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July 11, 2017

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

Re: Blue Cross and Blue Shield of Vermont 2018 Exchange Filing (SERFF # BCVT-131037743)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2018 Exchange Filing for Blue Cross and Blue Shield of Vermont (BCBSVT) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides individual and small group coverage to be sold on Vermont Health Connect (VHC). This filing develops premiums for BCBSVT's Qualified Health Plans (QHPs) to be offered on VHC, beginning January 1, 2018.

2. This filing addresses BCBSVT individual members and small groups. There are approximately 70,000 members currently enrolled.

3. The overall impact of this filing is a proposed average 12.7% or $62.57 per member per month (PMPM) increase in premiums. This average increase is broken down by metal level in the table below. The second table illustrates the final premium rate changes after last year's 2017 VHC filing.

2018 Proposed Rate Changes

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	5.8%	$13.92	0.3%
Bronze	14.4%	$57.21	13.5%
Silver	12.0%	$57.51	42.3%
Gold	12.8%	$63.40	25.4%
Platinum	13.0%	$77.83	18.5%
Overall	***12.7%***	***$62.57***	***100.0%***

2017 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	5.4%	$12.29	0.2%
Bronze	8.6%	$31.38	15.3%
Silver	8.5%	$37.19	42.6%
Gold	7.3%	$34.00	22.7%
Platinum	4.6%	$26.43	19.2%
Overall	***7.3%***	***$33.46***	***100.0%***

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the methodology used to calculate the proposed 2018 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees.

The changes to the morbidity assumptions and the population based factors are calculated using the approximately 70,000 members who have previously enrolled in a BCBSVT QHP product.

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

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

For medical trend, the total allowed amount is 4.7%. The unit cost trend for medical trend is projected to be 2.6% based on observations of recent contracting and provider budgetary changes. The utilization and intensity trend is projected to be 2.0%.

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

Exhibit 6A demonstrated the development of the expected claims and premiums which results in a loss ratio of 87.5%. Exhibit 8 and a response to an inquiry shows the proposed MLR is 91.1%, which exceeds the minimum requirement of 80.0%.

Exhibit 9 showed the proposed premiums, the requested rate increase by plan, and the calculation of the average rate increase of 12.7%.

L&E Analysis

The average proposed increase of 12.7% to the 2017 premiums is attributed to several factors, including trend, updated membership assumptions, and changes to state and federal programs, as illustrated in the table below. To create a consistent comparison for both companies filing VHC products, L&E categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component[1]	Percentage Change[2]	PMPM Change[3]
1. 2016 Actual/Projected Claims Experience	1.1%	$5.67
2. Difference in trend from 2016 to 2017	0.0%	-$0.14
3. Trend from 2017 to 2018	5.4%	$26.58
4. Changes to Population Morbidity Adjustment	0.7%	$3.73
5. Changes to Other Factor	2.6%	$13.96
6. Changes to Manual Rating Adjustment	0.0%	$0.00
7. Changes to Risk Adjustment	0.3%	$1.50
8. Changes in Administrative Costs	-0.4%	-$2.35
9. Changes in Contribution to Reserves	-0.1%	-$0.36
10. Changes in Taxes & Fees	3.2%	$17.48
11. Changes in Single Contract Conversion Factor	0.9%	$4.86
12. Changes in Actuarial Value[4]	-1.5%	-$8.36

1. *2016 Actual/Projected Claims Experience:* The actual 2016 claim experience was 1.1% higher than the projected 2016 costs. For the purposes of this report, L&E allocated two year trends evenly between both years. Since this change is driven by actual experience, this rate component appears to be reasonable and appropriate.

2. *Difference in trend from 2016 to 2017:* The assumed annual trend of 5.4% from 2016 to 2017 in the 2018 URRT is approximately equal to the assumed trend from 2016 to 2017 in the prior URRT. The assumed 5.4% trend assumption is discussed further in the next section.

3. *Trend from 2017 to 2018:* The Company projected an allowed medical trend of 4.7% and an allowed pharmacy trend of 8.9%. The combined allowed trend is 5.4%.

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

[2] The percentage changes are multiplicative and may not sum to the requested 12.7% premium increase.

[3] The PMPM changes may not add up to the overall average PMPM of $62.57 quoted on Page 1 because the PMPM changes seen in this table incorporate the Single Contract Conversion Factor change.

[4] Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), and membership shifts.

Cost Category	Unit Cost Trend	Utilization / Intensity Trend	Total Trend
Medical	2.6%	2.0%	4.7%
Pharmacy	8.4%	0.5%	8.9%
Total	***3.6%***	***1.7%***	***5.4%***

- *Medical Trend:* The Company is requesting an allowed medical trend of 4.7%, broken down into 2.6% for unit cost changes and 2.0% for utilization and intensity changes.

Unit Cost Trend
For the BCBSVT service area, the Company analyzed the changes to provider contracts. Estimates for 2018 unit cost trends use the most recent round of contract negotiations as a starting point.

Approximately 55% of medical costs are related to facilities impacted by the GMCB's Hospital Budget Review process. Adjustments were made to reflect ordered increases for several providers based on reviews of the actual results from FY2016 budgets[5]. For the ordered increases that went into effect in late 2016 and early 2017, L&E reviewed each facility's increases and consider them to be reasonable and appropriate.[6]

For providers outside the BCBSVT service area, the Company used the Fall 2016 Blue Trend Survey.

The analysis resulted in a unit cost trend of 2.6%, which is lower than recent filed unit cost trends of 5.3% in 2016 and 3.3% in 2017.

Based on L&E's preliminary and limited review of the proposed hospital budget submissions, significant investments are expected to reduce commercial rates in 2018 for facilities and providers that are impacted by the GMCB's Hospital Budget Review. L&E reviewed these increases for each facility and consider them to be reasonable and appropriate.

Utilization Trend and Intensity
The Company performed regression analysis over multiple historical periods and year over year analysis for the portion of trend related to the utilization and intensity of services.

The Company normalized the allowed costs for the past 48 months to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. The December 2015 claims were adjusted since inpatient claims were unexpectedly low. The Company was concerned that this month was impacting the trend analysis. This adjustment has a minor impact on the regressions shown below. The trend was then analyzed by using exponential regression over three different time periods and by using the calendar year 2016 PMPM over the calendar year 2015 PMPM. The Company determined that using the calendar year 2016 PMPM over the

[5] http://gmcboard.vermont.gov/content/fy-2016-actuals

[6] Due to timing and other confidential differences, the 2.2% unit cost trend for facilities impacted by the GMCB's Hospital Budget Review from 2016 to 2017 on page 9 of BCBSVT's Actuarial Memorandum does not match the total increase of 1.8% ordered by the GMCB for Fiscal Year 2017.

calendar year 2015 PMPM produced more appropriate results. The calculated trend was 2.9% before the adjustment for the December 2015 claims.

Time Period	Utilization Trend
12 Month Regression	10.6%
24 Month Regression	4.4%
36 Month Regression	3.1%
Year over Year	2.3%

Additionally, the year over year trend of 2.3% was adjusted to remove the impact of changes in induced utilization, population aging, and the impact of the Fraud, Waste and Abuse (FWA) program that began in 2014. After these adjustments, the utilization trend was reduced to 2.0%.

Due to the increased utilization trend compared to prior filings, L&E requested and analyzed more recent claims experience that became available after the initial filing submission. The following table summarizes L&E's analysis based on claims paid through April 2017.

	Utilization Trend Incurred Through			
Time Period	Oct 2016	Dec 2016[7]	Feb 2017	Average
12 Month Regression	-1.7%	10.0%	5.2%	**4.5%**
24 Month Regression	1.1%	4.2%	2.3%	**2.5%**
36 Month Regression	0.8%	3.1%	2.7%	**2.2%**
Year over Year	1.8%	2.2%	1.8%	**1.9%**

The additional utilization trends that L&E analyzed demonstrate that the utilization trends have increased relative to recently approved utilization trends, which is consistent with the Company's analysis. The Company's assumed 2.0% utilization trend appears reasonable and appropriate.

The Company noted that the main drivers of the increased utilization are:

- *PMPM costs for prescription drugs administered in the hospital or doctor's office.*

  These costs, which are subject to the medical benefit rather than the retail pharmacy benefit, increased by over 16% from 2015 to 2016. The majority of this increase was related to anti-cancer medications.

- *The frequency of preventive visits.*

  These visits are up about 1% year over year and there has been a 5% increase in the number of colonoscopies. The increase in appropriate primary care and

[7] The December 2017 regression analysis differs slightly from the Company's calculations, because this regression includes claims paid through April 2017, but the Company's original filing only had claims paid through February 2017 due to the timing of the filing.

preventive care utilization may ultimately lead to possible long-term cost reductions.

- *The increased intensity of inpatient services.*

  After several years of decreases, inpatient costs, after being normalized for increases to reimbursement schedules, are modestly on the rise. That is, while the number of inpatient days has decreased, there has been a significant increase in intensity resulting in a 0.7% utilization trend from 2015 to 2016.

Total Allowed Medical Trend

Combining the Company's proposed unit cost trend of 2.6% with the utilization trend of 2.0% results in an allowed medical trend of 4.7%. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market.

L&E's best estimate of the total allowed medical trend is equal to the Company's estimate of 4.7%, and L&E estimates that the actual results could ultimately range from 2.3% to 7.1%. However, it should be noted that each of the results in the range are not equally likely. That is, the trends on the low and high end of the range are not as likely to occur as the trends in the middle of the range. [8]

L&E considers the total allowed medical trend to be reasonable and appropriate.

- *Pharmacy Trend:* The Company is requesting an allowed pharmacy trend of 8.9%.

  Multiple methods can be used to determine the reasonableness of these trend assumptions. A typical approach analyzes the historical pharmacy claims costs on a PMPM basis; however, this does not account for other factors such as the slowing growth of the generic dispensing rate, drugs losing their patents in the projection period, as well as the adjustments to the future contract terms with the Company's Pharmacy Benefit Manager.

  The Company's approach utilized a complex analysis to account for the ever-changing pharmacy environment, including:
  - Adjusted historical experience for changes in benefits and aging population;
  - Cost and utilization trends for Brands, Generics, and Specialty drugs;
  - Generic dispensing rates; and
  - Specialty drugs with very high costs, including hepatitis C, PCSK9 and cystic fibrosis drugs.

[8] For example, the probability that the actual trend will be centered around the best estimate (between 4.6% and 4.8%) is 50% higher than being near the low end of the range (between 2.8% and 3.0%).

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	4.6%	1.4%	6.0%
Brand	12.4%	-6.3%	5.3%
Specialty	-	-	18.1%
Total	8.4%	0.5%	8.9%

L&E mirrored the Company's approach to estimate the pharmacy trends. L&E's best estimate of the total allowed pharmacy trend is equal to the Company's estimate of 8.9%, and L&E estimates that the actual results could ultimately range from 7.0% to 10.8%. However, it should be noted that each of the results in the range are not equally likely. That is, the trends on the low and high end of the range are not as likely to occur as the trends in the middle of the range.[9]

L&E considers the Company's requested allowed pharmacy trend to be reasonable and appropriate.

4. *Change to Population Morbidity Adjustment:* The Company is estimating that the projected 2018 population morbidity will be 0.2% higher than the experience period morbidity. Since the Company assumed morbidity improvement in the 2017 filing, the worsening of the morbidity assumption produces a 0.7% rate increase.

   The 0.2% increase from the 2016 base period to the 2018 projected period is itemized below:

   - *Changes in pool morbidity*: -0.1%

     The PMPM claims in the base period experience for members who did not voluntarily terminate coverage prior to the end of calendar year 2016 were 0.1% lower than the PMPM claims for all members in the base period experience. The Company reduced the projected 2018 claims to account for this healthier population that will continue to be covered in 2017.

   - *Impact of the Health Status of the New Members*: +0.1%

     In addition to the continuing population, the Company estimated the health status of the new members who enrolled in 2017. Since claims data was not available for these members, the Company assumed they would have the same morbidity as members who enrolled in the same line of business.

[9] For example, the probability that the actual trend will be centered around the best estimate (between 8.8% and 9.0%) is 50% higher than being near the low end of the range (between 7.0% and 7.2%).

- *Change in the Definition of Small Group:* -0.2%

  The Company adjusted the 2016 single risk pool claims for the groups that enrolled as a result of the change in the definition of small group to include groups with 51-100 employees.

- *Impact of different benefit plans:* +0.4%

  The Company estimated the change in the average utilization of services due to the change in the average cost sharing for the projected products compared to the experience period products. This accounts for an anticipated increase in induced utilization because members are expected to choose plans with lower cost sharing in 2018 compared to 2016.

L&E considers the morbidity adjustments that the Company made to be reasonable and appropriate.

5. *Change to Other Factor:* The Company made other various adjustments for changes in provider networks, demographics, impact of plan selection, and other non-system claims. The assumption change from the 2017 filing produces a 2.6% rate increase.

   The adjustment from the 2016 experience period to the 2018 projected period is an increase of 2.8%, which has been itemized below:

   - *Changes in demographics:* +1.0%

     The change in demographics represents the change in the average age-gender factors between the experience period membership and the projected membership. The impact of the aging population is an increase of 1.0%.

   - *Changes in Pharmacy Contract: -0.3%*

     The new pharmacy contract negotiated with the Company's Pharmacy Benefit Manager reduces the premium by 0.3%.

   - *Impact of selection:* +2.0%

     Healthy members generally select low cost plans, while less healthy members tend to choose plans with the richest benefits. The Affordable Care Act does not allow carriers to reflect selection at the plan level; therefore, the Company has included the impact of selection equally to all plans.

- *Non-System Claims:* +0.1%

  This includes pharmacy rebates, Blueprint payments, ITS fees, Vaccine payments, and net cost of reinsurance.

- *VHC Adjustment:* -0.1%

  VHC adjusts membership retroactively which understates the experience period claims PMPM. Since the company projects the retroactive membership adjustments to improve for 2018, this results in a 0.1% decrease to the projected claims.

L&E reviewed the Company's supporting documentation for these adjustments and L&E considers the Change to the Other Factor to be reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* The Company did not use a manual rate because the 835,621 member months of experience was considered fully credible. L&E considers this to be reasonable and appropriate.

7. *Changes to Risk Adjustment:* In the initial filing, BCBSVT projected the 2018 risk adjustment based on the most recent data available. The most recent data available was the interim report[10] published by CMS in early April and a confirmation of the number of months each carrier had submitted for the interim report. The interim report was based on incomplete data, which meant that BCBSVT had to adjust the results to reflect their anticipation of the projected final results, which were released in the final report[11] on June 30th.

   BCBSVT observed that MVP's risk score increased from the 2015 interim risk adjustment report to the final 2015 risk adjustment report relative to BCBSVT's risk score, which the Company attributed to MVP submitting a supplemental diagnosis file. Beginning in 2016, BCBSBVT started reviewing charts and ensuring that all diagnoses were included either in the claims or supplemental file. BCBSVT assumed that their supplemental diagnosis results would converge toward MVP's over time as their coding initiatives improved. The initial projection resulted in an estimated 2018 risk adjustment receivable of $113,132 or $0.13 PMPM.

   BCBSVT revised their calculation using the Final 2016 Risk Adjustment report that showed BCBSVT would receive $300,153 from the risk adjustment program, which was approximately $500,000 less than BCBSVT's initial 2016 estimate. Additionally, BCBSVT adjusted their calculation due to The Final Notice of Benefit and Payment Parameters for 2018[12] published by HHS which stated that the 2018 risk adjustment payments will be reduced by 14% to prevent risk adjusting administrative costs. Based on these updates, BCBSVT's revised estimate assumed that

[10] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2016_5CR_033117.pdf

[11] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[12] https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html

they would pay $853,414 or $1.02 PMPM for 2018, which would increase the rate increase from 12.7% to 12.9%.

L&E believes that it is unreasonable to assume that MVP's coding initiatives would continue to exceed BCBSVT's in future years. In particular, L&E believes that MVP's coding initiatives will not increase their risk score relative to BCBSVT risk score from the 2016 to 2018 final risk adjustment report. Therefore, L&E recommends revising BCBSVT's calculation by removing the coding growth for both companies.

This adjustment would produce an estimated 2018 risk adjustment receivable of $334,434 or $0.40 PMPM compared to the originally filed receivable of $0.13 PMPM.

8. *Changes in Administrative Costs:* The PMPM administrative costs are projected to increase by an annual rate of 2.4%. Since claims are projected to increase at a higher rate, the administrative costs are projected to decrease as a percentage of overall premiums by 0.4%.

   On a PMPM basis, the adjustment from 2016 to 2018 results in a PMPM increase of $1.32 which is 2.0%[13] and is itemized below:

   - Non-Recurring Expenses: -0.5% in administrative costs
     The Company removed any expenses incurred due to one-time, non-recurring events.

   - Trend: +2.4% in administrative costs
     The Company increased the base administrative costs for trend to project the 2018 administrative costs, using an annualized trend of 2.4%. This trend accounts for a 3% increase to personnel costs which make up 81.5% of administrative costs, while other operating costs are expected to remain flat.

   BCBSVT's administrative costs on both a PMPM and percentage of premium basis falls in the bottom tenth of BCBS plans nationwide based on a review of the 2016 NAIC Annual Statements. In other words, over 90% of the BCBS plans nationwide had higher administrative costs than BCBSVT in 2016.

   L&E considers the expense assumption to be reasonable and appropriate.

9. *Changes in Contribution to Reserves (CTR):* The Company's assumed CTR is 2.0% which is unchanged from last year's rate filing. The Company reduced the provision for uncollected premiums from 0.30% to 0.25%, which results in a 0.1% decrease in premiums.

   The Company believes that CTR should be managed to an adequate long-term level, rather than fluctuating significantly from year to year with changes in membership and health care cost trend. The Company notes that items, such as, regulatory action, membership growth, and unforeseen events, such as a flu epidemic or new technology, could create a one-time shock to capital and surplus levels.

[13] The percentage changes are multiplicative and may not sum to the 2.0% increase.

The Company provided support demonstrating that a 3.2% CTR is needed to maintain Risk Based Capital (RBC) levels in light of medical trend.

Even though the Company believes that additional CTR is required for 2018, the Company continued to request a CTR of 2.0%.

The table below shows the actual historical CTR and the expected CTR based on the Company's forecasting model, which incorporates final premiums including amendments ordered by the Board.

Year	GMCB Approved	Company Expected	Company Actual
2012	1.0%	0.9%	-3.4%
2013	0.8%	-2.0%	-2.0%
2014	0.5%	-1.6%[14]	2.8%
2015	1.0%	1.0%	-1.3%
2016	1.0%	0.8%	-5.1%[15]
Average	**0.9%**	**-0.5%**	**-1.8%**

L&E believes the proposed CTR is reasonable and allows the Company to offset the impact of trend and other potential adverse events with appropriate consideration given to maintaining the CTR at an adequate long-term level.

BCBSVT's target RBC range of 500% to 700% falls in the bottom half of actual RBCs for BCBS plans nationwide from 2012 to 2016 based on a review of the 2016 NAIC Annual Statements. In other words, over half of the BCBS plans nationwide have actual RBCs higher than BCBSVT's target RBC range.

While L&E does not recommend any changes to the CTR, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

Due to the required grace period under the Affordable Care Act, the Company included a risk margin for bad debt of 0.2% to pay for the claims for members for which premiums are never collected. The average amount of non-paid premiums due to the grace period over the last three years was 0.2%.

10. *Changes in Taxes & Fees:* The total taxes and fees increased from 0.9% in 2017 to 3.8% of premium due to the Federal Insurer Fee being reinstated for 2018. The 3.8% tax is made up of the Health Care Claims Tax, the Patient Centered Outcomes Research Institute Fee and the Federal Insurer Fee. The Company used the percentage of the total fee that they paid in 2016 along with the

[14] The expected 2014 CTR includes the impact of the decision to allow individuals and small groups to continue in their 2013 plan through the first quarter of 2014.

[15] The actual results include the impacts of the Transitional Reinsurance and Risk Adjustment program in the year they were incurred, not in the year when they were booked.

total insurer fee that the federal government will collect in 2018 to estimate the impact of the Insurer Fee in 2018. The taxes and fees increases the premium by 3.2%. This estimate is considered reasonable and appropriate

11. *Changes in Single Contract Conversion Factor:* A conversion factor[16] adjustment is essential to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single conversion factor increased about 0.9% from last year's assumption due to the Company using a more precise calculation by plan, rather than using an average for all plans. This is considered reasonable and appropriate.

12. *Changes in Actuarial Value:* This reflects other Pricing AV changes such as changes in Metal AVs of plans and changes in projected enrollment among plans. The assumed 2018 distribution is primarily based on the 2017 distribution by plan, with moderate projected membership shifts due to the introduction of new plans and the expectation that members will continue to buy less expensive plans due to rate increases. This results in a 1.5% decrease to the premiums. Since the 2018 plan distribution is primarily based on actual 2017 Exchange enrollment, L&E finds this to be reasonable and appropriate.

Cost Sharing Reduction (CSR) – Defunding Scenarios

CSRs are "extra savings" for families who earn less than 250% of the Federal Poverty Level. These savings, which are fully subsidized by the federal government, help people with their out-of-pocket costs like deductibles, coinsurance, and copayments.

Per a current legal challenge at the federal level, it is possible that these federal subsidies will not be available for 2018. If this were to occur, BCBSVT would be responsible for funding the previously subsidized additional benefits; however, the proposed premiums would be materially insufficient to offset the shortfall created by the revocation of the federal subsidies.

If the CSR is ultimately defunded for 2018, L&E recommends that the Board should permit carriers to increase their rates to compensate. This could be accomplished in either of two methods.

1. Premiums could be increased on Silver plans only, as only Silver plans are eligible for CSR. This approach would create a situation where Silver plans are nearly as expensive as gold plans. However, it should be noted that this approach would increase After Tax Premium Credits, since APTCs are based on the premium for the second lowest cost Silver plan. Under this approach, it would be expected that non-CSR eligible persons who currently purchase Silver plans, would change to either a Bronze or Gold plan due to the increased cost of the Silver plans. While this approach would maximize the subsidies that are provided by the federal government, it would likely cause a significant disruption to the Vermont small employer market since it is merged with the individual market.

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

2. Increase premiums for all plans which would maintain an appropriate benefit relativity between the metal tiers. This approach would likely produce rates that are less disruptive to the entire individual and small group market, but would result in lower subsidies provided by the federal government.

At the time of this report, BCBSVT was reviewing the impact of the first method. BCBSVT provided their analysis of the impact of the second method, which would increase BCBSVT's rates for all plans by 1.9%. L&E considers this reasonable.

Should the CSR program ultimately be defunded, L&E believes the Board should consult with the carriers and other stakeholders to arrive at a decision regarding the proper method for the market as a whole. Regardless of the approach selected, L&E recommends that the Board requires that all market participants to use the same method. Otherwise, it is anticipated that significant volatility and instability would be introduced the marketplace.

Recommendation

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

- *Trend from 2017 to 2018*: This report considers the information available to the carriers as of the time of this report. L&E recommends that the Board consider the impact of 2018 hospital budgets on unit cost trends once the 2018 budgets become publicly available.

- *Changes to Risk Adjustment*: Revise BCBSVT's projected risk adjustment calculation to remove the coding growth for both companies. This results in a decrease in rates of 0.3% from the Company's modified proposed rate increase of 12.9%.

After the modifications, the anticipated overall rate increase will reduce from the Company's modified 12.9% increase to approximately 12.6%.

Metal Tier	BCBSVT Original Proposed Rate Change	BCBSVT Modified Proposed Rate Change	L&E Modified Rate Change	Percent of Membership
Catastrophic	5.8%	6.1%	5.8%	0.3%
Bronze	14.4%	14.7%	14.3%	13.5%
Silver	12.0%	12.3%	12.0%	42.3%
Gold	12.8%	13.0%	12.7%	25.4%
Platinum	13.0%	13.2%	12.9%	18.5%
Overall	***12.7%***	***12.9%***	***12.6%***	***100.0%***

Sincerely,

Josh Hammerquist, FSA, MAAA
Vice President & Consulting Actuary
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David M. Dillon, FSA, MAAA
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Jacqueline B. Lee, FSA, MAAA
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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[17], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[18], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

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

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

Identification of Actuarial Documents
The date of this document is July 11, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 11, 2017.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

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

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

- The findings of this report are enclosed herein.

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

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

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

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

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