑	☑			☑	☐
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%		☑	☑			☐	☐

	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):	

	Output	
54	Calculate	
55	Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
56	Actuarial Value:	94.88%
57	Metal Tier:	Platinum

User Guide | Output1 | Output2 | Output3 | Output4 | Output5 | Output6 | AV Calculator | Platinum Cont. Table - Medical | Gold Cor ...

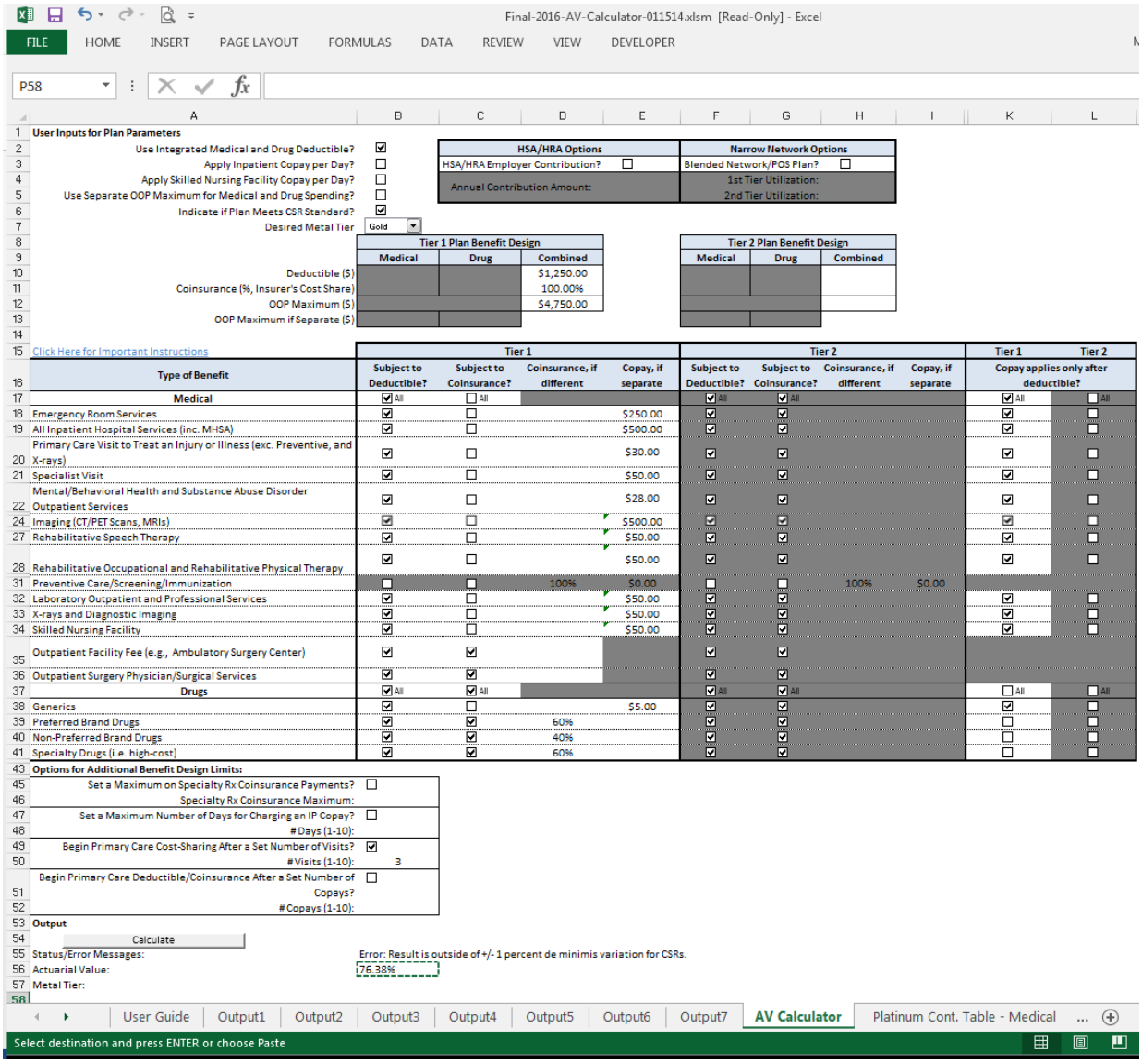
Select destination and press ENTER or choose Paste

[3] The AV calculator produces an AV of 94.91% 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
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 79%

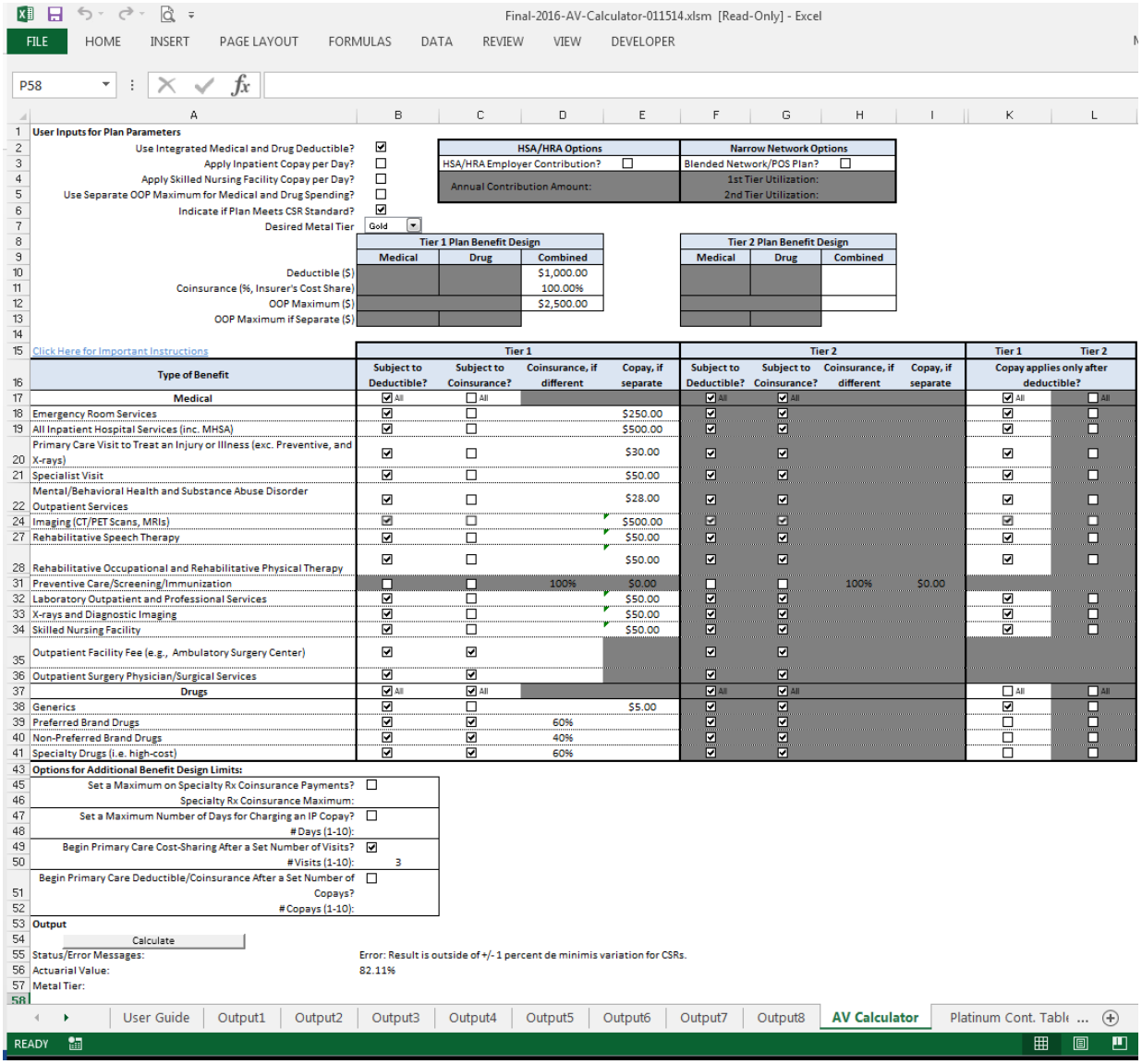
Items supported by the AV Calculator	Deductible	$1,250	
	Coinsurance	0%	
	OOPM	$4,750	
	Copayments after the deductible	See print below	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	76.38%
BCBSVT Model Output for items supported by the AVC		(b)	80.51%
BCBSVT Model Output for complete benefit design		(c)	82.48%
Estimated AVC value		(d)=(c)/(b)*(a)	**78.3%**



BLUE CROSS AND BLUE SHIELD OF VERMONT
2016 VERMONT EXCHANGE PRODUCTS
METAL ACTUARIAL VALUES CERTIFICATION

Plan: Blue Rewards (Non-Standard) Copayment Plan – Silver CSR 83%

Items supported by the AV Calculator	Deductible	$1,000	
	Coinsurance	0%	
	OOPM	$2,500	
	Copayments after the deductible	See print below	
	Three PCP visits at no cost share before the deductible		
AVC Output for items supported by the AVC		(a)	82.11%
BCBSVT Model Output for items supported by the AVC		(b)	83.84%
BCBSVT Model Output for complete benefit design		(c)	85.02%
Estimated AVC value		(d)=(c)/(b)*(a)	**83.3%**



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July 15, 2014

Ms. Ruth Greene
Vice President, Treasurer & CFO
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

Re: Projected CY 2015 Net Claims Costs for Pediatric Dental

Dear Ruth:

As you requested, we have developed projected CY 2015 net claims costs for pediatric dental services. The estimates assume the pediatric dental coverage is integrated with the medical coverage, as opposed to being offered as a standalone plan. We assumed the integrated deductible applies to all dental services except Class 1 services, except for the CDHP plans and the Catastrophic plan where it also applies to Class 1 services. This is a significant change from the 2014 benefits where the integrated deductible applies to Class 1 services for all plans. We modeled results for each of the six standard medical plans specified by the State, as well as the four non-standard plans designed by Blue Cross and Blue Shield of Vermont (BCBSVT). The projection is appropriate for CY 2015; adjustments should be made for rates that apply to subsequent periods.

The projected CY 2015 net claims cost per child per month amounts are shown below for each plan:

Medical Plan	**Projected Dental Cost**	
	Allowed	**Net**
Standard Platinum	$45.04	$38.77
Standard Gold	$44.15	$33.62
Standard Silver	$43.04	$28.78
Standard Bronze	$41.67	$25.71
Standard Silver CDHP	$40.28	$16.56
Standard Bronze CDHP	$39.60	$13.70
Non-Standard Gold	$43.49	$31.83
Non-Standard Silver	$42.68	$28.54
Non-Standard Bronze CDHP	$35.68	$6.28
Non-Standard Catastrophic	$33.71	$4.94

It should be noted there is a considerable amount of uncertainty in these projections. BCBSVT does not have credible dental claims experience, and as a result, the estimates are based on manual rates using the Milliman Dental Cost Guidelines (DCGs). Beyond the normal level of uncertainty associated with manual rates, there are a number of elements in this pricing that create significant additional uncertainty, such as the integration of medical and dental benefits, potential pent-up demand for dental services, no annual maximum benefit limit, and uncertainty in identifying medically necessary orthodontia services.

It is our understanding that these estimates will be added without any adjustment to BCBSVT's estimates of medical costs to develop premium rates, and that normalization for the expected impact of various rating factors does not apply.

These estimates are intended to assist BCBSVT with its development of proposed CY 2015 rates for individual and small group business that will be sold on the Vermont Exchange for a 1/1/2015 effective date. The estimates may not be appropriate for any other use.

Development of Projected Claims for Non-Orthodontia Services

The projected claims costs for non-orthodontia are based on the Milliman Dental Cost Guidelines (DCGs). The DCG starting costs reflect national average billed charges. The methodology consists of the following steps:

- *Starting Costs* – The DCGs contain starting data by age/gender category. We used the average claims costs for ages 0-21 based on the BCBSVT age mix within the 0-21 age band.

- *Area* – We adjusted the national average starting data to statewide Vermont based on area factors contained in the DCGs.

- *Trend* – We trended the CY 2013 starting data to CY 2015 using a 5% annual trend.

- *Discounts* – We used the 2013 fee level data provided by BCBSVT to develop discount percentages, which were then applied to the projected 2015 billed charges.

- *Benefit Richness* – We made adjustments to reflect the expected impact of member cost sharing on projected utilization levels. These adjustments are based on the Milliman Dental Cost Guidelines and actuarial judgment.

- *Pent-Up Demand* – We assumed most members would not have prior dental coverage based on information provided by BCBSVT. The DCGs suggest a factor of 1.30 for new business; however that factor applies to a standard population. We reduced the DCG factor to 1.15 to reflect the expected lower impact for the mix of services expected for children. BCBSVT expects this level to moderate to 1.10 for members in their second year of coverage. Based on the expected mix of first and second year members in 2015, BCBSVT estimates an average factor of 1.11.

- *Projected Allowed Costs* – Applying the adjustments described above results in the projected allowed costs for non-orthodontia costs.

- *Projected Net Costs* – As mentioned above, the projections assume the dental benefits are integrated with medical, as specified by BCBSVT. The projections reflect the medical benefits for the six medical plans specified by the State and the four non-standard plans designed by BCBSVT. The medical benefits are shown in the attached tables. The dental coinsurance is 100/70/50% on Classes 1-3 services, respectively, except that Space Maintainers are covered at 100% and Bridges and Simple Repairs are covered at 70%. We developed the net costs in two steps.

  In the first step, we modeled the medical benefits and determined the portion of the deductible and out-of-pocket maximum that would be filled by medical claims, and the portion that would remain to be applied to dental services. We modeled the medical benefits using a child claims probability distribution from the Milliman Health Cost Guidelines (HCGs), scaled to match the projected CY 2015 child allowed PMPM of $266 provided by BCBSVT. We performed a simulation of 10,000 members and tabulated the remaining deductible and out-of-pocket maximum amounts.

  In the second step, we used the remaining deductible and out-of-pocket maximum amounts and the dental coinsurance percentages to develop dental net claims costs for the each of the modeled 10,000 members. The dental development is based on a child non-orthodontia dental claims probability distribution from the DCGs that is scaled to the projected dental allowed claims PMPM described above. The overall projected dental net claims cost is the average of the dental net claims cost for each of the 10,000 modeled members.

  By assuming the medical benefits apply to the deductible and out-of-pocket maximum prior to any dental claims, the projected net claims cost for dental services is overstated. However, our understanding is that BCBSVT is not reflecting the impact of dental costs on the deductible and out-of-pocket maximum in its development of the medical costs, and these projected dental amounts are intended to represent the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT.

Development of Projected Costs for Orthodontia Services

The orthodontia coverage includes medically necessary orthodontia only. While the State's benefit description does include the criteria that define medical necessity, it was not possible to precisely identify medically necessary orthodontia in the orthodontia data available to us.

We started with a child orthodontia claims probability distribution from the DCGs, area adjusted to statewide Vermont and trended to CY 2015. We assumed that medically necessary orthodontia would have a higher average annual claims amount than non-medically necessary orthodontia. We assumed that 30% of children with orthodontia costs greater than $3000 would have medically necessary orthodontia. This results in just under 30% of the overall orthodontia costs being allocated to medically necessary orthodontia.

We modeled orthodontia claims separately from non-orthodontia claims. We assumed the integrated deductible and out-of-pocket maximum apply to orthodontia, and we applied 50% coinsurance. In the orthodontia development we assumed children with medically necessary orthodontia claims have

twice the level of medical claims on average due to the nature of their conditions, and average levels of non-orthodontia costs.

Limitations

The following limitations apply to our analysis.

- *Data Reliance* – In performing our analysis, we relied on data and other information provided by BCBSVT. We have not audited or verified this data and other information. Such a review is beyond the scope of our assignment. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

- *Variability* – It is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in the projections, the actual amounts will also deviate from the projected amounts. We recommend that BCBSVT monitor the emerging experience and make adjustments as warranted.

- *Distribution and Use* – This letter has been prepared for the use of and is only to be relied upon by the management of BCBSVT. No portion of this letter may be provided to any other party without Milliman's prior written consent, which consent shall not be unreasonably withheld but may be conditioned upon the execution by a third party of Milliman's standard release form; provided however, BCBSVT may provide the letter to any applicable governmental or regulatory agency as required by law. In the event such consent is provided, the letter must be provided in its entirety. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

Qualifications

This report may be considered a statement of actuarial opinion under guidelines promulgated by the American Academy of Actuaries. I am a member of the American Academy of Actuaries and meet its Qualification standards to render the opinion contained herein.

Please call me if you have any questions or if there is any additional assistance that we can provide.

Sincerely,

George N. Berry, FSA.
Principal and Consulting Actuary

GNB/pg/jpj
Enclosures

Table 1
Blue Cross Blue Shield of Vermont
Summary of Standard Plan Designs, Revised

Deductible/OOP Max	Platinum	Gold	Silver	Bronze	Silver CDHP	Bronze CDHP
Medical Ded	$150	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	Combined	Combined
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	No	No	No	Yes	Yes	Yes
Family Ded / OOP	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, Dental Class 1, Vision	Preventive, Dental Class 1	Preventive	Preventive
Drug Ded waived for:	N/A	Generic scripts	Generic scripts	N/A	Wellness scripts	Wellness scripts
Service Category	Copay / Coinsurance					
Inpatient	10%	20%	40%	50%	20%	50%
Outpatient	10%	20%	40%	50%	20%	50%
ER	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$25	$35	10%	50%
MH/SA Office Visit	$10	$15	$25	$35	10%	50%
Specialist Office Visit	$20	$25	$45	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
DME	10%	20%	40%	50%	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%

Table 2
Blue Cross Blue Shield of Vermont
Non-Standard Plans

Deductible/OOP Max	Gold	Silver	Bronze CDHP	Catastrophic
Medical Ded	$1,250	$2,000	$5,000	$6,600
Rx Ded	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$6,250	$6,250	$6,600
Rx OOPM	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes
Family Ded / OOP	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, 3 PCP/MH OV, Dental Class 1	Prev, 3 PCP/MH OV, Dental Class 1	Preventive Care	Preventive Care, 3 PCP/MH OV
Drug Ded waived for:	N/A	N/A	Wellness Drugs	N/A
Service Category	Copay / Coinsurance			
Inpatient	$500	$1,750	50%	0%
Outpatient	$500	$1,750	50%	0%
ER	$250	$250	50%	0%
Radiology (MRI, CT, PET)	$500	$1,750	50%	0%
Preventive	$0	$0	0%	0%
PCP Office Visit	3 visits/member combined PCP/MH at no cost share before deductible then $20 copay	3 visits/member combined PCP/MH at no cost share before deductible then $30 copay	50%	3 visits/member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit			50%	
Specialist Office Visit	$30	$50	50%	0%
Urgent Care	$30	$50	50%	0%
Ambulance	$30	$50	50%	0%
DME	$30	$50	50%	0%
Rx Generic	$5	$5	$25	0%
Rx Preferred Brand	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	0%

2016 Rates Table Template v5.05

*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*	1/1/2016
Rate Expiration Date*	12/31/2016

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	Family Tier: 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	543.64	1087.28	1049.23	1049.23	1049.23	1527.63	1527.63	1527.63
13627VT0380002	Rating Area 1	No Preference	Family Option	476.36	952.72	919.37	919.37	919.37	1338.57	1338.57	1338.57
13627VT0390001	Rating Area 1	No Preference	Family Option	518.23	1036.46	1000.18	1000.18	1000.18	1456.23	1456.23	1456.23
13627VT0390003	Rating Area 1	No Preference	Family Option	412.08	824.16	795.31	795.31	795.31	1157.94	1157.94	1157.94
13627VT0340002	Rating Area 1	No Preference	Family Option	671.04	1342.08	1295.11	1295.11	1295.11	1885.62	1885.62	1885.62
13627VT0340003	Rating Area 1	No Preference	Family Option	586.38	1172.76	1131.71	1131.71	1131.71	1647.73	1647.73	1647.73
13627VT0340004	Rating Area 1	No Preference	Family Option	496.03	992.06	957.34	957.34	957.34	1393.84	1393.84	1393.84
13627VT0350001	Rating Area 1	No Preference	Family Option	480.18	960.36	926.75	926.75	926.75	1349.31	1349.31	1349.31
13627VT0340005	Rating Area 1	No Preference	Family Option	419.44	838.88	809.52	809.52	809.52	1178.63	1178.63	1178.63
13627VT0350002	Rating Area 1	No Preference	Family Option	417.08	834.16	804.96	804.96	804.96	1171.99	1171.99	1171.99
13627VT0340001	Rating Area 1	No Preference	Family Option	238.96	477.92	461.19	461.19	461.19	671.48	671.48	671.48
13627VT0360001	Rating Area 1	No Preference	Family Option	543.64	1087.28	1049.23	1049.23	1049.23	1527.63	1527.63	1527.63
13627VT0360002	Rating Area 1	No Preference	Family Option	476.36	952.72	919.37	919.37	919.37	1338.57	1338.57	1338.57
13627VT0370001	Rating Area 2	No Preference	Family Option	518.23	1036.46	1000.18	1000.18	1000.18	1456.23	1456.23	1456.23
13627VT0370003	Rating Area 1	No Preference	Family Option	412.08	824.16	795.31	795.31	795.31	1157.94	1157.94	1157.94
13627VT0320001	Rating Area 1	No Preference	Family Option	671.04	1342.08	1295.11	1295.11	1295.11	1885.62	1885.62	1885.62
13627VT0320002	Rating Area 1	No Preference	Family Option	586.38	1172.76	1131.71	1131.71	1131.71	1647.73	1647.73	1647.73
13627VT0320003	Rating Area 1	No Preference	Family Option	496.03	992.06	957.34	957.34	957.34	1393.84	1393.84	1393.84
13627VT0330001	Rating Area 1	No Preference	Family Option	480.18	960.36	926.75	926.75	926.75	1349.31	1349.31	1349.31
13627VT0320004	Rating Area 1	No Preference	Family Option	419.44	838.88	809.52	809.52	809.52	1178.63	1178.63	1178.63
13627VT0330002	Rating Area 1	No Preference	Family Option	417.08	834.16	804.96	804.96	804.96	1171.99	1171.99	1171.99

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	NA
Date of Submission	5/15/2015
Proposed Effective Date	1/1/2016

	Before Rate Increase	After Rate Increase
Average annual premium per policy	$8,582	$9,301

Proposed Overall Rate Change	8.38%
Proposed Minimum Rate Change	4.70%
Proposed Maximum Rate Change	14.31%

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

	Description	Relativity
Claims Experience	The experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. We also included Large	0.9761
Age / Gender	The actuarial Wakely's Health Cost Guidelines (2014) age/gender factors after the experience membership for continuing members and the projected membership and compared the average factors	1.0144
Tier	The mandated tier factors remained unchanged	1.0000
Geography	N/A	1.0000
Tobacco	N/A	1.0000
Benefit Plan Relativities	As overall costs increase and the amounts that members pay in cost-sharing contributions stays the same, more of the total cost is transferred to premiums	1.0025
Mandated Benefit Changes	The notice of benefits and Payments Parameters for 2015 clarified that the individual MOOP cannot be over $6,850, even if the member is in a family policy. There were also several minor cost sharing changes stemming from the Metal	1.0078
Non-Mandated Benefit Changes	N/A	1.0000
Other	This includes trend, Transitional Reinsurance, Federal Insurer Fee, changes in pool morbidity, changes in administrative charges and other items	1.0834
	Total Average Relativity of Proposed vs. Current Scale	1.0838

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	532	987	40
Increase of 0.01% to 5.00%	116	120	0
Increase of 5.01% to 10.00%	27,926	46,296	3,695
Increase of 10.01% to 14.99%	13,893	22,611	1,510
Increase of 15.00% or more	0	0	0
Total	42,467	70,014	5,245

History of Rate Changes

Rate Effective Month and Year:	Average Annual Proposed Rate Change	Average Annual Approved Rate Change
2013	N/A	N/A
2014	N/A	N/A
2015	9.81%	7.70%

Experience Period Used in Rate Development

General Description of Experience Used in Rate Development (may be different than experience shown in LRRT)	The experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. We also included Large Groups that are expected to join the exchange due to the change in the definition
Does experience include pools/blocks of business not affected by proposed rate change?	No (Yes or No)

	Incurred From Month/Year	Incurred To Month/Year
Time period used for Experience Data in Rate Development	1/1/2014	12/31/2014

Total Written Premium in Experience Period	$297,310,928
Total Earned Premium in Experience Period	$297,310,928
Total Incurred Claims in Experience Period	$255,820,510
Loss Ratio	86.04%
Paid Through Date For Claims	2/28/2015
IBNR as % of Incurred Claims	-0.17%
IBNR as # of Months of Paid Claims	-0.02
Number of Contracts/Policyholders	467,598
Number of Covered Lives	773,719

Service Category	Incurred Claims $ PMPM	% Incurred
Inpatient Facility	$80.14	17.2%
Outpatient Facility	$176.72	37.8%
Professional	$112.63	24.1%
Prescription Drugs	$75.02	16.1%
Capitation and Other Provider Payments	$3.81	0.8%
Other	$18.82	4.0%
Total	$467.12	

Credibility Analysis

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

Alternative Data Sources

Description of Any Alternative Experience Data Used in Rate Development	NA
Description of Any Manual Rate Data Used in Rate Development	NA

Retention

	PMPM in effect during the experience period	PMPM from Most Recent Approved Rate Filing	Proposed PMPM for Effective Date	Proposed Change in PMPM Compared to Prior 12 months	Proposed Change in PMPM Compared to Most Recently Approved Filing
Payroll and Benefits	$13.78	$12.79	$14.41	4.54%	12.61%
Outsourced Services (EDP, claims, etc.)	$7.54	$6.92	$6.96	-7.61%	0.62%
Auditing and consulting	$2.30	$1.81	$2.40	4.54%	32.98%
Marketing & Advertising	$0.87	$0.33	$0.91	4.54%	177.60%
Legal Expenses	$0.22	$0.11	$0.23	4.54%	110.98%
Other General Admin Expense	$4.50	$4.82	$4.70	4.54%	-2.35%
Commissions & Brokers Fees	$0.00	$0.00	$0.00		
Taxes, Licenses & Fees	$0.52	$0.45	$0.55	4.54%	21.96%
Reinsurance	$0.00	$0.00	$0.00		
Profit/Risk Margin	-$1.83	$4.35	$9.48	-617.85%	117.96%

	As % of Premium during the experience period	As % of Premium from Most Recent Approved Rate Filing	Proposed As % of Premium for Effective Date	Proposed Change in % of Premium Compared to Prior 12 months	Proposed Change in % of Premium Compared to Most Recently Approved Filing
Payroll and Benefits	3.41%	2.94%	3.04%	-10.87%	3.43%
Outsourced Services (EDP, claims, etc.)	1.87%	1.59%	1.47%	-21.23%	-7.58%
Auditing and consulting	0.57%	0.41%	0.51%	-10.87%	22.15%
Marketing & Advertising	0.21%	0.08%	0.19%	-10.87%	154.98%
Legal Expenses	0.05%	0.03%	0.05%	-10.87%	93.79%
Other General Admin Expense	1.11%	1.11%	0.99%	-10.87%	-10.31%
Commissions & Brokers Fees	0.00%	0.00%	0.00%		
Taxes, Licenses & Fees	0.13%	0.10%	0.11%	-10.87%	12.02%
Reinsurance	0.00%	0.00%	0.00%		
Profit/Risk Margin	-0.45%	1.00%	2.00%	-541.51%	100.20%

Trend & Projection Assumptions

Adjustments from Experience Period to Current Calendar Year

	Start Period	End Period
	1/1/2015	12/31/2015

	Util. Adjustments to Current Rate					Unit Cost Adj to Current Rate			
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Total Util Factor	Provider Payment Change	Other Factor	Total Unit Cost Factor	Trend
Inpatient Facility	1.0201	1.0000	1.0000	1.0000	1.02006	1.0508	1.0000	1.05084	1.07192
Outpatient Facility	1.0201	1.0000	1.0000	1.0000	1.02006	1.0508	1.0000	1.05084	1.07192
Professional	1.0201	1.0000	1.0000	1.0000	1.02006	1.0508	1.0000	1.05084	1.07192
Prescription Drugs	1.0052	1.0000	1.0000	1.0000	1.00523	1.0595	1.0000	1.05953	1.06507
Capitation and Other Provider Payments	1.0201	1.0000	1.0000	1.0000	1.02006	1.0508	1.0000	1.05084	1.07192
Other	1.0201	1.0000	1.0000	1.0000	1.02006	1.0508	1.0000	1.05084	1.07192

Adjustments from Current Calendar Year to Projection Year

	Start Period	End Period
	1/1/2016	12/31/2016

	Util. Adjustments to Current Rate					Unit Cost Adj to Current Rate			
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Total Util Factor	Provider Payment Change	Other Factor	Total Unit Cost Factor	Trend
Inpatient Facility	1.0201	1.0000	1.0000	1.0000	1.02006	1.0556	1.0000	1.05561	1.07678
Outpatient Facility	1.0201	1.0000	1.0000	1.0000	1.02006	1.0556	1.0000	1.05561	1.07678
Professional	1.0201	1.0000	1.0000	1.0000	1.02006	1.0556	1.0000	1.05561	1.07678
Prescription Drugs	1.0052	1.0000	1.0000	1.0000	1.00523	1.0595	1.0000	1.05953	1.06507
Capitation and Other Provider Payments	1.0201	1.0000	1.0000	1.0000	1.02006	1.0556	1.0000	1.05561	1.07678
Other	1.0201	1.0000	1.0000	1.0000	1.02006	1.0556	1.0000	1.05561	1.07678

Service Category	Incurred Claims $ PMPM	Medical Trend
Inpatient Facility	$80.14	1.15422
Outpatient Facility	$176.72	1.15422
Professional	$112.63	1.15422
Prescription Drugs	$75.02	1.13437
Capitation and Other Provider Payments	$3.81	1.15422
Other	$18.82	1.15422
Aggregate	$467.12	1.151033603

Monthly Trend Analysis Based on Experience Data Time Period	Month	Member Months	Monthly Incurred Claims $ PMPM	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend

used for Rate Development						
	Jan-2012	63,462	$438.71			
	Feb-2012	63,490	$449.18			
	Mar-2012	63,770	$473.58			
	Apr-2012	63,954	$446.35			
	May-2012	63,884	$489.49			
	Jun-2012	63,877	$431.41			3.81%
	Jul-2012	63,934	$424.61			-5.78%
	Aug-2012	63,905	$448.25			-26.49%
	Sep-2012	64,197	$390.34			-26.68%
	Oct-2012	64,079	$486.91			-4.89%
	Nov-2012	64,212	$467.75			14.90%
	Dec-2012	64,343	$476.47		-1.36%	66.88%
	Jan-2013	64,089	$476.21		3.35%	33.19%
	Feb-2013	63,843	$433.55		2.07%	12.41%
	Mar-2013	63,507	$472.01		14.82%	-14.51%
	Apr-2013	63,819	$488.08		11.21%	-9.39%
	May-2013	63,695	$502.79		15.34%	21.76%
	Jun-2013	63,979	$459.74		9.73%	20.54%
	Jul-2013	64,444	$475.15		5.68%	14.51%
	Aug-2013	64,593	$471.52		10.16%	-11.66%
	Sep-2013	64,393	$483.25		5.09%	-1.68%
	Oct-2013	64,098	$562.01		10.77%	26.33%
	Nov-2013	64,088	$516.60		9.60%	50.62%
	Dec-2013	63,512	$542.95	8.68%	17.10%	59.53%
	Jan-2014	62,376	$470.83	7.51%	15.48%	-2.59%
	Feb-2014	62,137	$447.39	7.81%	8.97%	-30.14%
	Mar-2014	62,159	$465.10	7.46%	5.38%	-52.37%
	Apr-2014	62,186	$456.14	5.87%	-7.88%	-40.73%
	May-2014	64,475	$454.27	4.87%	-12.70%	-20.42%
	Jun-2014	64,839	$463.65	4.50%	-21.22%	-7.83%
	Jul-2014	65,640	$454.36	3.26%	-19.79%	20.72%
	Aug-2014	66,092	$448.90	2.52%	-15.77%	14.55%
	Sep-2014	65,979	$481.11	0.99%	-11.00%	17.04%
	Oct-2014	65,951	$519.43	-0.81%	3.11%	32.46%
	Nov-2014	66,022	$477.14	-2.05%	10.17%	40.50%
	Dec-2014	65,863	$530.56	-2.93%	21.97%	48.42%

Solvency

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

Loss Ratio

Time Period	Period Beginning Date	Period Ending Date	Member Months	Incurred Claims	Earned Premium	Loss Ratio	Expected Incurred Claims	A-to-E Claims Ratio	Quality Improvement Expenses	Adjustments to Earned Premium	Adj Medical Loss Ratio
Historical Year -4	1/1/2010	12/31/2010									#DIV/0!
Historical Year -3	1/1/2011	12/31/2011									#DIV/0!
Historical Year -2	1/1/2012	12/31/2012									#DIV/0!
Historical Year -1	1/1/2013	12/31/2013									#DIV/0!
Historical Year 0	1/1/2014	12/31/2014	638,492	231,441,129	249,496,313	92.8%	228,210,878	101.4%	1,942,476	10,813,729	97.8%
Historical Totals			638,492	231,441,129	249,496,313	92.8%	228,210,878	101.4%	1,942,476	10,813,729	97.8%
Interim Time Period	1/1/2015	12/31/2015	698,280	273,590,826	310,011,258	88.3%	273,590,826	100.0%	5,005,866	14,309,079	94.2%
Future Year 1	1/1/2016	12/31/2016	840,168	348,329,670	398,287,375	87.5%	348,329,670	100.0%	2,304,569	16,648,591	91.9%

Anticiptated Federal loss ratio standard in market	80%

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

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

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

Consumer Adjusted Premium Rate Development

Index Rate for Projected Period PMPM	$547.33
Risk Adjustment PMPM	$0.15
Net Reinsurance Contributions PMPM	($10.52)
Exchange User Fees PMPM	$0.00
Market Adjusted Index Rate PMPM	$536.95

Product	BCBSVT Platinum Plan		BCBSVT Gold Plan	T Blue Rewards Gold CD	BSVT Blue Rewards Silver	CBSVT Silver CDHP Pla	Blue Rewards Bronze C	BCBSVT Bronze CDHP Plan	e Rewards Catastrophic Plan
Product ID	13627VT034		13627VT034	13627VT037	13627VT038	13627VT035	13627VT037	13627VT035	13627VT034
Plan ID	13627VT0340002		13627VT0340003	13627VT0370001	13627VT0380002	13627VT0350001	13627VT0370003	13627VT0350002	3627VT0340001
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	0.890		0.810	0.780	0.718	0.701	0.620	0.610	0.612
Pricing AV Value	1.121		0.980	0.866	0.796	0.802	0.688	0.697	0.399
Projected Member Months	50184		34440	26844	52188	52968	22692	17580	1440
Market Adjusted Index Rate PMPM	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95	$536.95
Plan Adjustments (in multiplicative format)									
Actuarial value and cost-sharing design of the plan	1.001		0.868	0.760	0.694	0.700	0.593	0.601	0.624
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	0.514
Plan Adjustments (in % format)									
Distribution and administration costs	10.7%		11.4%	12.2%	12.7%	12.7%	13.8%	13.8%	19.7%
Plan Adjusted Index Rate	$601.77	$536.95	$525.84	$464.73	$427.18	$430.60	$369.54	$374.02	$214.32
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	$601.77	$536.95	$525.84	$464.73	$427.18	$430.60	$369.54	$374.02	$214.32

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

May 27, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 05/21/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated May 21, 2015, 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. *Please provide an actual to expected comparison of the contributions to reserves for the most recent 5 years.*

   We started reporting our expenses for Large Group and Small Group separately in 2011. We can therefore only provide four years of actual to expected comparison for the population covered by this filing. The expected contribution to reserve is from original filings, before any amendment required by regulators.

Year	Expected	Actual
2011	1.8%	1.9%
2012	1.4%	-3.4%
2013	1.8%	-2.0%
2014	1.1%	-0.5%

4. *Please provide the total allowed claims and total member months for calendar year 2014 with membership categorized by the first date that coverage was provided.*

   Below are the allowed claims and total member months for calendar year 2014. Note that 0.18% of allowed claims ($666,077) have been excluded from the chart since they were associated with a member that was retroactively cancelled.

Start of Coverage	Allowed Claims	Member Months
January 2014	290,407,396	619,094
February 2014	9,328,947	19,240
March 2014	9,632,896	20,836

April 2014	27,073,546	60,705
May 2014	8,163,114	18,497
June 2014	3,895,261	7,545
July 2014	5,986,016	11,171
August 2014	2,321,523	6,457
September 2014	1,712,373	4,588
October 2014	1,246,400	2,884
November 2014	903,668	1,670
December 2014	462,698	1,032

Note that the above amounts include all experience period data, including that from extended small group and individual business, as well as experience for members of employers of 51-100 assumed to move to QHPs in 2016.

5. *What level of pent-up demand was included in the manual rate for pediatric dental?*

   As described on page 2 of Attachment C, Milliman "assumed most members would not have prior dental coverage based on information provided by BCBSVT. The DCGs suggest a factor of 1.30 for new business; however that factor applies to a standard population. We reduced the DCG factor to 1.15 to reflect the expected lower impact for the mix of services expected for children. BCBSVT expects this level to moderate to 1.10 for members in their second year of coverage. Based on the expected mix of first and second year members in 2015, BCBSVT estimates an average factor of 1.11."

6. *Was there any evidence of pent-up demand in the 2014 experience for pediatric dental? i.e. higher usage in the first quarter of 2014*

   No, in fact utilization was sufficiently low that we believe that members were largely unaware of this new benefit. Below are the monthly allowed dental claims PMPM.

Incurred Month	PMPM
January 2014	1.25
February 2014	0.85
March 2014	1.45
April 2014	1.64
May 2014	2.33
June 2014	1.95
July 2014	2.47
August 2014	2.36
September 2014	1.32
October 2014	1.87
November 2014	2.62
December 2014	3.01

7. *Provide additional support for the appropriateness of using a blend of experience with the manual rate for pediatric dental and vision benefits. Does the Company have a standard for full credibility for these benefits?*

   As can be seen in the claims table in our response to Question 6, dental claims were significantly dampened in the first part of the year before trending sharply upward in the fourth quarter. We believe that members were largely unaware of the embedded dental benefit, and we expect that utilization will converge toward expected levels moving forward. Supporting this hypothesis is the observation that claims for the first four months of 2015 are 70% higher than for the same period in 2014. We did not apply standard credibility theory to the dental claims experience, opting instead to equally weight twelve months of actual, yet suspect, experience with our manual rate. We would anticipate relying heavily or exclusively on actual experience moving forward, as more consistent utilization patterns emerge.

8. *What is the estimated impact of the proposed legislation to change the blueprint program?*

   There are two proposed changes to the Blueprint program:

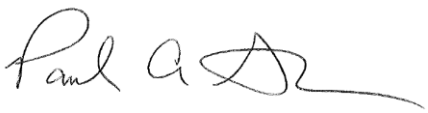
   First, there is a proposed increase to the Blueprint PMPM payment. The average PMPM for members with a Blueprint payment is $2.10. The proposed increase would bring it to $3.50. We project that 55% of our QHP members will be in the Blueprint. This increase would therefore increase our overall Blueprint PMPM, and therefore the Projected Index Rate, by $0.77.

   Second, there is a proposal to move to the Blueprint Manual for Community Health Team (CHT) payments. This would change the CHT payment to a PMPM amount for members in the Blueprint. The proposed PMPM amounts are $2.70 PMPM for the first six months of 2016 and $5.40 PMPM thereafter. Our current CHT payment calculates to $0.94 PMPM across all membership. The move to the Blueprint Manual would increase the Projected Index Rate by $1.28 PMPM.

   In the event that both of these proposed changes occur, our Projected Index Rate would be increased by $2.05 PMPM, resulting in an additional 0.45% average increase to premium.

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

June 4, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/01/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 1, 2015, here are *your questions* and our answers:

1. *Please provide the expected contributions to reserves for the most recent 4 years based on the final premiums after amendments made by regulators.*

   The below chart shows the expected contribution to reserves based on our forecasting model, which incorporates final premiums including amendments ordered by regulators. 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.

Year	Expected	Actual
2011	-0.3%	1.9%
2012	0.9%	-3.4%
2013	-2.0%	-2.0%
2014	-1.6%	-0.5%

   As the chart demonstrates, actual results have fluctuated fairly uniformly around our expectation, implying that filed pricing assumptions have been free of implicit margin over the past four years.

2. This question involves confidential and proprietary information and will be provided under separate cover.

3. *We note that the total fees collected for the federal insurer fee will increase by 41.25% compared to 2014. Please justify increasing the fee as a percentage of premium rather than on a PMPM basis.*

   It is important to assess this fee on the basis of percentage of premium so that the amount collected from insured customers automatically recalibrates to the level of benefit, and thereby premium, that members actually choose. That said, we recognize that applying the fee increase directly to the percentage of premium may not have been the most appropriate way to perform the calculation. We believe that the following development is a more accurate projection, and suggest that we amend the final filing to reflect the below figures:

2016 Projected Fully Insured Premium subject to the Federal Insurer Fee	a	$533,249,005
2016 Total Industry Assessment for Federal Insurer Fee	b	$11,300,000,000
BCBSVT Portion of Total Assessment (based on 2014 information)	c	0.1%
2016 Projected BCBSVT Federal Insurer Fee, grossed up for Federal Income Tax (20%)	d = b x c / 0.8	$14,074,814
2016 Estimated Required Charge as a percent of Total Premium	e = d / a	2.64%

4. *Please provide an explanation in the increase in the projected administrative costs from $25.78 in the prior filing to $28.83 in the current filing.*

As shown in the table below, the experience period administrative costs used in both filings were adjusted for expected one-time expenses associated with the startup of VHC and associated member outreach in much different proportions. BCBSVT continues to incur cost related to VHC implementation, support and ongoing contingency plans. It is expected that continuing cost related to this population will occur in 2016, similar to the ones incurred in the experience period, other than the excluded expenses.

	2016 Filing	**2015 Filing**
Experience Period	CY 2014	CY 2013
PMPM Experience	$28.40	$29.37
Excluded Expenses*	$0.82	$3.58
PMPM (adjusted)	$27.58	$25.78
Trend Adjustment (2 years)	2.2%	0.0%
PMPM used in the rates	$28.83	$25.78

* Excluded expenses were expected one-time costs

Questions 5 through 7 seek information on the calculation of various reasons cited for the average rate increase. It is important to note that none of these items are explicit steps in the build-up of premium rates. Rather, given the calculated rate increase, one must then back into these results by comparing assumptions used in the prior rate filing to those employed in the current filing. Necessarily, this involves selecting an order of applying each component of the increase. Results for any given component will differ depending on the order in which it is measured.

The exhibits supporting our results reflect the numerical values of various assumptions at the point in the order of calculations at which the assumption in question is changed. For instance, the plan level adjustments in the response to Question 5 do not reflect the final values, as those changes hadn't yet been measured at the point in time that we measured the change due to federally-mandated plan enhancements.

Please also note that the result in Question 7 differs very slightly from that shown in the actuarial memorandum. This is due to rounding that was necessary to allow the product of all reasons for rate increase to calculate to the correct overall average increase.

5. *Provide quantitative support for the 0.8% increase attributed to federally-mandated changes in the individual member out-of-pocket maximums for family policies within the plans with aggregate deductibles.*

   To calculate the impact of the changes in individual member out-of-pocket, we calculated Changes in Family Tier with and without this mandate. Please see *Responses to BCBSVT 2016 QHP Filings Inquiries - 06.01.2015.xlsx* for details.

6. *Provide quantitative support for the 1.1% impact on premium due to leveraging.*

   To calculate the impact of leveraging, we compared the calculated paid to allowed ratio for the 2015 benefits using both the 2015 and 2016 AV models. Please see *Responses to BCBSVT 2016 QHP Filings Inquiries - 06.01.2015.xlsx* for details.

7. *Provide quantitative support for the 0.8% decrease due to plan changes implemented by BCBSVT and the State of Vermont.*

   To calculate the impact of benefit changes, we compared the calculated paid to allowed ratio for the 2015 benefits and 2016 benefits, using the 2016 AV model. Please see *Responses to BCBSVT 2016 QHP Filings Inquiries - 06.01.2015.xlsx* for details.

8. *Please confirm that the exhibit demonstrating the estimated IBNR on page 7 of the Actuarial Memorandum has estimates from 2014. If not, please provide the correct estimates.*

   As you suggest, the table on page 7 of the actuarial memorandum was mislabeled. It should have read as follows:

	Incurred Claims	Allowed Claims
Claims incurred and paid through December 31, 2014	$255,382,946	$343,335,184
Estimate of IBNR as of February 28, 2015 for Claims	1,767,447	1,923,401
Estimate of IBNR as of February 28, 2015 for Pharmacy Rebates	($2,205,011)	($2,205,011)
Total Claims	$255,820,510	$343,616,795
Member Months	735,603	735,603
Total Per Member Per Month (PMPM)	$347.77	$467.12

9. *Please provide further qualitative support for the (1 + b9) factor on Exhibit 5 that adjusts the experience period claims for members that did not voluntarily terminate prior to 2015.*

   It is more accurate to state that the factor in question adjusts the experience period claims to remove the experience of members who voluntarily terminated during 2014, including those who did not renew into a BCBSVT QHP. We observed that the experience period claims costs for such members were significantly higher than those of the full QHP-eligible population. Because these individuals voluntarily left the QHP pool, we believe it appropriate to assume that they will not return to the single risk pool in 2016, and that their poor experience should therefore be removed from the projection. We hypothesize that these may be members who learned that they were eligible for Medicaid, which may explain both the midyear disenrollment and the above average claims cost, but we do not collect data on reasons for disenrollment.

10. *Please provide additional details on the terminated plans listed on page 33 of the Actuarial Memorandum. Will any of the QHP plans be terminated?*

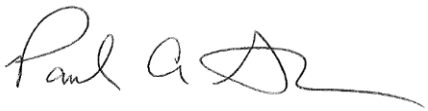
    The list of terminated plans on page 33 of the actuarial memorandum represent the benefit plans that were offered in 2013. Members with renewals between January and March were allowed to keep their 2013 plans until April 1, 2014. Members with renewals on or after April 1, 2014 only selected QHP plans at the time of their renewal. These plans were included in the single risk pool but they are no longer available. No QHP plans will be terminated on January 1, 2016.

11. *Please provide further qualitative support for the induced utilization adjustment (1 + c1). Were the experience and projected period paid to allowed ratios based on the same data source? Were the paid to allowed ratios calculated using the same method described on page 25 of the Actuarial Memorandum? If not, how were they calculated?*

    Since the experience period included members who were not in QHPs, we need to include an adjustment for induced utilization based on benefit changes. To do this calculation, two models were used. For the non-QHP experience, we used the most recent Large Group BRV datasets (see BCVT-129910512) to model the paid to allowed ratios. For the QHP experience and projection, we used the model described on page 25 of the actuarial memorandum. Both models are set up to adjudicate products in similar manners but the QHP model did not have all the details (different network adjustments, out-of-network claims, etc.) needed for non-QHP experience.

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.

Question 5

	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	Weighted Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0156	0.9745	0.9377	1.0818	1.0266	0.9741	0.9774	0.9388	0.9407	0.9428	
Paid to Allowed Ratio	83.56%	75.51%	65.44%	93.27%	85.37%	75.57%	76.38%	65.92%	66.51%	67.93%	
Changes in Family Tiers - With MOOP Adjustment	**0.9416**	**0.9302**	**0.9104**	**0.9926**	**0.9910**	**0.9866**	**0.9238**	**0.9787**	**0.9098**	**0.9136**	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5993	
Expected Claims Cost	**$430.21**	**$368.46**	**$300.76**	**$539.18**	**$467.57**	**$391.04**	**$371.31**	**$326.09**	**$306.44**	**$188.78**	**$416.65**
Administrative Charges Plan Level Adjustment	1.0639	1.0738	1.0904	1.0506	1.0581	1.0695	1.0733	1.0834	1.0890	1.1437	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$480.19**	**$415.11**	**$344.05**	**$594.29**	**$519.05**	**$438.75**	**$418.11**	**$370.64**	**$350.10**	**$226.50**	**$465.69**
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190

	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	Weighted Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0156	0.9745	0.9377	1.0818	1.0266	0.9741	0.9774	0.9388	0.9407	0.9428	
Paid to Allowed Ratio	83.56%	75.51%	65.44%	93.27%	85.37%	75.57%	76.38%	65.92%	66.51%	67.93%	
Changes in Family Tiers - Without MOOP Adjustment	**0.9423**	**0.9439**	**0.9678**	**0.9926**	**0.9910**	**0.9866**	**0.9379**	**0.9787**	**0.9614**	**0.9750**	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5997	
Expected Claims Cost	**$430.52**	**$373.91**	**$319.70**	**$539.18**	**$467.57**	**$391.04**	**$376.99**	**$326.09**	**$323.80**	**$201.62**	**$420.09**
Administrative Charges Plan Level Adjustment	1.0639	1.0728	1.0850	1.0506	1.0581	1.0695	1.0722	1.0834	1.0842	1.1345	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$480.51**	**$420.82**	**$363.93**	**$594.29**	**$519.05**	**$438.75**	**$424.06**	**$370.64**	**$368.32**	**$239.97**	**$469.30**

Impact of the MOOP Adjustment	**0.78%**

Question 6

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0082	0.9694	0.9360	1.0789	1.0224	0.9750	0.9781	0.9389	0.9473	0.9402	
Paid to Allowed Ratio - 2015 benefits - 2015 model	**82.13%**	**74.77%**	**65.84%**	**92.46%**	**84.44%**	**75.96%**	**76.36%**	**67.03%**	**69.24%**	**67.10%**	
Changes in Family Tiers	0.9402	0.9253	0.9121	0.9960	0.9940	0.9894	0.9186	0.9812	0.9145	0.9118	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5991	
Expected Claims Cost	**$419.11**	**$361.06**	**$302.64**	**$534.89**	**$461.96**	**$394.50**	**$369.35**	**$332.48**	**$322.92**	**$185.55**	**$416.01**
Administrative Charges Plan Level Adjustment	1.0656	1.0753	1.0898	1.0510	1.0588	1.0688	1.0737	1.0818	1.0845	1.1462	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$468.54**	**$407.34**	**$346.03**	**$589.79**	**$513.17**	**$442.38**	**$416.05**	**$377.34**	**$367.40**	**$223.11**	**$465.02**
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0107	0.9712	0.9357	1.0766	1.0216	0.9760	0.9792	0.9388	0.9473	0.9401	
Paid to Allowed Ratio - 2015 benefits - 2016 model	**83.38%**	**76.20%**	**67.22%**	**92.88%**	**85.13%**	**77.15%**	**77.56%**	**68.43%**	**70.51%**	**68.47%**	
Changes in Family Tiers	0.9402	0.9253	0.9121	0.9960	0.9940	0.9894	0.9186	0.9812	0.9145	0.9118	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5993	
Expected Claims Cost	**$426.55**	**$368.68**	**$308.84**	**$536.18**	**$465.43**	**$401.09**	**$375.58**	**$339.38**	**$328.86**	**$189.37**	**$421.05**
Administrative Charges Plan Level Adjustment	1.0644	1.0738	1.0880	1.0509	1.0584	1.0677	1.0725	1.0801	1.0829	1.1432	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$476.35**	**$415.33**	**$352.53**	**$591.15**	**$516.81**	**$449.29**	**$422.59**	**$384.58**	**$373.63**	**$227.12**	**$470.30**

Impact of Leveraging	**1.14%**

Question 7

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0107	0.9712	0.9357	1.0766	1.0216	0.9760	0.9792	0.9388	0.9473	0.9401	
Paid to Allowed Ratio - 2015 benefits - 2016 model	**83.38%**	**76.20%**	**67.22%**	**92.88%**	**85.13%**	**77.15%**	**77.56%**	**68.43%**	**70.51%**	**68.47%**	
Changes in Family Tiers	0.9402	0.9253	0.9121	0.9960	0.9940	0.9894	0.9186	0.9812	0.9145	0.9118	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5993	
Expected Claims Cost	**$426.55**	**$368.68**	**$308.84**	**$536.18**	**$465.43**	**$401.09**	**$375.58**	**$339.38**	**$328.86**	**$189.37**	**$421.05**
Administrative Charges Plan Level Adjustment	1.0644	1.0738	1.0880	1.0509	1.0584	1.0677	1.0725	1.0801	1.0829	1.1432	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$476.35**	**$415.33**	**$352.53**	**$591.15**	**$516.81**	**$449.29**	**$422.59**	**$384.58**	**$373.63**	**$227.12**	**$470.30**
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	$538.37	
Benefit Richness Adjustment	1.0144	0.9734	0.9367	1.0806	1.0254	0.9730	0.9763	0.9378	0.9396	0.9417	
Paid to Allowed Ratio - 2016 benefits - 2016 model	**83.38%**	**75.91%**	**66.47%**	**92.88%**	**85.13%**	**75.84%**	**76.28%**	**67.09%**	**67.47%**	**67.93%**	
Changes in Family Tiers	0.9402	0.9253	0.9121	0.9960	0.9940	0.9894	0.9186	0.9812	0.9145	0.9118	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5992	
Expected Claims Cost	**$428.12**	**$368.05**	**$305.73**	**$538.15**	**$467.14**	**$393.06**	**$368.28**	**$332.35**	**$312.10**	**$188.18**	**$417.13**
Administrative Charges Plan Level Adjustment	1.0644	1.0739	1.0889	1.0507	1.0581	1.0691	1.0739	1.0818	1.0874	1.1441	
Taxes and Fees Plan Level Adjustment	1.0386	1.0386	1.0386	1.0387	1.0387	1.0386	1.0386	1.0386	1.0386	1.0386	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$478.11**	**$414.68**	**$349.27**	**$593.21**	**$518.60**	**$440.87**	**$414.92**	**$377.20**	**$356.04**	**$225.87**	**$466.19**

Impact of Benefit Changes	**-0.87%**

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

June 15, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/11/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 11, 2015, here are *your questions* and our answers:

1. *Were any outside sources for utilization trend considered? If so, please provide. i.e. nationwide sources.*

   While we reviewed external sources for utilization trend, we did not directly consider results from these surveys for two reasons.

   First, our utilization trend includes the impact of intensity, or mix of services, in addition to pure utilization. Most national surveys use measures such as number of visits or admissions as the basis for their utilization trend. This captures only a portion of utilization trend as we are defining it for this filing. As such, it would be inappropriate to directly compare the findings of these surveys with our utilization trend pick, particularly given that the bulk of our 2% utilization trend is due to intensity rather than volume.

   Second, we considered only the continuing portion of the QHP-eligible population in establishing our trend. We recognize that this yields a higher utilization trend than recent filings wherein we have used a total-population approach. However, we found it important to consider this result in conjunction with the aggressive membership assumptions we are using, particularly with respect to our treatment of terminating members. We were unable to identify national surveys that used a similar "continuing member" approach, and again found it inappropriate to compare our result to that from surveys using a total population.

   Finally, we'd like to reiterate that it is essential to consider assumptions that are reasonable both individually *and as a whole*. In particular, the utilization trend assumption must be considered in conjunction with our various membership assumptions. Decreasing utilization trend to levels found in national surveys and recent filings – beyond creating inappropriate comparisons to such information – would reduce our requested rate increase to a level that does not make sense in light of the loss sustained on 2014 QHP business, known increases in the amounts providers are paid, and increases required due to mandated changes associated with the ACA.

2. *The results of the regression analysis on utilization trends are influenced by seasonality in the data. In particular, the claims in the fourth quarter have been 13.9% higher on average than the claims for the first three quarters from 2011 - 2014.*

   The table below shows annualized trends calculated from the data in Exhibit 3B that are lower than the trends calculated using monthly regression. This is most evident by looking at the difference between the one year annualized trend of 2.3% compared to the twelve month regression of 18.8%. We note that the impact of seasonality is less evident in the longer monthly regressions, but it is not fully removed.

   Please discuss the impact of seasonality on the selected trends. Were any alternate methods to calculate utilization trends considered?

	Adjusted Allowed	Member Months	PMPM
2011	$84,607,139	230,243	$367.47
2012	$134,664,221	387,464	$347.53
2013	$161,466,345	423,628	$381.15
2014	$168,285,889	431,407	$390.09

	Annual Trends[1]	Regression Analysis
1 year	2.3%	18.8%
2 year	5.9%	6.1%
3 year	2.0%	6.7%

[1] 5.9% = (390.09/347.53)^0.5

We agree that the one-year regression analysis gives a nonsensical result because of the seasonality. We never seriously considered using that figure in any way. However, the impact of seasonality is mitigated or arguably eliminated through the use of multiple years of data. In comparing the two-year results, we can see that the regression yields a figure that is very close to the discrete annual trend. Avoiding the random and sensitive nature of a discrete end point and smoothing results through a curve are, in fact, the primary benefits of using a regression analysis.

Using a discrete approach lends itself to results that are very sensitive to changes in population or marketplace. In this case, the three-year trend is heavily impacted by the addition of a large Association group into the data as of January 1, 2012, which increased membership by some 50%. At the opposite end of the scale, the one-year trend is greatly influenced by the rush to services that was experienced in late 2013 in the build-up to the Exchange, as well as the significant dampening of utilization in Q1 2014 that occurred both as individuals were experiencing a significant difficulty in obtaining ID cards and because of the natural trough that corresponds to the peak in the fourth quarter of 2013. For these reasons, the two-year data point is the only one that both includes a consistent population and adequately compensates for the impact of the movement to QHPs and Vermont Health Connect. The fact that this result was is close to the two-year regression gave us a good deal of comfort that we were choosing an appropriate utilization trend assumption.

3. *Please provide the estimated impact of induced utilization for the 36 month period from 2012 – 2014, similar to Exhibit 3C.*

   Please see the Q3 tab of the attached file *Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.xlsx*.

4. *Please provide additional quantitative support for the estimated impact of aging on page 16 of the Actuarial Memorandum and expand the data to include 2012.*

   Please see the Q4 tab of the attached file *Responses to BCBSVT 2016 QHP Filing Inquiries - 06.11.2015.xlsx*.

5. *In the response dated 6/4/2015, please provide quantitative support for the 2016 projected fully insured premium subject to the federal insurer fee.*

   The total projected fully insured premium for 2016 is $533,249,005. This can be split between QHP products and Large Group products. The QHP projected premium is $397,277,296, as shown on Exhibit 7B. The remainder of the premium, $135,971,709 is for groups expected to still be Large Group in 2016. Notably this excludes groups with 51-100 employees that are not expected to migrate to QHPs in 2016. These groups would have to find a self-funded option and therefore they would not be included in this total.

   To project the 2016 premium, we started with premium as of April 2015 and increased it by 10 percent, which represents the projected average rate increase for these groups from the Large Group Rating Program Filing (BCVT-129910512), increased slightly for anticipated Blueprint increases that were not contemplated in that filing. We did not assume additional migration to ASO business among large groups.

6. *Please elaborate on the possible impact from difficulties in enrolling through VHC on seasonal drug utilization.*

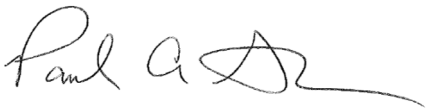
   We have observed significant increases in pharmacy utilization in each of the last two years, beyond that expected due to the seasonality of benefits. This was certainly not unexpected in 2013, as the State of Vermont, knowing that enrollment was unlikely to be processed in a timely manner, even went so far as to send letters to individuals attempting to sign up through VHC to encourage them to refill their prescriptions in December, if possible, rather than waiting until January. We suspect that similar fears played into behavior patterns in December of 2014 as well. Because of the utilization spike in Q4 2014, we felt it would be inappropriate to include that quarter in our trend analysis, particularly since the offsetting dampening in Q1 2015 could not easily be included in the analysis.

7. *We note that the regression for non-specialty drug utilization was selected with the period ending September 2014 due to the impact of seasonality. Please provide support for selecting the year ending November 2014 for specialty drugs.*

   Quite simply, this is because specialty scripts are always filled as 30-day supplies. Non-specialty prescriptions, on the other hand, are available as 30-day or 90-day supplies. Ending any non-specialty analysis with a calendar quarter is therefore desirable in order to avoid an unintended consequence of adding seasonality to the trend calculation (fills of 90-day scripts are highly seasonal within calendar quarter). Since the same concern does not exist with Specialty medications, we found it appropriate to include as much information as possible, exclusive of the December data that is unduly influenced by the prospect of accumulators resetting.

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.

Month	Membership	Adjusted Claims - Normalized for Contract Changes	Adjusted PMPM	Regression on Adjusted PMPM - 36 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 - 36 Months
Jan-12	30,617	$10,235,183	$334.30	$337.97	0.8914	1.0225	$10,465,948	$341.83	$347.42
Feb-12	30,831	$11,484,116	$372.49	$339.82	0.8912	1.0228	$11,746,105	$380.98	$349.03
Mar-12	31,211	$11,444,062	$366.67	$341.56	0.8905	1.0236	$11,714,542	$375.33	$350.54
Apr-12	31,477	$10,541,984	$334.91	$343.44	0.8906	1.0235	$10,789,967	$342.79	$352.17
May-12	31,763	$11,400,368	$358.92	$345.26	0.8906	1.0235	$11,668,630	$367.37	$353.74
Jun-12	32,073	$10,570,585	$329.58	$347.15	0.8908	1.0233	$10,816,513	$337.25	$355.38
Jul-12	32,408	$10,359,973	$319.67	$349.00	0.8913	1.0227	$10,595,454	$326.94	$356.98
Aug-12	32,733	$10,788,099	$329.58	$350.91	0.8914	1.0225	$11,031,230	$337.01	$358.63
Sep-12	33,111	$9,941,818	$300.26	$352.84	0.8918	1.0222	$10,162,047	$306.91	$360.29
Oct-12	33,427	$12,356,784	$369.66	$354.71	0.8920	1.0218	$12,626,500	$377.73	$361.91
Nov-12	33,770	$12,826,984	$379.83	$356.66	0.8926	1.0212	$13,099,015	$387.89	$363.58
Dec-12	34,073	$12,714,266	$373.15	$358.55	0.8930	1.0207	$12,977,839	$380.88	$365.21
Jan-13	34,913	$12,575,252	$360.19	$360.52	0.8966	1.0166	$12,784,266	$366.17	$366.91
Feb-13	35,143	$12,380,809	$352.30	$362.49	0.8963	1.0169	$12,590,271	$358.26	$368.61
Mar-13	35,395	$13,319,805	$376.32	$364.29	0.8963	1.0170	$13,545,858	$382.71	$370.15
Apr-13	35,405	$13,418,782	$379.01	$366.29	0.8963	1.0170	$13,646,417	$385.44	$371.86
May-13	35,390	$13,997,660	$395.53	$368.23	0.8963	1.0170	$14,235,050	$402.23	$373.53
Jun-13	35,384	$12,672,929	$358.15	$370.25	0.8963	1.0169	$12,887,427	$364.22	$375.26
Jul-13	35,404	$12,397,163	$350.16	$372.22	0.8963	1.0170	$12,607,771	$356.11	$376.94
Aug-13	35,424	$12,204,075	$344.51	$374.26	0.8963	1.0170	$12,411,577	$350.37	$378.69
Sep-13	35,353	$13,204,675	$373.51	$376.31	0.8959	1.0174	$13,434,407	$380.01	$380.44
Oct-13	35,314	$15,965,762	$452.11	$378.31	0.8961	1.0172	$16,240,413	$459.89	$382.15
Nov-13	35,332	$14,296,018	$404.62	$380.39	0.8962	1.0171	$14,539,856	$411.52	$383.92
Dec-13	35,171	$15,033,413	$427.44	$382.40	0.8962	1.0171	$15,290,992	$434.76	$385.64
Jan-14	35,342	$14,218,588	$402.31	$384.50	0.9116	0.9999	$14,216,750	$402.26	$387.43
Feb-14	35,411	$12,488,942	$352.69	$386.61	0.9125	0.9990	$12,475,904	$352.32	$389.22
Mar-14	35,492	$13,226,797	$372.67	$388.53	0.9132	0.9981	$13,201,778	$371.96	$390.85
Apr-14	35,371	$12,854,001	$363.41	$390.66	0.9112	1.0004	$12,858,543	$363.53	$392.66
May-14	35,928	$13,432,921	$373.88	$392.73	0.9111	1.0004	$13,438,415	$374.04	$394.42
Jun-14	36,050	$13,790,002	$382.52	$394.89	0.9115	1.0000	$13,789,765	$382.52	$396.25
Jul-14	36,146	$13,402,523	$370.79	$396.98	0.9114	1.0002	$13,404,614	$370.85	$398.03
Aug-14	36,276	$13,168,028	$363.00	$399.16	0.9113	1.0003	$13,171,521	$363.09	$399.87
Sep-14	36,308	$14,377,482	$395.99	$401.35	0.9113	1.0003	$14,381,378	$396.09	$401.72
Oct-14	36,360	$16,069,659	$441.96	$403.48	0.9114	1.0001	$16,071,213	$442.00	$403.53
Nov-14	36,392	$14,605,064	$401.33	$405.69	0.9113	1.0002	$14,608,478	$401.42	$405.40
Dec-14	36,331	$16,651,882	$458.34	$407.85	0.9115	1.0000	$16,651,882	$458.34	$407.21
		Annual Increase		6.7%					5.6%

Regressions

	Adjusted PMPM - 36 Months
1.00018	0.2474
0.00004	1.6249
37.34%	0.0744
20.25859	34

	Adjusted PMPM - 36 Months
1.00015	0.7792
0.00004	1.6576
29.02%	0.0759
13.89831	34

Impact of Benefit Chages **-0.99%**

Year	Age Group	Gender	Member Months
2013	A 0-1	F	1,769
2013	A 0-1	M	1,905
2013	B 2-6	F	5,840
2013	B 2-6	M	5,977
2013	C 7-18	F	23,730
2013	C 7-18	M	24,479
2013	D 19-22	F	9,184
2013	D 19-22	M	9,812
2013	E 23-24	F	2,460
2013	E 23-24	M	2,672
2013	F 25-29	F	7,775
2013	F 25-29	M	7,981
2013	G 30-34	F	10,867
2013	G 30-34	M	10,500
2013	H 35-39	F	11,844
2013	H 35-39	M	11,781
2013	I 40-44	F	18,518
2013	I 40-44	M	17,338
2013	J 45-49	F	23,599
2013	J 45-49	M	21,469
2013	K 50-54	F	29,346
2013	K 50-54	M	27,267
2013	L 55-59	F	32,012
2013	L 55-59	M	28,924
2013	M 60-64	F	18,724
2013	M 60-64	M	17,154
2013	N 65+	F	1,859
2013	N 65+	M	2,708
			387,494
	Average Age-Gender Factor		1.1881

Year	Age Group	Gender	Member Months
2013	A 0-1	F	1,506
2013	A 0-1	M	1,591
2013	B 2-6	F	5,757
2013	B 2-6	M	6,303
2013	C 7-18	F	24,427
2013	C 7-18	M	25,157
2013	D 19-22	F	10,214
2013	D 19-22	M	10,790
2013	E 23-24	F	4,070
2013	E 23-24	M	4,674
2013	F 25-29	F	8,514
2013	F 25-29	M	8,645
2013	G 30-34	F	12,296
2013	G 30-34	M	11,240
2013	H 35-39	F	12,699
2013	H 35-39	M	13,122
2013	I 40-44	F	18,538
2013	I 40-44	M	17,668
2013	J 45-49	F	23,883
2013	J 45-49	M	21,676
2013	K 50-54	F	30,650
2013	K 50-54	M	28,296
2013	L 55-59	F	34,658
2013	L 55-59	M	30,715
2013	M 60-64	F	26,334
2013	M 60-64	M	23,948
2013	N 65+	F	2,640
2013	N 65+	M	3,617
			423,628
	Average Age-Gender Factor		1.2159

Year	Age Group	Gender	Member Months
2014	A 0-1	F	554
2014	A 0-1	M	709
2014	B 2-6	F	5,443
2014	B 2-6	M	5,767
2014	C 7-18	F	23,221
2014	C 7-18	M	23,956
2014	D 19-22	F	10,790
2014	D 19-22	M	11,167
2014	E 23-24	F	4,792
2014	E 23-24	M	5,300
2014	F 25-29	F	8,605
2014	F 25-29	M	8,841
2014	G 30-34	F	12,215
2014	G 30-34	M	10,982
2014	H 35-39	F	13,110
2014	H 35-39	M	13,361
2014	I 40-44	F	17,035
2014	I 40-44	M	16,562
2014	J 45-49	F	23,457
2014	J 45-49	M	21,225
2014	K 50-54	F	30,374
2014	K 50-54	M	27,315
2014	L 55-59	F	34,681
2014	L 55-59	M	30,923
2014	M 60-64	F	33,017
2014	M 60-64	M	29,360
2014	N 65+	F	3,765
2014	N 65+	M	4,880
			431,407
	Average Age-Gender Factor		1.2488

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

June 22, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/18/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 18, 2015, here are *your questions* and our answers:

1. *You state that "Members without a pharmacy benefit were excluded" in the base period data (Page 7 of the Actuarial Memorandum):*
   a. *Why were these members not included since individuals not electing pharmacy would be expected to be healthier?*

      The excluded members were grandfathered Safety Net members who elected to stay in their existing policy for up to three months in 2014.The Safety Net program was created in 1992 by Vermont Act 160 to provide a health insurance safety net for members whose small group or individual policy carrier left the Vermont market because of the new community rating law. All of these excluded policies were originally issued by either Fortis or Mutual of Omaha. Safety net was for many years a privileged class of insureds insulated from some of the rate increases affecting the rest of the market, and whatever initial selection effects existed would have worn off long ago. Also, the decision to exclude this very small population was influenced by the fact that it would be mechanically complicated to include them directly and their impact on premiums would be minimal.

   b. *How many member months were represented by these members?*

      These members represented 384 member months.

   c. *What would be the impact on the premium rates if these individuals were included with an adjustment to add the pharmacy benefit?*

      If we had included these members in our filing, with the assumption that their projected pharmacy costs would be similar to the rest of the single risk pool, the increase would have been approximately 0.02 percent lower than the filed increase.

2. *What adjustment, if any, did you make for the relative morbidity of the groups with 51-100 employees currently insured by Cigna that will purchase coverage in the exchange?*

   Our market intelligence is that Cigna insures very few groups of 51-100. While they have a number of self-funded clients, BCBSVT and MVP dominate the market for insured business of that size. We believe it is unlikely that groups currently self-insured would move to a QHP. We did not assume that BCBSVT would gain any additional small groups not already with BCBSVT.

3. *In the development of the pharmacy rebate adjustment why was the cost trend (12.8 percent) used for brand rather than the total trend (5.5 percent) including utilization decreases (-6.5 percent)? If you agree that the utilization decrease should have been included in the calculations please calculate the resulting impact on the premium rates.*
   Historically, the rebate amount per eligible script has been increasing faster than the cost trend to offset the decreasing utilization. Since we apply the trend to the PMPM, and not at the eligible script level, we used the Brand cost trend as a proxy for all the moving pieces. Using the total brand trend (5.5 percent) would increase the premiums by about 0.1 percent.

4. *Please provide administrative costs per-member-per-month from the Supplemental Health Care Exhibit for the individual market, small group market, and combined market for years 2012, 2013 and 2014.*
   Statutory basis administrative costs as reported on the Supplemental Health Care Exhibit (SHCE), on an aggregate and per-member-per-month (PMPM) basis, were as follows:

Year	Market Segment	Member Months	Administrative Costs	Per Member Per Month
2012	Individual	200,766	5,924,451	29.51
	Small Group	537,551	22,156,092	41.22
	Combined	738,317	28,080,543	38.03
2013	Individual	223,664	7,450,597	33.31
	Small Group	513,031	21,984,687	42.85
	Combined	736,695	29,435,284	39.96
2014	Individual	323,259	12,544,267	38.81
	Small Group	417,185	19,747,943	47.34
	Combined	740,444	32,292,210	43.61

The small group figures in the table above represent the aggregate of the SHCE filings for both Blue Cross and Blue Shield of Vermont and The Vermont Health Plan.

Administrative costs as reported in NAIC statutory basis filings include certain items which are not factored into the base administrative expense charge in the 2016 QHP filing. These include federal Affordable Care Act (ACA) related fees and assessments, Vermont's HCCT claims assessment, broker commission expense, fees paid to Vermont Collaborative Care (VCC) for utilization review and management of mental health and substance abuse claims and fees paid to vendors for HRA and/or HSA integration service. These charges and fees are included elsewhere in the filing. Additionally, the base administrative expense charge in BCBSVT's QHP filings has and continues to exclude one-time expenses associated with the startup of VHC and related member outreach, VHC implementation, support and contingency plans and resource augmentation of certain enrollment functions. Removing these expenses from the filed statutory basis figures shown in the table above yields the following results that are consistent with the base administrative charge in the QHP filing, which is based upon GAAP reporting:

Year	Market Segment	Member Months	Administrative Costs	Per Member Per Month
2012	Individual	200,766	5,924,451	29.51
	Small Group	537,551	15,789,848	29.37
	Combined	738,317	21,714,299	29.41
2013	Individual	223,664	6,562,511	29.34
	Small Group	513,031	14,620,884	28.50
	Combined	736,695	21,183,395	28.75
2014	Individual	323,259	8,851,767	27.38
	Small Group	417,185	12,630,475	30.28
	Combined	740,444	21,482,242	29.01

5. *Please explain any measures you have taken to control administrative costs including costs in relation to staff compensation in the past five years.*

From 2010 to 2014 we have reduced administrative costs per member per month by 24 percent to less than 7 cents of each dollar paid on behalf of our members. Our efforts to control administrative costs are a multi-pronged approach, including:

A highly disciplined process to establish our administrative expense budget for each year. Establishment of corporate, divisional and cost center budget targets at the beginning of the process, with the requirement that budget managers not exceed target in their budget submissions.

Established guidelines for the competitive bid process that must be followed for vendor engagement, and for vendor contracting to ensure that all vendor relationships are managed effectively and efficiently on behalf of our members. RFP's are conducted regularly to make sure BCBSVT is getting the best vendor prices and services available in the market.

Within the budget target setting process, each year the employee merit increase allowance is limited to a specified percentage of base salary for all employees up to and including the CEO. Over the last five years, that percentage has been either 2.5 or 3.0 percent each year, which we believe is consistent with, if not lower than, other companies in the State of Vermont.

Within the budget process, or at any other point that it becomes appropriate, vacant staff positions are reviewed to determine whether they may be eliminated or redeployed based on current resource needs within each functional department.

BCBSVT has implemented a corporate-wide organizational efficiency program to promote continuous process improvement, efficient resource deployment and ultimately, administrative costs savings to benefit our members. In 2014, Blue IDEAs generated $1.5 million in administrative cost savings. In 2015, BCBSVT has established a goal to identify another $1.0 million in savings.

Also, BCBSVT participates in an annual administrative expense benchmark survey. On an overall per member per month basis, in 2013 BCBSVT achieved the median result out of 19 BCBS plans, despite being the smallest plan in the survey. Without the benefit of the economies of scale enjoyed by larger Blue plans, and in a geographic location where costs are generally higher than the average across the country, for BCBSVT to be at the median administrative cost validates the time and effort we put into our administrative cost control programs. Results for 2014 have not yet been published, but we expect to be lower than the median for last year.

6. *Please explain why the adjustments for risk adjustment and reinsurance in Exhibit 5 were not divided by the Paid to Allowed ratio as described on page 21 of the 2016 Unified Rate Review Template instructions.*
   Page 21 of the 2016 Unified Rate Review Instructions describes how to fill out Worksheet 1 of the Unified Rate Review Template (URRT). As stated in the Actuarial Memorandum, the URRT does not demonstrate the process used to develop rates. Exhibit 5 represents the build-up of the Market Adjusted Index Rate. Per page 59 of the same instructions, "Since the Index Rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program, risk adjustment program, and the Marketplace user fees should be on an allowed basis."

7. *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 2015 session that were not included in your SERFF filing and that will affect rates. Provide details about each adjustment.*
   The only adjustment needed for this filing is related to the implications of the changes to funding of the Blueprint program that the legislature approved for Medicaid. Implementation guidance is forthcoming from GMCB on how this will impact commercial carriers, and we would prefer to delay our answer to this question until the details are known, which we expect to be soon.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,

Martine Brisson-Lemieux, A.S.A., M.A.A.A.

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

June 26, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/25/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 26, 2015, here are *your questions* and our answers:

1. *Please provide the estimated impact on the 2014 CTR due to the recently released report that 2014 reinsurance recoveries will be reimbursed at 100 percent for individual market plans' covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000.*

   The previously reported CTR for the QHP business was -2.7 percent. When combined with other Individual and Small Groups lines (as in our response to question 1 of your May 27, 2015 inquiries), the reported CTR was -0.5 percent. With this change in the Transitional Reinsurance program, we expect to receive an additional $4.3M in recoveries. This would bring our CTR for the QHP business to -1.0 percent, and to +1.0 percent for the combined Individual and Small Group lines.

2. *Please provide support for the projected earned premium on the "rate review detail" in SERFF of $397,744,608.*

   The projected premium in SERFF should have been $397,277,296, as shown on Exhibit 7A.

   Note that the requested revisions for the changes in Blueprint regulation and the estimated Federal Insurer Fee, described below, generate an updated projected premium of $397,825,765. Please see tab "Q2" of the attached *Responses to BCBSVT 2016 QHP Filing Inquiries – 06.25.2015.xlsx* for details.

3. *When available, please post a summary of the results of the risk adjustment transfers that are expected to be sent to health plans on June 30th.*

   We will provide a summary of the results of the risk adjustment transfers once available. Our intention is to provide this through a "Note to Reviewer" within SERFF.

4. *The Market Adjusted Index Rate is required to be included in the Actuarial Memorandum and page 59 of the 2016 URRT Instructions states that: "Since the Index Rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program,*

risk adjustment program, and the Marketplace user fees should be on an allowed basis." Please revise the Market Adjusted Index Rate accordingly.

We have revised the order of operations on Exhibit 6C and the Market Adjusted Index Rate to comply with the Unified Rate Review Instructions. The updated Market Adjusted Index Rate is $535.38. This change as no impact on premium. Please see tab "Q4" of the attached *Responses to BCBSVT 2016 QHP Filing Inquiries – 06.25.2015.xlsx* for details.

Note that this exhibit also reflects the changes to the Blueprint funding described below, as they impact the Market Adjusted Index Rate.

Subsequent to the submission of this inquiry letter, you requested the detailed calculation of the contract conversion factor on Exhibit 9. Please see tab "Q5" of attached *Responses to BCBSVT 2016 QHP Filing Inquiries – 06.25.2015.xlsx* for the requested details.

Finally, per the June 25 request of the GMCB, we are using this response to provide updated versions of Exhibit 9 (Rate Exhibit) that reflect the now-known impact of regulatory changes to the Blueprint program, along with the previously agreed-upon change to our estimate of the Federal Insurer Fee.

On June 22, 2015, we received an updated Blueprint Manual that details the changes to the Blueprint program. The changes impact funding for both portions of the program: Community Health Teams (CHT) and Patient Centered Medical Homes (PCMH). For the CHT funding, the market share of each participating carrier is updated quarterly to reflect recent market share information. We project that our market share for 2016 will be approximately 40.7 percent, or $2.50 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. Based on Medicaid's projection for their population, we assumed that the average payment for PCMH would be $3.25.

The incorporation of all of these changes produces an expected 2016 Blueprint payment (CHT+PCMH) of $5.75 PPPM. Based on membership figures through May, BCBSVT projects that 59.0 percent of the QHP membership will be attributed to a PCMH. The projected Blueprint payment is therefore $3.39 PMPM. This change will increase the rates by 0.23 percent (as shown on tab "Exh 9A" of *Responses to BCBSVT 2016 QHP Filing Inquiries – 06.25.2015.xlsx)* from the originally-filed rates.

As discussed in our response dated June 4, 2015, we have agreed to change our methodology for estimating the Federal Insurer Fee, thereby reducing our estimate to 2.63 percent. The combined impact of the change in the estimated Federal Insurer Fee and the funding of the Blueprint program is an increase of 0.14 percent (as shown on tab "Exh 9B" of *Responses to BCBSVT 2016 QHP Filing Inquiries – 06.25.2015.xlsx)* from the originally-filed 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.

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$488.63	$465.83	$428.28	$370.64	$602.87	$526.95	$445.92	$431.71	$377.24	$375.12	$215.39	
PMPM to Single Contract Conversion Factor	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	
2016 Proposed Rates												
Single Rate	$544.88	$519.46	$477.59	$413.31	$672.27	$587.61	$497.26	$481.40	$420.67	$418.31	$240.19	
Couple Rate	$1,089.76	$1,038.92	$955.18	$826.62	$1,344.54	$1,175.22	$994.52	$962.80	$841.34	$836.62	$480.38	
Adult and Child(ren) Rate	$1,051.62	$1,002.56	$921.75	$797.69	$1,297.48	$1,134.09	$959.71	$929.10	$811.89	$807.34	$463.57	
Family Rate	$1,531.11	$1,459.68	$1,342.03	$1,161.40	$1,889.08	$1,651.18	$1,397.30	$1,352.73	$1,182.08	$1,175.45	$674.93	$380,981,781.60
2015 Approved Rates												
Single Rate	$493.87		$428.14	$360.49	$624.18	$541.75	$465.61	$436.20	$395.78	$384.02	$228.24	
Couple Rate	$987.74		$856.28	$720.98	$1,248.36	$1,083.50	$931.22	$872.40	$791.56	$768.04	$456.48	
Adult and Child(ren) Rate	$953.17		$826.31	$695.75	$1,204.67	$1,045.58	$898.63	$841.87	$763.86	$741.16	$440.50	
Family Rate	$1,387.77		$1,203.07	$1,012.98	$1,753.95	$1,522.32	$1,308.36	$1,225.72	$1,112.14	$1,079.10	$641.35	$350,712,794.16
2015 Proposed Rate Increases												
Single Rate	10.3%		11.5%	14.7%	7.7%	8.5%	6.8%	10.4%	6.3%	8.9%	5.2%	
Couple Rate	10.3%		11.5%	14.7%	7.7%	8.5%	6.8%	10.4%	6.3%	8.9%	5.2%	
Adult and Child(ren) Rate	10.3%		11.6%	14.7%	7.7%	8.5%	6.8%	10.4%	6.3%	8.9%	5.2%	
Family Rate	10.3%		11.6%	14.7%	7.7%	8.5%	6.8%	10.4%	6.3%	8.9%	5.2%	**8.631%**
Inforce Contracts												
Single Rate	1,091		2,819	1,376	4,470	2,898	6,665	3,511	1,253	1,709	113	
Couple Rate	286		730	352	1,634	847	2,182	1,168	359	461	0	
Adult and Child(ren) Rate	69		104	76	358	186	301	206	55	89	2	
Family Rate	297		220	299	1,330	705	1,003	997	207	435	1	

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$488.16	$465.39	$427.88	$370.29	$602.30	$526.45	$445.50	$431.30	$376.89	$374.77	$215.19	
PMPM to Single Contract Conversion Factor	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	
2016 Proposed Rates												
Single Rate	$544.36	$518.96	$477.14	$412.92	$671.64	$587.05	$496.78	$480.95	$420.27	$417.91	$239.96	
Couple Rate	$1,088.72	$1,037.92	$954.28	$825.84	$1,343.28	$1,174.10	$993.56	$961.90	$840.54	$835.82	$479.92	
Adult and Child(ren) Rate	$1,050.61	$1,001.59	$920.88	$796.94	$1,296.27	$1,133.01	$958.79	$928.23	$811.12	$806.57	$463.12	
Family Rate	$1,529.65	$1,458.28	$1,340.76	$1,160.31	$1,887.31	$1,649.61	$1,395.95	$1,351.47	$1,180.96	$1,174.33	$674.29	$380,620,715.88
2015 Approved Rates												
Single Rate	$493.87		$428.14	$360.49	$624.18	$541.75	$465.61	$436.20	$395.78	$384.02	$228.24	
Couple Rate	$987.74		$856.28	$720.98	$1,248.36	$1,083.50	$931.22	$872.40	$791.56	$768.04	$456.48	
Adult and Child(ren) Rate	$953.17		$826.31	$695.75	$1,204.67	$1,045.58	$898.63	$841.87	$763.86	$741.16	$440.50	
Family Rate	$1,387.77		$1,203.07	$1,012.98	$1,753.95	$1,522.32	$1,308.36	$1,225.72	$1,112.14	$1,079.10	$641.35	$350,712,794.16
2015 Proposed Rate Increases												
Single Rate	10.2%		11.4%	14.5%	7.6%	8.4%	6.7%	10.3%	6.2%	8.8%	5.1%	
Couple Rate	10.2%		11.4%	14.5%	7.6%	8.4%	6.7%	10.3%	6.2%	8.8%	5.1%	
Adult and Child(ren) Rate	10.2%		11.4%	14.5%	7.6%	8.4%	6.7%	10.3%	6.2%	8.8%	5.1%	
Family Rate	10.2%		11.4%	14.5%	7.6%	8.4%	6.7%	10.3%	6.2%	8.8%	5.1%	**8.528%**
Inforce Contracts												
Single Rate	1,091		2,819	1,376	4,470	2,898	6,665	3,511	1,253	1,709	113	
Couple Rate	286		730	352	1,634	847	2,182	1,168	359	461	0	
Adult and Child(ren) Rate	69		104	76	358	186	301	206	55	89	2	
Family Rate	297		220	299	1,330	705	1,003	997	207	435	1	

	NON-STANDARD PLANS				STANDARD PLANS						
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic
	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Projected Contracts for BCBSVT 2016 QHP *		CDHP		CDHP							
Single Rate	1,136	288	2,847	1,391	4,668	3,028	6,665	3,581	1,299	1,756	113
Couple Rate	302	105	740	358	1,707	894	2,182	1,194	376	478	0
Adult and Child(ren) Rate	73	24	106	77	375	197	301	212	59	93	2
Family Rate	315	115	231	305	1,409	757	1,003	1,025	225	454	1
2016 Proposed Rates											
Single Rate	$544.36	$518.96	$477.14	$412.92	$671.64	$587.05	$496.78	$480.95	$420.27	$417.91	$239.96
Couple Rate	$1,088.72	$1,037.92	$954.28	$825.84	$1,343.28	$1,174.10	$993.56	$961.90	$840.54	$835.82	$479.92
Adult and Child(ren) Rate	$1,050.61	$1,001.59	$920.88	$796.94	$1,296.27	$1,133.01	$958.79	$928.23	$811.12	$806.57	$463.12
Family Rate	$1,529.65	$1,458.28	$1,340.76	$1,160.31	$1,887.31	$1,649.61	$1,395.95	$1,351.47	$1,180.96	$1,174.33	$674.29

* These are different from the Inforce Contracts on Exhibit 9 because they include groups with 51-100 employees expected to purchase QHPs in 2016.

Total Projected Annual 2016 Premium $397,825,765

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014
Projected Period Allowed Claims for Experience EHB	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76	$539.76
Paid to Allowed Ratio for EHB Portion	83.86%	80.34%	75.89%	66.30%	93.42%	85.64%	75.95%	77.00%	66.38%	67.21%	68.82%	79.82%
Projected Period Paid Claims for Experience EHB	$452.64	$433.61	$409.61	$357.86	$504.22	$462.23	$409.96	$415.60	$358.31	$362.79	$371.45	$430.83
Additional EHB Allowed Claims	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30	$5.30
Additional EHB Paid Claims	$3.92	$2.44	$3.58	$1.11	$4.59	$4.07	$3.58	$2.31	$3.29	$1.96	$0.98	$3.41
Non-System Claims	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32	$3.32
Market Wide Adjustments	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00	-$13.00
Market Adjusted Index Rate	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38	$535.38
Total Paid Claims	$449.51	$428.99	$406.13	$351.92	$501.76	$459.25	$406.49	$410.86	$354.54	$357.69	$365.37	$427.18
Paid to Allowed Ratio	83.96%	80.13%	75.86%	65.73%	93.72%	85.78%	75.92%	76.74%	66.22%	66.81%	68.25%	79.79%

	NON-STANDARD PLANS				STANDARD PLANS								
	GOLD Blue Rewards	Gold Blue Rewards CDHP	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	TOTAL	
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014	
													Membership Split by Tier
Single	1,136	288	2,847	1,391	4,668	3,028	6,665	3,581	1,299	1,756	113	1.00	63.0%
Couple	302	105	740	358	1,707	894	2,182	1,194	376	478	0	2.00	19.6%
Adult and Child(ren)	73	24	106	77	375	197	301	212	59	93	2	1.93	3.6%
Family	315	115	231	305	1,409	757	1,003	1,025	225	454	1	2.81	13.8%

Average Members per Subsriber	1.6487
Average Tier Factor	1.4785
Contract Conversion Factor	1.1151

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

June 30, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/29/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 29, 2015, here are *your questions* and our answers:

1. *We note that the 2014 administrative expenses on a PMPM basis were used to project the 2016 administrative expenses. Please provide quantitative support for the increased projected membership for 2016 compared to 2014, which should exclude membership that is projected to shift to QHPs from other BCBSVT products. How was the increased membership, if any, accounted for in the projected 2016 administrative expenses?*

   The increased membership was not accounted for in projected 2016 administrative expenses. We propose that the following adjustment to the projection is warranted:

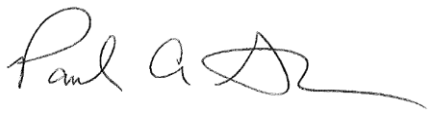
2014 member months in QHP-eligible lines of business	**(A)**	735,603
2016 projected QHP member months exclusive of medium groups	**(B)**	804,600
Additional 2016 projected QHP member months for medium groups	**(C)**	35,568
Total 2016 projected QHP member months	**(D)**=(B)+(C)	840,168
2014 member months for BCBSVT-administered lines of business	**(E)**	2,409,526
2016 projected member months for BCBSVT-administered lines of business	**(F)**=(E)+(B)-(A)	2,478,523
2014 QHP member months as a percentage of total	**(G)**=(A)/(E)	30.53%
2016 projected QHP member months as a percentage of projected total	**(H)**=(D)/(F)	33.90%
Filed 2016 PMPM administrative costs for QHP	**(I)**	$28.83
Projected 2016 PMPM administrative costs for BCBSVT-administered lines	**(J)**	$25.21
Filed 2016 administrative costs allocated to QHP	**(K)**=(I)*(A)	$21,210,446
Projected 2016 administrative costs allocated to BCBSVT-administered lines	**(L)**=(J)*(E)	$60,737,769
Adjusted 2016 administrative costs allocated to QHP	**(M)**=(I)*(H)/(G)	$23,551,095
Adjusted 2016 PMPM administrative costs for QHP	**(N)**=(M)/(D)	$28.03

   This build-up assumed that there are no variable costs associated with additional membership. Previous studies have suggested that variable costs are roughly half of total administrative costs. Using that figure as a proxy, we calculate an impact of $0.40 PMPM on administrative costs, which would lead to a premium decrease of about 0.1%.

2. This question involves confidential and proprietary information and will be provided under separate cover.

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 1, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/30/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated June 30, 2015, here are *your questions* and our answers:

1. *Your Actuarial Memorandum states at page 9 "These groups will either have to offer QHPs or move to a self-funded alternative. We assumed that only groups that would realize lower premium by choosing QHPs would join the risk pool." Considering the risks to small employers of being self-insured and the logistics involved in setting up a self-funded plan, please explain why you assume that all of the lower cost groups would move to self-funded plans, including any support you have for this assumption. Please calculate the impact on rates if all the groups with 51-100 employees choose to offer QHPs rather than choosing a self-funded option.*

   Virtually all groups in the 51-100 category work with a broker. The Vermont broker community has been directing smaller employers toward self-funded options for several years now as a means to maintain closer control over benefit design and to avoid various premium fees and taxes. A large number of smaller employers have selected Cigna's self-insured level-funded product. Various brokers in Vermont have or are pursuing relationships with captives as another alternative for smaller groups with good experience. Both of these self-funded approaches incorporate specific and aggregate stop loss insurance with low attachment points, which greatly reduces the risk to small employers associated with self-insuring. Nearly every fully-insured renewal request over the last twelve months has included a request for a quote on at least one self-funded approach.

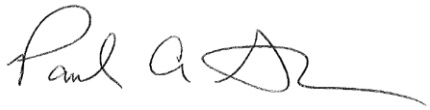
   This prevailing trend is accelerating for the 2016 renewal season in that the broker community is proving to be extremely reluctant to advocate for QHPs as a viable option, even for groups with poor experience. Fear of the "Exchange" plays a role, while control over benefits and avoidance of fees continue to be of concern.

   Given these market dynamics, we find it extremely unlikely that employers in the 51-100 segment will choose to offer QHPs unless it is clearly in their financial benefit to do so.

   As per your request, we have calculated the rate impact if all the groups with 51-100 employees choose to offer QHPs rather than choosing a self-funded option. Use of this assumption would reduce rates by approximately 0.5 percent. Again, it seems quite clear from an understanding of the Vermont large group market that this is not a realistic scenario.

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 8, 2015

Mr. Josh Hammerquist, A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 07/01/2015 Questions re: Blue Cross and Blue Shield of Vermont 2016 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130082559)

Dear Mr. Hammerquist:

In response to your request dated July 1, 2015, here are *your questions* and our answers:

1. *Please provide the estimated impact on the 2014 CTR due to the report that CCIIO released with the actual reinsurance recoveries and risk adjustments for 2014.*
   The previously reported CTR for the QHP business was -2.7 percent. When combined with other Individual and Small Groups lines (as in our response to question 1 of your May 27, 2015 inquiries), the reported CTR was -0.5 percent. Per the CCIIO reports released on June 30, 2015, we expect to receive a total of $25.1 million for Transitional Reinsurance recoveries and $2.7 million for Risk Adjustment transfers. This will reduce our previously reported claims by almost $7.0 million, bringing our CTR for the QHP business to 0.1 percent, and to +1.9 percent for the combined Individual and Small Group lines.

2. *Please discuss what impact the risk adjustment transfer should have on the 2016 premiums. Provide proposed changes, if any, to the 2016 premiums with updated exhibits.*
   The risk adjustment program is one of the premium stabilization programs established by the Affordable Care Act. This program is a permanent program designed to reduce incentives to attract lower risk population by providing payment to issuers that have higher-risk members funded by the issuers with lower-risk populations. The program is a zero-sum game: payments from issuers with lower-risk populations are equal to receipts by issuers with higher-risk populations. These payments are calculated by market, based on enrollment data for QHPs.

   The risk adjustment formula, as shown below, is a complex formula[1] with multiple variables, many of which are both currently unknown and very difficult to estimate.

$$T_i = \left[\frac{PLRS_i \times IDF_i \times GcF_i}{\sum_i (s_i \times PLSR_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GDF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times CGF_i)}\right] \times \bar{P}_s$$

   This formula is calculated for each product (i) offered in the market, across all issuers. The variables are:

   - S: plan's membership share of the total market

[1] https://www.cms.gov/mmrr/Articles/A2014/MMRR2014_004_03_a04.html

- PLSR: plan liability risk score, which represents both the plan's actuarial value and the enrollees health status risk
- IDF: induced demand factor
- GCF: geographic cost factor, which is equal to 1.0 for all VT plans
- AV: metal level actuarial value
- ARF: allowable rating factor, which accounts for age rating, or in VT's case, for the specified tier factors
- Ps: statewide enrollment-weighted average premium

With only two carriers, Vermont was not eligible to participate in risk adjustment modeling offered by Wakely consulting. Therefore, the only information we have about the program is from the CMS report[2] received on June 30, 2015. That report, which demonstrated a net transfer from MVP to BCBSVT of $2.7 million, included all the variables described above for BCBSVT and the market wide information for 2014.

The most reasonable approach to projecting the 2016 transfer is to modify the actual 2014 payment for changes in estimable variables. We assumed that market share, average risk score and distribution of membership among metal levels relative to the market would be unchanged for each carrier in 2016 because no publicly-available information exists that would allow us to make a more refined projection for any of these variables. (Note that we felt it would be inappropriate to rely on information contained within other carriers' 2016 filings.)

The enrollment-weighted average premium is therefore the lone estimable variable. Since BCBSVT currently has the vast majority of the QHP market, we used our actual average premium in 2014 and projected average premium for 2016 to approximate the 2016 risk adjustment receivable we expect to receive, as demonstrated below:

Average 2014 Premium PMPM for QHP	(a)	$407.14
Total Risk Adjustment Transfer for 2014	(b)	$2,670,249
Projected 2016 Premium PMPM for QHP before RA	(c)	$473.51
Projected Risk Adjustment Transfer for 2016	(d) = (c)/(a)x(b)	$3,105,503

The net impact on premiums is a decrease of 0.8 percent compared to the revised premiums provided in our responses dated June 26, 2015. Please see attached *Responses to BCBSVT 2016 QHP Filing Inquiries – 07.01.2015.xlsx* for revised exhibits 5, 6A, 8 and 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.

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf

Index Rate : Experience Period Allowed Claims for EHB	A	$466.72
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of the Change in Small Group definition	$1+b_1$	1.0019
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	0.9911
Impact of insured formerly on Employer coverage	$1+b_4$	1.0000
Impact of new enrollment from prior high risk pool	$1+b_5$	1.0000
Impact of mandated coverage on morbidity	$1+b_6$	1.0000
Impact of Pent-up demand	$1+b_7$	1.0000
Impact of Premium Subsidy	$1+b_8$	1.0000
Changes in pool morbidity	$1+b_9$	0.9720
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	0.9947
Changes in provider networks	$1+c_2$	1.0109
Changes in demographics (age, gender, region, etc.)	$1+c_3$	1.0144
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in network delivery system	$1+c_5$	1.0000
Impact of Selection	$1+c_6$	1.0206
Adjusted Experience Period Allowed Claims for EHB		$468.98
Trend Factors		
Cost Trend	$1+d_1$	1.1115
Utilization Trend	$1+d_2$	1.0355
Projected Period Allowed Claims for Experience EHB		$539.76
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$4.66
Projected Blue Print Payments	e_2	$3.39
Projected ITS Fees	e_3	$1.39
Projected Vaccine Payments	e_4	$2.24
Projected Net cost of Reinsurance	e_5	$0.95
Additional Adjustments for Additional Mandated Benefits		
Projected Allowed Claims for Pediatric Vision	e_6	$0.37
Projected Allowed Claims for Pediatric Dental	e_7	$4.93
Projected Index Rate : Projected Period Expected Allowed Claims	$F = A\prod_{n=1}^{8}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$548.38
Market Wide Adjustments		
Risk Adjustment Payments and Fees	g_1	-$4.45
Transitional Reinsurance Payments and Recoveries	g_2	-$13.18
Vermont Exchange Fees	g_3	$0.00
Market Adjusted Index Rate	$H = F + \sum_{n=1}^{3} g_n$	**$530.75**

	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	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	$530.75	
Benefit Richness Adjustment	1.0157	0.9960	0.9742	0.9370	1.0825	1.0268	0.9739	0.9772	0.9381	0.9400	0.9421	
Paid to Allowed Ratio	84.00%	80.13%	75.82%	65.61%	93.84%	85.83%	75.89%	76.71%	66.10%	66.70%	68.14%	
Changes in Family Tiers	0.9427	0.9575	0.9443	0.9678	0.9920	0.9904	0.9863	0.9385	0.9786	0.9615	0.9749	
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	0.5044	
Expected Claims Cost	**$426.87**	**$405.56**	**$370.24**	**$315.78**	**$534.82**	**$463.29**	**$386.89**	**$373.39**	**$322.11**	**$319.93**	**$167.55**	**$414.33**
Administrative Charges Plan Level Adjustment	1.0712	1.0744	1.0813	1.0956	1.0565	1.0650	1.0778	1.0808	1.0934	1.0946	1.1794	
Taxes and Fees Plan Level Adjustment	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	1.0379	
Contribution to Reserve Plan Level Adjustment	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	1.0204	
Plan Level Adjusted Index Rate	**$484.28**	**$461.51**	**$424.01**	**$366.42**	**$598.42**	**$522.57**	**$441.62**	**$427.43**	**$373.02**	**$370.90**	**$209.28**	**$470.76**
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
Expected Direct Claims PMPM	$440.94	$419.63	$384.30	$329.83	$548.89	$477.36	$400.96	$387.45	$336.17	$333.98	$181.62	$428.39
Transitional Reinsurance Recoveries PMPM	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77	-$12.77
Risk Adjustment Transfer Payment PMPM	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70	-$3.70
Adjustments for Health Care Quality PMPM*	$5.23	$5.21	$5.21	$5.21	$2.17	$2.17	$2.16	$2.17	$2.16	$2.18	$5.20	$2.74
MLR Claims	**$429.70**	**$408.38**	**$373.04**	**$318.58**	**$534.60**	**$463.06**	**$386.66**	**$373.15**	**$321.87**	**$319.70**	**$170.36**	**$414.67**
Premium PMPM	$484.28	$461.51	$424.01	$366.42	$598.42	$522.57	$441.62	$427.43	$373.02	$370.90	$209.28	$470.76
Licensing and regulatory fees	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40	-$2.40
Taxes & Fees PMPM	-$17.34	-$16.53	-$15.18	-$13.12	-$21.43	-$18.72	-$15.82	-$15.31	-$13.36	-$13.28	-$7.49	-$16.86
MLR Premium	**$464.55**	**$442.59**	**$406.43**	**$350.90**	**$574.59**	**$501.46**	**$423.41**	**$409.72**	**$357.26**	**$355.22**	**$199.40**	**$451.51**
Expected Loss Ratio	92.5%	92.3%	91.8%	90.8%	93.0%	92.3%	91.3%	91.1%	90.1%	90.0%	85.4%	91.8%
Projected Membership	3,159	987	5,435	3,498	14,626	8,304	15,586	10,519	3,049	4,731	120	70,014

*Approximately 7.19% of current BCBSVT Administrative Charges are for health care quality plus the Blue Rewards PMPM

	NON-STANDARD PLANS				STANDARD PLANS							
	GOLD	Gold	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards CDHP	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$484.28	$461.51	$424.01	$366.42	$598.42	$522.57	$441.62	$427.43	$373.02	$370.90	$209.28	
PMPM to Single Contract Conversion Factor	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	1.1151	
2016 Proposed Rates												
Single Rate	$540.03	$514.64	$472.82	$408.60	$667.31	$582.73	$492.46	$476.63	$415.96	$413.60	$233.37	
Couple Rate	$1,080.06	$1,029.28	$945.64	$817.20	$1,334.62	$1,165.46	$984.92	$953.26	$831.92	$827.20	$466.74	
Adult and Child(ren) Rate	$1,042.26	$993.26	$912.54	$788.60	$1,287.91	$1,124.67	$950.45	$919.90	$802.80	$798.25	$450.40	
Family Rate	$1,517.48	$1,446.14	$1,328.62	$1,148.17	$1,875.14	$1,637.47	$1,383.81	$1,339.33	$1,168.85	$1,162.22	$655.77	$377,497,083.96
2015 Approved Rates												
Single Rate	$493.87		$428.14	$360.49	$624.18	$541.75	$465.61	$436.20	$395.78	$384.02	$228.24	
Couple Rate	$987.74		$856.28	$720.98	$1,248.36	$1,083.50	$931.22	$872.40	$791.56	$768.04	$456.48	
Adult and Child(ren) Rate	$953.17		$826.31	$695.75	$1,204.67	$1,045.58	$898.63	$841.87	$763.86	$741.16	$440.50	
Family Rate	$1,387.77		$1,203.07	$1,012.98	$1,753.95	$1,522.32	$1,308.36	$1,225.72	$1,112.14	$1,079.10	$641.35	$350,712,794.16
2015 Proposed Rate Increases												
Single Rate	9.3%		10.4%	13.3%	6.9%	7.6%	5.8%	9.3%	5.1%	7.7%	2.2%	
Couple Rate	9.3%		10.4%	13.3%	6.9%	7.6%	5.8%	9.3%	5.1%	7.7%	2.2%	
Adult and Child(ren) Rate	9.3%		10.4%	13.3%	6.9%	7.6%	5.8%	9.3%	5.1%	7.7%	2.2%	
Family Rate	9.3%		10.4%	13.3%	6.9%	7.6%	5.8%	9.3%	5.1%	7.7%	2.2%	**7.6%**
Inforce Contracts												
Single Rate	1,091		2,819	1,376	4,470	2,898	6,665	3,511	1,253	1,709	113	
Couple Rate	286		730	352	1,634	847	2,182	1,168	359	461	0	
Adult and Child(ren) Rate	69		104	76	358	186	301	206	55	89	2	
Family Rate	297		220	299	1,330	705	1,003	997	207	435	1	