LEWIS & ELLIS
Actuaries and Consultants
700 Central Expressway South
Suite 550
Allen, TX 75013
972-850-0850
lewisellis.com

July 10, 2018

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05620

Re: Blue Cross and Blue Shield of Vermont 2019 Individual and Small Group Rate Filing (SERFF # BCVT-131497882)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2019 Individual and Small Group 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 coverage, small and large group coverage to employers, and Medicare Supplement coverage in Vermont. This filing develops premiums for BCBSVT's Qualified Health Plans (QHPs) to be offered on Vermont Health Connect (VHC), beginning January 1, 2019.

2. This filing addresses BCBSVT individual members and small groups. There are approximately 54,000 members enrolled in plans affected by this filing.

3. Beginning in 2019, Vermont will offer "Silver Reflective" plans in addition to the Silver plans offered on Vermont Health Connect. As required by law, VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters at certain income levels who will pay a limited premium as a percentage of their income. So, while the VHC premiums for Silver plans are increasing substantially, most or all members in these plans in 2019 will not have to pay out of pocket for the rate increase described below due to an increase in the federal premium subsidies.

4. The overall impact of this filing is a proposed average 7.5% or $40.41 per member per month (PMPM) increase in premiums, including the large rate increase for VHC Silver plans ("Silver Loaded"). 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 2018 VHC filing.

2019 Proposed Rate Changes

Plan Type	Percent Change	PMPM Change	Percent of Membership
Catastrophic	1.2%	$3.07	0.5%
Bronze	4.9%	$21.52	12.7%
Silver Loaded	16.0%	$86.59	20.6%
Silver Reflective	4.0%	$20.01	20.8%
Gold	5.0%	$27.11	26.1%
Platinum	6.8%	$44.56	19.3%
Overall	***7.5%***	***$40.41***	***100.0%***

2018 Proposed and Approved Rate Changes

Plan	Proposed Percent Change	Approved Percent Change	Approved PMPM Change	Percent of Membership
Catastrophic	5.8%	2.7%	$6.42	0.3%
Bronze	14.4%	10.8%	$43.16	13.5%
Silver	12.0%	8.6%	$40.94	42.3%
Gold	12.8%	9.3%	$46.10	25.4%
Platinum	13.0%	9.5%	$56.78	18.5%
Overall	***12.7%***	***9.2%***	***$45.36***	***100.0%***

Standard of Review

Pursuant to 8 V.S.A. § 4062, 18 V.S.A. § 9375(6), and 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 2019 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 54,000 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 non-specialty drugs are projected and then split into seven categories to separately model unit cost by category. Specialty drugs are analyzed on a PMPM basis due to the relative infrequency and high cost nature of these drugs.

For medical trend, the total allowed amount is 4.1%. The unit cost trend for medical trend is projected to be 2.7% based on observations of recent contracting and provider budgetary changes. The utilization and intensity trend is projected to be 2.0% for 2018 and 0.9% for 2019 which is an average of 1.4% annually.

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 traditional loss ratio of 90.2%. Exhibit 8 and a response to an inquiry shows the proposed federal MLR is 91.8%, 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 proposed rate increase of 7.5%.

L&E Analysis

The average proposed increase of 7.5% over the 2018 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
1. 2017 Actual/Projected Claims Experience	-0.5%	-$2.71
2. Difference in trend from 2017 to 2018	1.2%	$6.69
3. Trend from 2018 to 2019	5.9%	$31.89
4. Changes to Population Morbidity Adjustment	2.9%	$16.69
5. Changes to Other Factor	0.4%	$2.29
6. Changes to Manual Rating Adjustment	0.0%	$0.00
7. Changes to Risk Adjustment	-2.5%	-$14.62
8. Changes in Administrative Costs	0.2%	$1.35
9. Changes in Contribution to Reserves	1.0%	$5.73
10. Changes in Taxes & Fees	-2.8%	-$16.21
11. Changes in Single Contract Conversion Factor	0.0%	$0.00
12. Changes in Actuarial Value[3]	1.6%	$9.31
Total Rate Change	7.5%	$40.41

1. *2017 Actual/Projected Claims Experience:* The actual 2017 claim experience was 0.5% lower than the projected 2017 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 2017 to 2018:* The assumed annual trend of 5.9% from 2017 to 2018 in the 2019 URRT is 1.2% higher than the assumed trend from 2017 to 2018 in the prior URRT. The assumed 5.9% trend assumption is discussed further in the next section.

3. *Trend from 2018 to 2019:* The Company projected an allowed medical trend of 4.1% and an allowed pharmacy trend of 13.3%. The combined allowed trend is 5.9%.

[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 7.5% premium increase.

[3] Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), membership shifts, and Cost Sharing Reduction (CSR) defunding.

Cost Category	Unit Cost Trend	Utilization / Intensity Trend	Total Trend
Medical	2.7%	1.4%	4.1%
Pharmacy	11.0%	2.1%	13.3%
Total	***4.2%***	***1.6%***	***5.9%***

- *Medical Trend:* The Company is requesting an allowed medical trend of 4.1%, broken down into 2.7% for unit cost changes and 1.4% for utilization and intensity changes.

Unit Cost Trend

For the BCBSVT service area, the Company analyzed the changes to provider contracts. Estimates for the 2019 unit cost trends use the most recent round of contract negotiations as a starting point.

Approximately 53% of medical costs are related to facilities impacted by the GMCB's Hospital Budget Review process. Adjustments were made to reflect hospitals that publicly announced different intended commercial rate increases[4]. For the ordered increases that went into effect in late 2017 and early 2018, L&E reviewed each facility's increases reported in this filing and consider them to be reasonable and appropriate.[5]

For providers outside the BCBSVT service area, the Company used the Fall 2017 Blue Trend Survey.

GMCB HOSPITAL BUDGET REVIEW

The 2.7% unit cost medical trend includes 2.2% for facilities and providers that are impacted by the GMCB's Hospital Budget Review and 3.2% for other facilities and providers that are not subject to the Hospital Budget Review. If all facilities and providers were subject to the 2.2% trend, then the overall rate increase would be reduced by 0.7%.

The overall increase for hospital-based charges differs from the Board's Vermont-wide projections for several reasons:

- BCBSVT's costs are distributed slightly differently from the entire commercial market producing a different average across all facilities.
- The medical services covered by these plans are not all provided by hospitals subject to the GMCB hospital budgeting process.
- The hospital budgets are not effective on a calendar year basis, while the rates are being set for calendar year 2019.

[4] http://gmcboard.vermont.gov/sites/gmcb/files/A17N99%20NARR.pdf

[5] Due to timing and other considerations, the unit cost trend for facilities impacted by the GMCB's Hospital Budget Review from 2017 to 2018 will not match the Board's previously ordered increases.

BCBSVT's analysis resulted in a unit cost trend of 2.7%, which is lower than recent filed unit cost trends of 5.3% in 2016 and 3.3% in 2017 and similar to the 2.6% filed in 2018.

L&E reviewed the ordered increases for 2018, as well as the hospitals that publicly announced in early 2018 different intended commercial rate increases for 2019, for each facility and consider them to be reasonable and appropriate.

Utilization Trend and Intensity

The Company normalized the allowed costs to remove the impact of unit cost changes, isolating the change in utilization and intensity of services. The data was also 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.

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 believes that their standard methodologies overstate the utilization trend. Therefore, they removed claims for members who exceeded $250,000 in allowed medical claims in a calendar year.

Trend Analysis	Standard Methodology	Excluding Claims above $250,000
Exponential Regression – 24 Months	2.2%	2.0%
Exponential Regression – 36 Months	2.8%	2.3%
Year-Over-Year	1.5%	1.8%
Average	**2.2%**	**2.0%**

In addition to their standard historical approaches, the Company performed time series analyses using the data that excludes the large claims. The Company used six different times series methods and calculated each of them over 24 and 36 months of historical data. The results range from a minimum utilization trend of -0.4% to a maximum of 4.2%.

Trend Analysis	24 Months	36 Months	Average
Holt-Winters' Multiplicative	1.5%	2.1%	1.8%
Damped Trend Seasonal Multiplicative	1.9%	2.2%	2.1%
Holt-Winters' Additive	2.0%	2.2%	2.1%
Damped Trend Seasonal Additive	2.1%	2.2%	2.1%
Damped Trend Non-Seasonal	4.2%	-0.4%	1.9%
Double Exponential Smoothing	4.2%	-0.4%	1.9%
Average	**2.6%**	**1.3%**	**2.0%**

The Company selected a 2.0% utilization trend, which is in line with the exponential regression, the year-over-year analysis and the times series analysis.

L&E independently calculated a best estimate for the projected trend of 2.0%, and L&E's estimated range for the utilization trend is 1.6% to 2.4%. The Company's projected 2.0% utilization trend is equal to our best estimate. Since the Company's utilization is within L&E's range, L&E considers it be reasonable and appropriate.

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

- *Pharmaceuticals dispensed in a medical setting.*
  These costs are up over 14.3% year-over-year and driven by high-cost cancer, rheumatoid arthritis and immunodeficiency medications. Similar to specialty drugs, innovation and utilization for these expensive therapies is not expected to subside in the near future.

- *The frequency of office and preventive visits.*
  Office and preventive visits are up 3.6% and 7.5% respectively from 2015 to 2017. The increase in appropriate primary care and preventive care utilization may ultimately lead to possible long-term cost reductions.

- *The increased use of diagnostic services, including outpatient labs, x-rays and high-dollar imaging.*
  Diagnostic services were up nearly seven percent from 2016 to 2017, which is likely driven by the increase in office and preventive visits.

Cost Containment Strategy
The Company works with their network providers and OneCare Vermont to use the results of collaborative clinical research focusing on reducing the overall medical costs. The Company is targeting a 4% reduction in inpatient admissions by reducing readmissions and a 5% reduction in emergency room visits. Both of these targets are expected to be achieved through enhanced collaborative care coordination support to members with a goal of redirecting care to primary care providers where appropriate.

The Company's new methods seek to identify emerging risk patients before they become high cost and complex cases.

The Company's current claims system provides notification of events usually 60 days after an event has occurred. By using new technology, the Company will be receiving real time data on admissions, discharges and transfers from an external vendor who is able to interface with state Health Information Exchange (HIE) and hospital systems throughout the country. The vendor is located in the Northeast and has connections with all VT hospitals as well as most hospitals in the Boston area, NH, NY, and Maine. These real-time notifications also contain clinical information and algorithms such as the New York University classification system for avoidable emergency room visits allowing targeting of patients in need of care management support and education about alternative sites of care such as their primary care, urgent care and the Company's new telehealth capabilities.

The Company estimates that the utilization in 2019 will be 1.1% lower as a result of these cost containment strategies. The utilization assumption is 2.0% for 2018 and 0.9% for 2019 which is an average of 1.4% each year. The reduction in inpatient admissions and emergency room visits are expected to be replaced with lower cost services and drugs. The total projected savings from these initiatives reduces the proposed rates by 0.9%.

Total Allowed Medical Trend

Combining the Company's proposed unit cost trend of 2.7% with the utilization trend of 1.4% results in an allowed medical trend of 4.1%. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market.

L&E's independent calculation of the best estimate of the total allowed medical trend is equal to the Company's estimate of 4.1%, and L&E estimates that the actual results could ultimately range from 3.6% to 4.6%. 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. 6

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

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost in the 2019 premium rate calculations.

- *Pharmacy Trend:* The Company is requesting an allowed pharmacy trend of 13.3%.

  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 approach 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.

[6] For example, the probability that the actual trend will be centered around the best estimate (between 4.0% and 4.2%) is over 50% higher than being near the low end of the range (between 3.6% and 3.8%).

The Company's approach utilized an analysis to account for changes in the pharmacy drugs, 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 PCSK9, cystic fibrosis and multiple sclerosis drugs.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	3.5%	2.1%	5.7%
Brand	11.8%	2.1%	14.2%
Specialty	-	-	20.3%
Total	-	-	13.3%

L&E believed the Company's approach to estimate the pharmacy trends is reasonable and appropriate; therefore, L&E used that same approach to develop its estimate. L&E's best estimate of the total allowed pharmacy trend is equal to the Company's estimate of 13.3%, and L&E estimates that the actual results could ultimately range from 11.0% to 15.7%. However, it should be again 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.[7]

Due to the significant increase in the overall pharmacy 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 compares the Company's projected PMPM trend to the experienced PMPM trend for the first 5 months of 2018 based on claims incurred through May 2018 and paid through June 2018.

Tier	Projected PMPM Trend	Experienced PMPM Trend	Difference
Non-Specialty	7.6%	10.5%	+2.9%
Specialty	20.3%	33.4%	+10.1%
Total	13.3%	20.3%	+7.0%

It appears that the most recent claims experience in 2018 validates the Company's projected increase in pharmacy trends. 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 2019 population morbidity will be 3.1% higher than the experience period morbidity. The morbidity assumption produces a 2.9% rate increase; however, it is partially offset by a projected increase in risk adjustment receivables which are discussed in section 7.

[7] For example, the probability that the actual trend will be centered around the best estimate (between 13.2% and 13.4%) is 55% higher than being near the low end of the range (between 11.0% and 11.2%).

The 2.9% increase from the 2017 base period to the 2019 projected period is itemized below:

- *Changes in pool morbidity*: 2.4%
  The PMPM claims in the base period experience for members and groups that did not voluntarily terminate coverage prior to the end of calendar year 2017 were 2.3% higher than the PMPM claims for all members in the base period experience. The Company increased the projected 2019 claims to account for this less healthy population that will continue to be covered in 2018.

  L&E asked BCBSVT to clarify the projected relationship between the changes in pool morbidity and the impact of benefit changes. In response, the Company proposed a revised calculation which normalizes the impact of induced utilization when calculating the changes in pool morbidity. The revised calculation reduces the morbidity factor and the proposed premiums by 1.3%. L&E believes this revision is reasonable and appropriate and this adjustment is included in the proposed recommendation section of this report.

- *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 2018. 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.

- *Change in the Definition of Small Group:* +0.2%
  In last year's filing, the Company decreased the 2016 single risk pool claims by 0.2% for the groups that enrolled as a result of the change in the definition of small group to include groups with 51-100 employees. This year no such impact is included, so this results in a 0.2% rate increase.

- *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 2019 compared to 2017.

L&E considers the morbidity adjustments and the revised pool morbidity calculation 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, other non-system claims and the removal of the penalty for the individual mandate. The assumption change from the 2017 filing produces a rate increase of 0.4%, because the factors have increased from 2.7% to 3.1%, which has been itemized below:

- *Removal of the Penalty for the Individual Mandate:* +2.0%
  The Company estimated the impact of the removal of the individual mandate by assuming that all members that had no claims or only had preventive claims in the individual market in 2017 and are not receiving premium assistance would not purchase an ACA policy in 2019.

  The Company's approach is different than the approach taken in a study published jointly by the GMCB and the Vermont Department of Financial Regulation (DFR), but the Company's result is equal to the midpoint of the projected impact from this study. L&E considers the projected impact reasonable and appropriate.

  After the initial rate increase was filed, H.696 was signed into law which will enforce the individual mandate in Vermont starting on January 1, 2020. The Company does not expect the 2020 Vermont individual mandate will impact their member's decisions to maintain minimum essential coverage in 2019. These members will have the opportunity to obtain coverage again in 2020 on a guaranteed issue basis to avoid the penalty in 2020.

  Based on L&E's mandate analysis, which considered both financial and non-financial impacts related to the elimination of a mandate, L&E considers BCBSVT's decision to not modify their mandate impact as a result of H.696 as reasonable and appropriate.

- *Changes in demographics:* 0.0%
  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%. The projected impact for the change in demographics matches the projected impact in last year's filing, so this assumption does not have an impact on the rates.

- *Changes in Pharmacy Contract:* -0.9%
  BCBSVT established a new contract with its pharmacy benefit manager, ESI, to mitigate premium increases with discount improvements effective January 1, 2018. The new pharmacy contract negotiated with the Company's Pharmacy Benefit Manager reduces the premium by 1.2%, which is a 0.9% improvement on top of the 0.3% improvement included in the prior filing.

- *Impact of selection:* -0.7%
  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. The impact is expected to be 0.7% less than the expected impact in last year's filing.

  When researching the different impacts by carrier for the impact of Act 88 (2018), which is discussed later in this report, the Company found an issue with their calculation of the impact of selection in the initial filing. The impact is calculated by metal tier, but the

Company did not account for the differences between the reflective and loaded silver plans. The revised calculation increases the selection factor and the proposed premiums by 0.4%. L&E believes this revision is reasonable and appropriate and this adjustment is included in the proposed recommendation section of this report.

- *Non-System Claims:* -0.1%
  This includes pharmacy rebates, Blueprint payments, Interplan Teleprocessing System (ITS) fees[8], Vaccine payments, and net cost of reinsurance.

- *VHC Adjustment:* 0.1%
  VHC adjusts membership retroactively which understates the experience period claims PMPM. In the prior filing, the Company assumed a 0.1% decrease to claims due to retroactive cancellations. In this filing, the Company notes the impact is immaterial, so no adjustment is made which results in a 0.1% increase to the rates.

L&E reviewed the Company's supporting documentation for these adjustments and L&E considers the Changes to the Other Factor and the revised impact of selection to be reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* The Company did not use a manual rate because the 819,824 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 2019 risk adjustment based on the most recent data available. The most recent data available was the interim report[9] published by CMS in early April and a confirmation of the number of months each carrier had submitted for the interim report.

   In anticipation of the 2019 Exchange filings, L&E requested that both carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports from CMS in order to compile them confidentially and provide both carriers with an updated risk adjustment estimate. This calculation indicated that BCBSVT's risk adjustment receivable for 2017 would be 3.4% lower than what BCBSVT assumed in their initial filing. Given the 2017 value, we believe that BCBSVT's methodology of assuming that members who are no longer with BCBSVT in 2018 have migrated to MVP Health Plan and that these members will have the same risk scores in 2018 is reasonable.

[8] BCBSVT provides members with healthcare coverage wherever they go across the country and around the world.

[9] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2017.pdf

On July 9th, CMS released the 2017 Summary Report on Permanent Risk Adjustment Transfers[10], which confirmed L&E's preliminary calculation of the 2017 risk adjustment amount.

L&E recommends revising the risk adjustment calculation such that each carrier begins with the same value for calendar year 2017. L&E recommends that each company use a 2017 estimate of $5,700,399 based on the final report from CMS. Updating the starting point from the $6,132,482 calculated from the interim report to the $5,700,399 from the final report, the resulting premium impact is a reduction in projected risk adjustment receivable from $13.66 to $13.17 PMPM. Therefore, L&E recommends revising BCBSVT's calculation by updating based on the final report from CMS resulting in a premium increase of 0.1%.

FUTURE OF RISK ADJUSTMENT

On February 28, 2018, the United States District Court for the District of New Mexico in *New Mexico Health Connections v. United States Department of Health and Human Services* invalidated HHS's risk adjustment formula as "arbitrary and capricious," and on July 7, 2018, the Trump Administration indicated it was suspending payments under the program. If these payments truly do cease, the rates contained in this filing will no longer be actuarially sound. In that event, L&E recommends that the Board allow the carriers to modify their rates, or consider implementing a state program to replace the federal risk adjustment system. However, based on the resolution of the similar case in Massachusetts and the indispensable nature of risk adjustment to the functioning of the Exchange marketplace, we have assumed that risk adjustment will continue as normal after the resolution of NMHC v. HHS and all payments accrued will eventually be paid.

8. *Changes in Administrative Costs:* The PMPM administrative costs are projected to increase by 9.0% over the administrative costs that were projected in the prior filing. Since administrative costs are projected to increase at a higher rate than claims, the administrative costs are projected to increase as a percentage of premiums by 0.2%.

On a PMPM basis, the adjustment from 2017 to 2019 results in a PMPM increase of $2.70 which is 7.7%[11] and is itemized below:

- Non-Recurring Expenses: -0.9% in administrative costs
  The Company removed any expenses incurred due to one-time, non-recurring events.

[10] https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf

[11] The percentage changes are multiplicative and may not sum to the 7.7% increase.

- Trend: +2.5% in administrative costs each year for two years
  The Company increased the base administrative costs for trend to project the 2019 administrative costs, using an annualized trend of 2.5%. This trend accounts for a 3% increase to personnel costs which make up 83.5% of administrative costs, while other operating costs are expected to remain flat. L&E reviewed the historical increases in personal income per capita in Vermont and the 3% increase is consistent with the average increase over the past ten years.

- Loss of Membership: +3.4% in administrative costs
  BCBSVT is projecting a decrease in overall membership for 2019. Since fixed expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charges results.

In addition to reviewing each of the specific modifications proposed by BCBSVT, L&E also reviewed BCBSVT's administrative costs relative to other BCBS plans as a comparison for reasonableness. BCBSVT's administrative costs on both a PMPM and percentage of premium basis falls in the bottom 5% of BCBS plans nationwide based on a review of the 2017 National Association of Insurance Commissioners (NAIC) Annual Statements. In other words, approximately 95% of the BCBS plans nationwide had higher administrative costs than BCBSVT in 2017 for administering Individual and Small Group products.

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

9. *Changes in Contribution to Reserves (CTR):* The Company's proposed CTR is 1.5%. The proposed CTR was reduced from 2.0% in the prior filing because of the Tax Cuts and Jobs Bill of 2017 that reduced the tax rate to 0% for 2018. The proposed CTR is an increase from the 0.5% CTR that was ordered by the Board for 2018. The Company reduced the provision for uncollected premiums from 0.2% to 0.1% which combined with the increase from the approved CTR results in a 1.0% increase 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.

   The Company provided support demonstrating that a 1.5% CTR is needed to maintain Risk Based Capital (RBC) levels in light of medical trend, population and membership changes.

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

Year	GMCB Approved	Company Expected	Company Actual
2013	0.8%	-2.0%	-2.0%
2014	0.5%	-1.6%[12]	2.8%
2015	1.0%	1.0%	-1.3%
2016	1.0%	0.8%	-5.1%[13]
2017	2.0%	1.0%	-0.5%
Average	**1.1%**	**-0.2%**	**-1.2%**

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.

L&E reviewed BCBSVT's RBC relative to other BCBS plans as a comparison for reasonableness. BCBSVT's target RBC range of 500% to 700% falls in the bottom half of actual RBCs for BCBS plans nationwide from 2012 to 2017 based on a review of the 2017 NAIC Annual Statements. In other words, over half of the BCBS plans nationwide have actual RBCs higher than the maximum of BCBSVT's targeted RBC range.

Due to the required grace period under the Affordable Care Act, the Company included a risk margin for bad debt of 0.1% 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 four years was 0.1%.

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.

10. *Changes in Taxes & Fees:* The total taxes and fees decreased from 3.8% in 2018 to 1.2% of premium due to the Federal Health Insurer Fee being temporarily suspended for 2019. The 1.2% tax is made up of the GMCB Billbacks, Health Care Claims Tax and the Patient Centered Outcomes Research Institute Fee. A small portion of the decrease is due to the expiration of the Patient-Centered Outcomes Research Institute (PCORI) fee, which amounted to $0.20 PMPM in the 2018 filing. The change in taxes and fees decreases the premium by 2.8%. This estimate is considered reasonable and appropriate

11. *Changes in Single Contract Conversion Factor:* A conversion factor[14] adjustment is used to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single

[12] 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.

[13] 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.

[14] 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.

conversion factor is approximately equal to last year's assumption. 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, changes in projected enrollment among plans and the Cost Sharing Reduction (CSR) defunding. The assumed 2019 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. Vermont passed Act 88[15] allowing a strategy to take advantage of the federal advanced premium tax credit program to offset the loss of CSR funding and protect all Vermont Exchange enrollees, which is discussed in further detail in the next section. This results in a 1.6% increase to the premiums. L&E finds this to be reasonable and appropriate.

Cost Sharing Reduction (CSR) – Impact of Act 88

In 2019, there are substantial AV changes resulting from the defunding of the Cost Sharing Reduction (CSR) payments from the federal government. CSRs are "extra savings" for families who earn less than 250% of the Federal Poverty Level, manifested in lower deductibles and copayments for On-Exchange Silver plans. In past years, the difference between plan cost sharing and CSR-level cost sharing was reimbursed by the federal government. However, as this reimbursement will no longer be paid, the plan is responsible for coverage that is substantially richer than the Silver coverage that the 2018 plans are intended to cover. The proposed rate increase includes substantial increases to Silver plans to cover these extra costs (Silver loaded plans). These changes combined result in an increase of 2.2% in rates.

Act 88 was passed in Vermont in order to allow members who do not receive subsidized coverage to purchase a similar Silver plan off-exchange. This Act allows carriers to increase the rates for subsidized members while keeping the increase largely or wholly funded by the federal government and to keep the premiums affordable for non-subsidized members who elect to keep a Silver plan. We note that many households receive premium subsidies for their coverage that is capped at a certain percentage of their income, including most CSR recipients. As a result, this substantial increase will not be paid directly by most of the households who will elect to retain Silver plan coverage in the individual market. The following table summarizes the rate increase with and without the Silver on-Exchange members.

[15]https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT088/ACT088%20As%20Enacted.pdf

Plan Type	Overall Rate Change	Actual Rate Change felt by Vermonters
Catastrophic	1.2%	1.2%
Bronze	4.9%	4.9%
Silver Loaded	16.0%	N/A[16]
Silver Reflective	4.0%	4.0%
Gold	5.0%	5.0%
Platinum	6.8%	6.8%
Overall	***7.5%***	***5.3%***

Additionally, as the premium subsidies available to all metal tiers in the individual market are based on the second-lowest Silver premium, the material increase in silver premiums will result in increased subsidies for many households. This means that, in the individual market, a substantial portion of the 5.3% increase will be borne by the federal government rather than by policyholders.

During the review, the Company noted in responses to questions that they implicitly assumed that members receiving premium subsidies but no CSR subsidies would choose to pay the silver load rather than moving to a similarly priced gold plan or significantly less expensive bronze plan. Due to the outreach of the Vermont Health Connect as well as the Company to educate consumers on their choices, L&E recommends revising the projected membership to assume that members will choose plans that are in their own best interest by selecting Gold or Bronze plans. The revised membership projections will increase the overall rate increase by 0.5% and the rate increase felt by Vermonters by 0.1%.

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:

- *Changes in pool morbidity*: During the review, L&E raised concerns with double counting changes in the pool morbidity factor. When asked, the Company agreed and proposed a revised calculation to normalize the impact of induced utilization before calculating the changes in pool morbidity factor. L&E has reviewed the revised calculation and recommends that the Board reduce the changes in pool morbidity factor by 1.3%.

- *Impact of selection:* The Company's proposed revision to the calculation of the impact of selection more accurately reflects the effect of the Reflective and Loaded Silver plans. L&E has reviewed the revised calculation and L&E recommends that the Board increase the changes in impact of selection by 0.4%.

[16] This table assumes that no Vermonters who are not eligible for APTC premium subsidies will purchase On-Exchange Silver plans. While this cannot be guaranteed with absolute certainty, the State of Vermont is undertaking outreach and education efforts to minimize this as much as possible, as non-APTC members will almost uniformly be better off purchasing bronze or gold plans or purchasing coverage Off-Exchange.

- *Changes to risk adjustment*: Modify the projected risk adjustment payable reflect the most recent data available, resulting in an increase in rates of 0.1%.

- *Changes to the mapping of non-CSR members to bronze and gold plans:* L&E recommends revising the projected membership to assume that members will choose plans that are in their own best interest by selecting Gold or Bronze plans. The revised membership projections will increase the overall rate increase by 0.5% and the rate increase felt by Vermonters by 0.1%.

- *Trend from 2018 to 2019*: If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost in the 2019 premium rate calculations.

After the modifications, the anticipated overall rate increase will reduce from 7.5% to approximately 7.2% and the rate increase felt by Vermonters will reduce from 5.3% to 4.6%.

Metal Tier	BCBSVT Proposed Overall Rate Change	L&E Recommended Overall Rate Change	BCBSVT Proposed Rate Change Felt by Vermonters	L&E Recommended Rate Change Felt by Vermonters	Percent of Membership
Catastrophic	1.2%	0.7%	1.2%	0.7%	0.5%
Bronze	4.9%	4.2%	4.9%	4.2%	12.7%
Silver Loaded	16.0%	17.3%	N/A	N/A	20.6%
Silver Reflective	4.0%	3.3%	4.0%	3.3%	20.8%
Gold	5.0%	4.3%	5.0%	4.3%	26.1%
Platinum	6.8%	6.1%	6.8%	6.1%	19.3%
Overall	***7.5%***	***7.2%***	***5.3%***	***4.6%***	***100.0%***

Sincerely,

Josh Hammerquist, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

David M. Dillon, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

Jacqueline B. Lee, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

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).

Identification of Actuarial Documents

The date of this document is July 10, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 10, 2018.

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.
- 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.

[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.

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.