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2021 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING
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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, 2021

1.2. Company Contact Information

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

1.3. Scope and Purpose

The purpose of this rate filing is to provide the rates and a description of the rate development for the ACA-compliant plans for the Vermont Individual and Small Group merged market that Blue Cross and Blue Shield of Vermont (BCBSVT) proposes to offer for the 2021 benefit year. This rate filing applies to plans both On-Exchange and Off-Exchange.

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
- Vermont State Law 18 V.S.A. § 9375(b)(6)
- DFR Order establishing tier rate structure and multipliers (Docket No. 13-002-I)
- Vermont Agency of Human Services Health Benefits Eligibility and Enrollment Rule, Parts 1 and 2
- Green Mountain Care Board, Rule 2.000
- Federal Regulation 45 C.F.R. Part 147
- Federal Regulation 45 C.F.R. Part 153
- Federal Regulation 45 C.F.R. Part 154
- Federal Regulation 45 C.F.R. Part 155
- Federal Regulation 45 C.F.R. Part 156
- Federal Regulation 45 C.F.R. Part 158
- Federal Regulation 26 IRC § 223

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1.4. Proposed Rate Increase(s)

The average increase is 6.3 percent. Increases for specific plans range from -0.7 percent to 13.3 percent. The range of increases is due to changes to the actuarial values and plan designs. Apart from the Catastrophic plan and the Vermont Select CDHP Gold, the increases range from 3.4 percent to 7.2 percent.

1.5. Reason for Rate Increase(s)

The starting point of any renewal rate analysis is an assessment of actual to expected experience results. The basis for this rate filing is calendar year 2019 experience. Claims experience for 2019 was very slightly favorable relative to the expectation embedded within the 2020 filing, driven by a 1.3 percent improvement due to BCBSVT cost containment programming that exceeded expectations. The addition of a favorable risk adjustment transfer resulted in a net decrease to 2021 rates of 1.4 percent for rebasing to the correct 2019 base experience

The 2020 approved rates included assumptions for projecting from 2019 to 2020. Because this 2021 filing is based on updated actuarial assumptions that reflect current data, those assumptions must be re-examined. While some assumptions restated upward and others downward, the current projection of 2020 implicit in the 2021 rates does not differ from the projection in the 2020 filing. Therefore, the impact of rebasing the 2020 projection is zero.

Rebasing of 2020	2021 Rate Impact
Impact of updated trends	0.7%
Impact of updated 2020 risk adjustment transfer	0.7%
Impact of updated population changes	-1.4%
Total impact of rebasing the 2020 projection	0.0%

An additional year of projected trend applies from 2020 to 2021. The overall anticipated increase in rates due to the additional year of projection is 9.2 percent:

2020 to 2021 Trend Component	Filed 2021	2021 Rate Impact
Medical Utilization	4.0%	3.2%
Medical Unit Cost	3.8%	3.1%
Pharmacy	13.4%	2.7%
Dental	0.7%	0.0%
Vision	0.0%	0.0%
Total		9.2%

Population changes from 2020 to 2021 have the effect of very slightly increasing rates by 0.4 percent. We project a higher risk adjustment receivable in 2021, driven primarily by population

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changes, premium increases, and continual changes to the HHS model. The higher projected receivable reduces rates by 1.0 percent.

Benefit changes made by the Department of Vermont Health Access for standard plans and by BCBSVT for non-standard plans only partially offset the impact of benefit leverage. Altogether, factors related to plan design, actuarial value, silver loading and induced utilization increased rates by 0.9 percent.

BCBSVT base administrative charges increase premiums by 0.4 percent. BCBSVT is preparing to take over the billing for VHC enrolled members. Further, starting in plan year 2021, BCBSVT will offer members the opportunity to pay their premiums via debit or credit card. Projected 2021 expenses for these additional services increase premium by 0.6 percent.

Federal and state taxes and fees are expected to decrease substantially in 2021. Driven primarily by the repeal of the federal insurer fee (also known as the Health Insurer Tax) after a one-year return, taxes and fees decrease premiums by 2.0 percent.

BCBSVT has embarked on numerous efforts to mitigate premium increases. BCBSVT has continued to work closely with its pharmacy benefit manager to improve network pricing and maximize rebates. We have also developed strategies in partnership with our contracted lab benefit manager that have dramatically reduced expenditures on laboratory services. Altogether, these rate mitigation measures result in a reduction of 1.7 percent, or a projected \$5.2 million.

1.6. Historical Financial Results

BCBSVT has been offering QHP products since the start of the program in 2014. Prior to offering QHPs, BCBSVT offered Individual and Small Group products. All Vermonters that were previously purchasing Individual and Small Group products were required to move to a QHP in 2014. The State allowed individuals and small groups to remain in their 2013 products through the first quarter of 2014. All financial information below includes only the QHP experience in 2014.

Year	Member Months	Filed Contribution to Reserve	Approved Contribution to Reserve*	Actual Contribution to Reserve	Actual operating gains/ (losses)
2014	638,492	1.0%	-0.1%	1.0%	\$2,570,373
2015	768,293	1.0%	1.0%	-1.4%	(\$7,971,613)
2016	835,541	2.0%	0.8%	-3.8%	(\$14,311,831)
2017	820,156	2.0%	1.0%	1.0%	\$4,053,501
2018	630,163	2.0%	-3.8%	-3.4%	(\$11,999,422)
2019	520,854	1.5%	0.0%	-0.4%	(\$1,396,912)
Cumulative	4,213,499	1.6%	-0.2%	-1.4%	(\$29,055,904)

*Includes explicit cuts to CTR as well as reductions to actuarial factors that were beyond those recommended by the Board's contracted actuary.

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The actual contribution to reserve was calculated by restating financial results to include the impacts of transitional reinsurance, risk adjustment and other prior year events in the year they were incurred, rather than the year when they were booked.

Since inception, BCBSVT has lost over \$29 million on this line of business, leading to a reduction of approximately 126 percentage points of Risk-Based Capital (RBC).

1.7. Environmental Factors

All Payer Model

The All Payer Model agreement between the State and CMS officially began Performance Year 1 on January 1, 2018. The first year of the program included scale target and performance requirements for an Accountable Care Organization (“ACO”) centric value based care arrangement. For the first time, Medicare, Medicaid and BCBSVT held risk based contracts with OneCare Vermont, LLC (“OneCare”). ACO performance for the All Payer Model is assessed by comparing per capita medical expense growth to the 2017 benchmarks. Under this new model, Medicare, Medicaid, and Commercial payers all enter into risk sharing agreements with the ACO, focusing on transitioning to value-based reimbursement methodologies. All beneficiaries keep their current benefits and provider choice – there are no network or benefit restrictions. BCBSVT remains the sole commercial health plan participating in Vermont’s All Payer Model.

Through deployment of new care models, the All Payer Model requires that the ACO strive to reduce cost and meet three health improvement goals: improved access to primary care, reduced deaths from suicide and drug overdose, and reduced prevalence and morbidity of chronic disease. BCBSVT’s agreement with OneCare aligns with the All Payer Model, including quality metrics, member engagement programs and collaboration efforts focusing on underlying programs supporting success in this program, as well as a medical expense target methodology aligned with filed and approved premiums. Alignment between BCBSVT premiums and the medical expense target is necessary both to demonstrate OneCare’s impact on health plan rates and to share savings with policyholders.

Continuation of the BCBSVT and OneCare agreement through 2020 and beyond demonstrates BCBSVT’s continuing leadership and support of health care payment reform and the goals of the All Payer Model. Together, BCBSVT and OneCare made tremendous progress in 2019 to increase participation in the program by including a substantial percentage of BCBSVT’s large group clients in the program. The addition of several thousand members provides additional scale to the All Payer Model, providing additional support to providers who are working to transform patient care.

Though a final reconciliation of 2019 results has not yet been completed, preliminary analysis indicates that OneCare’s performance likely did not result in savings relative to the medical expense target.

While shared accountability of total cost of care with providers is an important step, BCBSVT continues to evaluate areas to achieve savings and improve the health and experience of BCBSVT members. Applying experience and knowledge gained from the first two years of the shared risk agreement, BCBSVT is continuing to work closely with OneCare on targeted approaches to improve access to primary care and close gaps in care in a way that meaningfully impacts the

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cost of care. These efforts are necessary to support the provider system as it works to improve the efficiency and effectiveness of the care delivery system.

Though BCBSVT remains committed to and optimistic about this important work, the performance to date of this arrangement gives no clear basis for projecting savings in the near term; as such, this filing does not include any adjustment to projected expenditures related to the OneCare program.

Cost Share Reduction Funding and the Vermont Silver Solution

As part of the Affordable Care Act, the federal Cost Share Reductions (CSR) program is available to benefit low income Vermonters. The CSRs reduce out-of-pocket expenses through lower deductibles, copayments and out-of-pocket maximums if the member enrolls in a Silver level plan, and must meet specific metal actuarial values (AVs).

Beginning in 2019, after the passage of Act 88¹, issuers are allowed to “load” Silver plans by including the estimated CSR cost into the premium for Silver Level Exchange Plans and offer non-loaded off exchange “Reflective Silver Plans.” This remains a temporary solution due to the present lack and future uncertainty of federal funding.

We believe that silver loading had a positive impact on the market, both by avoiding subsidization of the federal government by policyholders and by allowing subsidized members more freedom of choice through higher federal premium subsidies. Blue Cross is continuing to pursue a legal case to require payment for the lost CSR federal funding. While still in progress, developments in related cases are positive. If these funds are paid in 2021 or a future year, they will be used to mitigate future rate increases by replenishing member reserves that had been depleted by the loss of federal funding in 2017 and 2018.

Vermont State Legislature

The rates submitted reflect current law coverage, benefits and cost sharing amounts in place for 2021. The Vermont legislature is currently in session, and there are a number of bills being considered that could impact the 2021 rates described in this filing. If any of these bills pass and become effective for the 2021 plan year, BCBSVT expressly reserves the right to amend these submitted rates to reflect any changes required by new law.

COVID-19

The COVID-19 pandemic has caused unprecedented disruption to the health care system. Actuarial considerations for projecting 2021 costs are discussed in section 3.4.8. A more complete exploration of the BCBSVT response to COVID-19 can be found in Attachment C.

¹ <https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT088/ACT088%20As%20Enacted.pdf>

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1.8. Vermont Statutory Rate Review Criteria

When reviewing a proposed rate the Green Mountain Care Board must consider:

whether a 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 laws of this State.

8 V.S.A. § 4062(a)(3). The Board must also consider the Department of Financial Regulation’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)(B). The purpose of this memorandum is to provide the actuarial basis for the proposed rate. Although a number of the rate review criteria are not technically actuarial in nature, this section briefly explains how BCBSVT’s actuarial calculations relate to the criteria, with the understanding that (consistent with Board practice) these issues will be more fully developed during the rate review process.

The in § 4062(a)(3) criteria are interdependent and, in some cases, in tension. This tension reveals itself most clearly in the interplay among promoting “access to health care,” “quality care” and determining whether a rate is “affordable.” For example, lowering rates to make them more “affordable” can render the rates insufficient to cover members’ claims, which in turn threatens access to quality care for insured. As another example, excluding coverage for new, high-cost specialty medications would certainly make rates more affordable, but at the expense of denying access to care for those in need of the medications.

Unlike quality care and access to care, “protection of insurer solvency” is demonstrably not in conflict with affordability. The Vermont Department of Financial Regulation considers insurer solvency to be the most fundamental aspect of consumer protection². Insurer solvency is a necessary pre-condition for affordability, because reducing rates to levels that result in insurer insolvency would place the entire burden of the cost of care on consumers. Because members cannot likely afford their full cost of care, this result would cut off consumer access to care and impede providers’ ability to provide high-quality care. Furthermore, reductions producing rates that are inadequate to any extent do not promote long-term affordability, as they simply shift costs from current policyholders to future policyholders. The full funding of adequate rates is thereby critical to both insurer solvency and affordability³.

The federal rate review criteria of “not excessive” and “not inadequate” are tested by actuarial analysis. Actuarial Standard of Practice No. 8⁴ provides guidance to actuaries preparing regulatory filings for health insurance premium rate increases. It defines rates as “adequate” if they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency or profit margins. Similarly, rates are “excessive” if they exceed the amount necessary for these items. As documented in Section 5.2, the rates filed herein are neither excessive nor inadequate. It follows that rates that are adequate but not excessive

² See, for instance, DFR solvency opinion in filing BCVT-131497882.

³ While it is true that “affordability” is in conflict with “insurer profitability,” the latter quantity is not among Vermont rate review criteria.

⁴ http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop008_100.pdf

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cannot jeopardize insurer solvency or be deemed to be unjust, unfair, inequitable or misleading. Neither are the rates contrary to Vermont law.

Here, projected increases in health care costs would have fueled a premium increase of 9.2 percent in the absence of actions undertaken by BCBSVT to mitigate the increase⁵.

Spending on specialty pharmaceuticals, through both the retail pharmacy and medical benefits, is driving 3.7 percentage points of the total rate increase. BCBSVT supports and protects our members by ensuring access to medications that significantly improve quality of life, and in many cases save lives. The cost of these drugs is an appropriate topic for public policy discussion, particularly given their impact on rates. However, in the absence of federal or state legislation mitigating the very high cost of these drugs, and given the need to provide access to this care, BCBSVT must include those costs in the rate development. The additional cost of providing these life-altering therapies is expected to lead to greater affordability and/or quality of life in the long term.

Finally, these rates strike the best balance available among affordability, access to care and quality care by providing coverage for necessary medical services that improve the quality of life of Vermonters at a cost of insurance that is far lower than that allowed by federal and State medical loss ratio requirements (see section 3.8.9). Increases in BCBSVT base administrative costs added only 0.4 percent, or just over a million dollars, to premiums, while new programming implemented by BCBSVT shaved over \$5 million from required rates.

⁵ The premium increase was further mitigated by Congress permanently eliminating the Federal Insurer Fee.

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2. PROPOSED BENEFITS

2.1. Description of Benefits

BCBSVT will be offering two types (Standard and Non-Standard) of plans to the Individual and Small Group market in 2021. These plans include coverage for all Essential Health Benefits (EHBs). All plans are on the Exclusive Provider Organization (EPO) network and offer members access to a nationwide network of providers, including over 94 percent of the providers in Vermont.

BCBSVT Standard Plans: BCBSVT is providing rates for the Standard plans with benefits as approved by the Green Mountain Care Board, which are outlined in Exhibit 1A - “State of Vermont Standard Plan Designs.” The form filing for these products can be found under BCVT-132314197 for deductible plans and BCVT-132314338 for CDHP plans. BCBSVT is also providing rates for the catastrophic plan, also outlined in Exhibit 1A. The form filing for this plan can be found under BCVT-132314394.

BCBSVT Non-Standard Plans: BCBSVT is providing rates for two non-standard products. The first product, Vermont Select CDHP, offers HSA compatible plans with deductible at the same level as the out-of-pocket. The second product, Vermont Preferred, offers plans with zero cost share for some primary care or mental health visits and some specialist visits to manage diabetes and heart disease. Both products waive deductibles for wellness drugs. Please see Exhibit 1B - “Non-Standard Plan Designs” for details on the benefit structure. The form filing for these products can be found under BCVT-132314366 for Vermont Preferred and BCVT-132314340 for Vermont Select CDHP.

Reflective Silver Plans

As described in section 1.7, pursuant to Act 88, BCBSVT will be offering certain silver plans only off-exchange for the 2021 plan year. These plans will be “reflective” of the Exchange plans and only have a \$5 copayment, 5% coinsurance or \$25 deductible difference from the Exchange plan.

Uniform Compliance

Benefits of all Standard plans and Vermont Select CDHP are in compliance with 45 CFR §147.106. Specifically, the benefits continue to be offered on BCBSVT’s Exclusive Provider Organization (EPO) network and continue to cover the same service area. Some cost sharing levels were modified to maintain the same metal tier levels. Each product covers the same benefits as covered for plan year 2020.

The changes to the Vermont Preferred benefit are not a uniform modification. The benefits continue to be offered on BCBSVT’s Exclusive Provider Organization (EPO) network and continue to cover the same service area. Each product covers the same benefits as covered for plan year 2019. However, in order to provide new and unique benefits to members with certain diagnosed conditions, some cost sharing levels were modified beyond those required only to maintain the same metal tier levels. BCBSVT received approval to withdraw the 2020 plans and replace with 2021 versions. The table below shows the mapping for this change:

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Market	2020 Name	2020 QHPID	2021 Name	2021 QHPID
Small Group	Blue Rewards Gold	13627VT0360001	Vermont Preferred Gold	13627VT0360005
Small Group	Blue Rewards Silver	13627VT0360002	Vermont Preferred Silver	13627VT0360006
Small Group	Blue Rewards Silver - Reflective	13627VT0360004	Vermont Preferred Silver - Reflective	13627VT0360008
Small Group	Blue Rewards Bronze	13627VT0360003	Vermont Preferred Bronze	13627VT0360007
Individual	Blue Rewards Gold	13627VT0380001	Vermont Preferred Gold	13627VT0380005
Individual	Blue Rewards Silver	13627VT0380002	Vermont Preferred Silver	13627VT0380006
Individual	Blue Rewards Silver - Reflective	13627VT0380004	Vermont Preferred Silver - Reflective	13627VT0380008
Individual	Blue Rewards Bronze	13627VT0380003	Vermont Preferred Bronze	13627VT0380007

2.2. AV Metal Values

Standard plans are designed by the State of Vermont and offered by all issuers in the VISG market. Please see *Attachment A - Standard Plans AV Certification - 2021* for the certification provided by the State.

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 - Non-Standard Plans AV Certification - 2021*, for the actuarial certification, which includes the process used to develop the AV Metal Values.

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3. EXPERIENCE RATING

3.1. Experience Period Premium and Claims

Our analysis begins with the 2019 experience of Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group markets. We will refer to this population as the Single Risk Pool.

We analyzed claims incurred January 1, 2019 through December 31, 2019 and paid through February 29, 2020. We completed both the paid claims and the allowed charges using BCBSVT's monthly reserving models that underpin 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). For the purpose of calculating completion factors, the reserving method categorizes claims by reporting/payment process (Local, BlueCard, Pharmacy, Medicare Supplement, etc.). We calculate completion factors separately for each category. 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 January 1, 2019 through December 31, 2019 and paid through February 29, 2020	\$292,938,515	\$ 347,812,930
Estimate of IBNR for claims incurred January 1, 2019 through December 31, 2019 as of February 29, 2020	\$2,151,106	\$1,606,760
Estimate of IBNR pharmacy rebates incurred January 1, 2019 through December 31, 2019 as of February 29, 2020	(\$3,157,054)	(\$3,157,054)
Total completed experience period claims	\$291,932,567	\$346,262,636
Member months	520,581	520,581
Total per member per month (PMPM)	\$560.78	\$665.15

The experience period total allowed charges PMPM are \$665.15.

In the experience period, the earned premium was \$309,718,520. BCBSVT will not be required to pay Minimum Loss Ratio (MLR) rebates for the 2019 calendar year. Vermont does not currently have a 1332 waiver for a Reinsurance program. The estimated 2019 risk adjustment receivable, based on the information from the Interim Report, is \$20,997,656.

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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). We then separate facility claims 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.

We populate the prescription drug benefit category for claims processed through our pharmacy benefit manager.

We populate the capitation benefit category 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 allowed charges per member per month in the experience totals \$703.28. In 2017, BCBSVT removed an exclusion for routine circumcision (see section 3.8.3 for details). Those services are not considered EHB and must be removed from the experience to calculate the Index Rate.

	PMPM
Allowed Claims in section 1 of worksheet 1 of URRT	\$665.15
Allowed Claims for Non-EHB	\$0.08
Experience Index Rate in section 2 of worksheet 1 of URRT	\$665.07

The experience index rate for 2019 is \$665.07.

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 are not subject to the projection factors described in the following sections. They are 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. We use the FFS equivalent rather than the capitation.

These adjustments are included in the “Other” factor in the section II of worksheet 1 of the URRT.

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	Total Dollars	PMPM
Allowed Claims in section 1 of worksheet 1 of URRT	\$346,262,636	\$665.15
Remove BlueCard Fees	(\$1,248,364)	(\$2.40)
Remove Pharmacy Rebates	\$9,924,906	\$19.07
Remove Payments to Blueprint Program	(\$1,992,320)	(\$3.83)
Replace Capitation with FFS equivalent	(\$1,562,706)	(\$3.00)
Line A of Exhibit 5	\$351,384,152	\$675.98

3.3.1. Pooling experience claims

Starting in 2020, BCBSVT purchased reinsurance coverage for the VISG population that covers the portion of claims above one million dollars that is not already reimbursed by the high cost risk pool. To project the claims above the pooling point, we cap the claims and include the full cost of reinsurance and high cost risk pool. To cap the projected claims, we calculate the de-trended pooling level by removing the total trend (see section 3.4.7 for details) from the attachment point of one million dollars. We then exclude the claims above the resulting de-trended limit of \$849,023.

CY 2019 total allowed claims (including AHP returning to VISG)	A	\$364,168,549
Claims above \$849,023	B	\$1,225,572
Capped Claims	C = A - B	\$362,942,977
Impact of capping claims (1+a ₃ on Exhibit 5)	D = C / A	0.9966

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3.4. Projection Factors

3.4.1. Membership Projections

As of February 2020, BCBSVT had 39,195 members enrolled in the single risk pool, either individually through Vermont Health Connect or directly as individuals or small group employees.

We used this information as the starting point to project the 2021 enrollment and the distribution by plan.

BCBSVT currently covers employees and dependents of a sizable group whose members are younger than the remainder of the single risk pool and are exclusively enrolled in the Platinum plan. As this group was established for a specific and temporary effort, we do not expect them to continue enrollment into 2021. We are excluding these members from all our membership projection factors.

Exhibit 2A shows the 2021 BCBSVT Individual and Small Group projected population by plan and market.

BCBSVT expects to cover 461,052 member months with this filing.

We use this projected membership to adjust our Index Rate for demographics, morbidity, benefit changes, and other allowable adjustments described below.

3.4.2. Changes in the Morbidity of the Population Insured

Impact of Association Health Plans (1+b₅)

Starting in 2019, Association Health Plans (AHPs) became available to Small Employers. Renewal of these plans was prohibited by federal law. Some, but not all, employers who had purchased AHP benefits in 2019 enrolled in BCBSVT VISG products in 2020. To adjust for these members, we included their claims and member months along with VISG small groups in the various population factors described below. We also made an explicit adjustment to reflect their level of claims compared to the single risk pool in 2019. Pediatric dental and vision benefits we either not offered through BCBSVT or were offered as a rider to the groups. We assume that AHP groups would have had the same PMPM pediatric dental and vision experience as VISG small groups. The calculation of the 1+b₅ factor on Exhibit 5 is shown on Exhibit 2B.

Changes in pool morbidity (1+b₉)

This factor measures morbidity differences between the experience period population and projection period population due to choices made by small groups and individuals to voluntarily disenroll from BCBSVT VISG coverage. The impact is measured by observing experience period claims costs for groups and members known to be no longer enrolled as of February 2020.

The base for our experience period is calendar year 2019. Using February 2020 enrollment, we grouped members into broad categories of active and canceled. We can further divide canceled members into two categories: voluntary cancellation and cancellation due to death. We can further break down voluntary cancellations by aging out, cancellations from normal group turnover, and individual cancellations. We capture individuals aging out in our demographic

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adjustment (see section 3.4.5). In 2020, we again experienced significant cancelations in the Small Group segment. To reflect this, we are adjusting for Small Group members leaving BCBSVT VISG. If all members in a group are no longer enrolled in BCBSVT VISG, we exclude them under the assumption that the entire group moved to a different carrier or different product. If members that canceled were part of a group that is still with BCBSVT VISG, we assumed that group turnover will lead to the hiring of similarly-situated individuals; therefore, an adjustment is not needed for such members. We also excluded members from a sizable group established for a specific and temporary effort, as we do not expect them to continue enrollment into 2021.

We split the experience claims costs based on these categories in order to compare the different populations. We adjusted the allowed charges from the experience period to reflect the average claims cost of members who did not voluntarily terminate or are part of a small group still enrolled with BCBSVT prior to the end of calendar year 2019.

To ensure that the morbidity and benefit change factors are independent, we adjusted the PMPM to reflect the underlying average induced utilization.

	Voluntary Cancellation in the Individual Market	Members in Groups that are no longer with BCBSVT VISG	All Other Members	Total
Experience Period Allowed	██████████	██████████	\$304,699,425	\$364,197,058
Member Months	██████████	██████████	450,000	540,594
PMPM	██████████	██████████	\$677.11	\$673.70
Experience Period Average Induced Utilization	██████████	██████████	1.0003	1.0000
PMPM after normalization for induced utilization	██████████	██████████	\$676.91	\$673.70

The factor (1+b₉ on Exhibit 5) to adjust for the change in pool morbidity is $\$676.91/\$673.70 = 1.0048$.

3.4.3. Changes in Benefits

Impact of changes in benefits (1+c₁)

The impact of benefit changes (1+c₁ line on Exhibit 5), represents the anticipated change in the average utilization of services due to the change in average cost sharing in the projection period compared to the experience period. In previous filings, we used BCBSVT VISG allowed relativities to calculate this factor. This approach implicitly includes the impact of selection and morbidity. We believe it is more appropriate to use the HHS induced utilization factors by metal to limit the quantification to only the impact of varying cost shares between the experience plan distribution and the projected plan distribution. For groups in AHP in 2019, we assigned a metal level to each of the plans offered. Using the experience member months for members included in the “All Other Members” category of the morbidity factor described above and the projected

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membership by metal, we calculated an average induced utilization factor for each and compared the two averages to generate the impact of changes in benefits. The impact of the movement among benefit plans is 0.9961, as shown on Exhibit 2C.

3.4.4. Changes in Demographics

Impact of changes in demographics (1+c₃)

To ensure that we accounted for all moving pieces of the reasons for the change in demographics, we have changed our method for developing the change in demographic factor (factor 1+c₃ on Exhibit 5). We calculated factors for small groups, including AHP groups who return to BCBSVT VISG, and for individuals. We then combined the factors based on projected membership.

For both market segments, we used the age-gender factors from the SOA's report Health Care Cost - From Birth to Death⁶ to calculate the age-gender factors for the experience membership to those of the projected 2021 membership.

For small groups, we first observed the historical annual increases in average age-gender factors for continuing and new groups, excluding a sizable group established for a specific and temporary effort. After adjusting for excluding this sizable group, we apply the most recent increase including the new groups to the experience average age-gender factor, to project from 2019 to 2020. Because we assume no material enrollment shifts in 2021, we apply the most recent increase *excluding* new groups from 2020 to 2021.

For individuals, we first split into VHC-enrolled and direct-enrolled members. We then categorized each member in the following sub-categories: continue, retired, newborn, to other BCBSVT line of business, and voluntarily canceled. For continuing members, we aged all members by one year starting with their February 2020 age and calculated the average duration by age. We assigned the age one duration to members age zero in 2020. We assessed historical persistency by age for members who are eligible for Medicare. Based on historical patterns, we assumed that 28 percent of members age 64 in 2020 would remain enrolled through 2021, and that 55 percent of members age 65 and over in 2020 would remained enrolled through 2021. Finally, in order to complete the age distribution, we added new members age zero in 2021. Again, we examined historical patterns to develop newborn assumptions. For the VHC enrolled population, we expect newborns to comprise 0.35 percent of the total population with an average duration of 3.52 months. For direct enrolled members, we expect the newborns to comprise 0.55 percent with an average duration of 4.84 months. We applied these percentages to the inforce 2020 enrollment to estimate the newborns in 2021. We then compared the experience period average age-gender factor to the projected period average age-gender factor.

Finally, we combined the individual and small group impacts based on projected enrollment to calculate the demographic adjustment of 1.0070 (1+c₃ factor on Exhibit 5).

Details of the calculation are shown on Exhibit 2D.

⁶ <https://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx>

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3.4.5. Other Adjustments

The buildup of the Projected Index Rate also includes a factor to reflect new pharmacy contracts and adjustments for non-system claims⁷.

Changes in Provider Network (1+c₂)

Since the experience period claims and the projection period claims are both on the EPO network, the factor for the change in provider networks (factor 1+c₂ on Exhibit 5) is 1.000.

Impact of the ACO program (1+b₄ and 1+b₆)

In 2019, BCBSVT and OneCare VT (OCV) had a shared-risk/shared-savings agreement covering approximately 20,000 lives within the VISG market. The agreement provides for 50/50 sharing of savings or risk up to six percent above or below the expected medical spend, which is derived from the final approved GMCB rate order for the VISG market. [REDACTED]

[REDACTED] Our current best estimate of the 2019 transfer is zero. Therefore the factor for this program (1+b₄ on Exhibit 5) is 1.000.

BCBSVT extended the shared risk/shared-savings agreement with OneCare into 2020 and expects to continue the program in 2021. Due to the impact of the COVID-19 pandemic on providers, members and payers, we expect 2021 to be a recovery year. We therefore include no projected savings from health care reform initiatives in 2021. The factor for these initiatives (1+b₆ on Exhibit 5) is 1.000.

3.4.6. Non-System Claims

We add other costs to the buildup of the Projected Index Rate to account for non-system claims (Items e₁-e₈ on Exhibit 5). As previous explained in section 3.3, these non-system claims are claims that are independent from the benefits but considered claims from an MLR standpoint.

- Pharmacy Rebates (e₁):
Since we have not yet received the details underlying the rebate payment for the fourth quarter of the 2019 calendar year, we use actual rebates from October 2018 through September 2019 as the base. We expect pharmacy rebates to trend at the same rate as Brand Drugs. As shown on Exhibit 3G, the projected total trend for Brand drugs is 7.6 percent, which brings projected pharmacy rebates to \$29.91 PMPM.
- Blueprint Payments (e₂):
BCBSVT participates in the Vermont Blueprint for Health⁸ program. The Vermont Blueprint for Health Manual, effective October 1, 2018, details the funding for both portions of the program: Community Health Teams (CHT) and Patient Centered Medical Homes (PCMH). We do not expect the funding for either CHT or PCMH to change in 2021. Therefore, we assumed that the experienced PMPM of \$3.84 would continue to 2021.

⁷ Non-system claims are payments that are not processed through the claims adjudication system.

⁸ <http://blueprintforhealth.vermont.gov/>

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- **Interplan Teleprocessing System (ITS) (e₃):**
The BlueCard® Program gives BCBSVT members healthcare coverage wherever they go across the country and around the world. The fees associated with this program are independent of the amount of the claims and therefore solely dependent on utilization of BlueCard participating providers. As described below, we have selected an annual medical utilization trend, before the impact of the cost containment strategy, of 3.6 percent; therefore, these fees are assumed to increase at 3.6 percent annually. The experience period fees (\$2.46 PMPM) are projected to grow to \$2.64 PMPM in 2021.
- **Vermont Vaccine Purchasing Program Payments (e₄):**
The Vermont Vaccine Purchasing Program⁹ (VPPP) offers health care providers state-supplied vaccines at no charge by collecting payments from health plans, insurers and other payers. This assessment is a PMPM charge applied to members residing in Vermont who are under age 65. On May 1, 2020, the Vermont Vaccine Purchasing Program released a memo¹⁰ that included the rates for SFY2021 and the anticipated rates for SFY2022¹¹: *“The new monthly rate for child covered lives will be \$9.26. The new monthly rate for adult covered lives will be \$0.96. [...] For planning purposes, the best estimate at this time for the SFY2022 assessment rate is \$10.60 per child covered life per month and \$1.09 per adult covered life per month.”*

Using the projected enrollment for children and adults, we calculate a projected period PMPM of \$2.11 PMPM.

Age Category	Weighted Rate for CY 2021	Weight
Child	\$10.27	11.7%
Adult	\$1.06	86.1%
Over 65	\$0.00	2.2%

- **Net Cost of Reinsurance (e₅):**
BCBSVT uses reinsurance to protect itself against very high claims. Starting in 2020, BCBSVT purchased reinsurance for 40 percent of claims above \$1 million. When combined with the High Cost Risk Pool program, BCBSVT is fully-reinsured at an attachment point of \$1 million. Since we capped claims in the projected period allowed claims for EHB (line D of Exhibit 5) at \$1 million, we include the full cost of reinsurance. The projected rate for this coverage in 2021 is \$████ PMPM.
- **OneCare Coordination Fee (e₆):**
BCBSVT is paying OneCare VT a PMPM care coordination fee for attributed BCBSVT members to directly support ACO providers, including community providers, as they deploy new care models. This model mirrors the investment Medicaid has made in the ACO provider network

⁹ <http://www.vtvaccine.org/>

¹⁰ [https://www.vtvaccine.org/vtvaccine.nsf/documents/ApprovalofFY2021AssessmentRateNoticeandLetterfromCommissioner2.html/\\$File/2020-04-23%20Assessment%20Rate%20Notice%20SFY2021%20and%20Commissioner%20Letter.pdf](https://www.vtvaccine.org/vtvaccine.nsf/documents/ApprovalofFY2021AssessmentRateNoticeandLetterfromCommissioner2.html/$File/2020-04-23%20Assessment%20Rate%20Notice%20SFY2021%20and%20Commissioner%20Letter.pdf)

¹¹ The State Fiscal Year runs from April 1 through March 31.

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and supports the comprehensive care models being tested within the ACO program. The monthly PMPM for members attributed to OneCare is \$3.25. For 2021, we expect that the commercial ACO network will include the same hospitals as in the 2020 network. As of March 2020, 50 percent of the Single Risk Pool was attributed to the 2020 OneCare network. The projected PMPM is therefore $\$1.63 = \3.25×0.50 .

- **ESI Additional Administration Fees (e₇):**
ESI offers additional services to BCBSVT for clinical management programs. These programs include prior authorizations, step therapy, quantity reviews, copay reviews, and pharmacy vaccination programs, as well as ESI's RationalMedSM program, which protects patients against potentially harmful drug interactions. The total PMPM in the experience period was \$ [REDACTED] PMPM for these services, and we project them to be the same in 2021.
- **Accordant Health Services Fees (e₈)**
BCBSVT partners with Accordant Health Services to provide members support with managing their rare diseases. The program targets patients with complex, chronic diseases in neurology, rheumatology, hematology and pulmonology. Accordant provides early intervention and patient compliance services to support BCBSVT's care management strategies, improve patient health and strengthen physician-patient relationships. The total PMPM in the experience period was \$ [REDACTED] PMPM for these services, and we project the PMPM to be the same in 2021.

3.4.7. Trend Factors (cost/utilization)

The source of the data is BCBSVT's data warehouse, except where noted below. To ensure accuracy of claims information, the data has been reconciled against internal reserving, enrollment, and other financial reports. The analysis examined claims incurred between January 1, 2015 and December 31, 2019, completed through February 29, 2020. We applied completion factors, based on best estimates from financial reporting before margin for conservatism, to estimate the ultimate incurred claims for each period shown in the exhibits.

The data includes claims from the Single Risk Pool and the non-VISG experience for groups with 51-100 employees that joined the Single Risk Pool in 2016, when Vermont changed the definition of Small Group to include groups with 51-100 employees. Over the past few years, we have experienced membership retroactivity, primarily associated with members enrolled through VHC. This retroactivity causes some claims to no longer be associated with active membership. The data excludes claims that are no longer associated with active enrollment.

BCBSVT experienced large membership movement out of the VISG market in 2018, 2019 and 2020. We analyzed the individual and small group markets separately, except for pharmaceuticals that are part of the medical benefit. Due to significant changes in membership, we included only membership and claims from small groups that have been with BCBSVT since 2015. Using a static population with demographic adjustment normalizes for changes in population morbidity over time. We did not include a similar restriction in the individual market analysis; however, the individual market adjusted year over year utilization trends for facility, professional and retail pharmacy are consistent with or lower than those for the small group market, indicating that demographic adjustment has appropriately removed any increased

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morbidity from the individual market trends. We weighted the adjusted results for each market segment by in-force membership to reflect the mix between the markets, thereby normalizing for the unequal membership shifts by market over time.

3.4.7.1. Medical Trend Development

Using the historical contracted reimbursement schedules, we calculate network factors that represent the various contracts. Using these factors, we can modify the claims to reflect a common 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. We normalize historical experience for contract changes so that we can derive a utilization trend in the absence of unit cost changes. We develop future unit cost trends 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.

Unit Cost

Observations of recent contracting and provider budgetary changes are the main source of unit cost trend. During calendar year 2019, about 53 percent of total medical claims dollars occurred at Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board (GMCB). For hospitals under the jurisdiction of the GMCB, we start with the assumption that the GMCB will approve hospital budgets for October 1, 2020 and October 1, 2021 that support identical commercial increases as those approved for October 1, 2019. [REDACTED]

[REDACTED] Based upon the above assumptions concerning hospital budget and fee schedule changes, 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 the VISG market.

Similarly, we assumed for other providers within the BCBSVT service area that overall 2020 and 2022 budget increases would be identical to those implemented during calendar 2019, with the exception that we have reflected any more recent information gleaned from our early negotiations with providers. Again, the provider contracting and actuarial departments worked closely together to assess the impact these assumptions about other providers within the BCBSVT service area would have on contract negotiations specific to the EPO network used for the VISG market.

BCBSVT entered into a contract with a lab benefit manager (LBM) in August 2019 that instigated dramatic changes in the cost of independent labs. To recalibrate to the LBM fee schedule, we recalculated the cost of labs using the October 2019 fee schedule for January 2019 through September 2019 and assumed that 2020 and 2021 would remain at that level.

For drugs dispensed in a facility or office, we used the average increase for each facility or provider group to calculate an estimated unit cost trend. As described below, we calculated an overall allowed trend for these drugs but, per the URRT instructions, we must separate cost and

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utilization. This estimated unit cost trend is used for URRT purposes as actual unit cost increases by type of service are not readily available.

Finally, unit cost increases for providers outside the BCBSVT service area were derived from the Fall 2019 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

The chart below summarized the results of the analysis:

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in Experience	Cost Trend from 2019 to 2020	Cost Trend from 2020 to 2021	Total Annual Cost Trend
Vermont facilities and providers impacted by GMCB’s Hospital Budget Review	53.2%	4.2%	4.2%	4.2%
Other facilities and providers	46.8%	2.3%	3.4%	2.9%
Total	100.0%	3.3%	3.8%	3.6%

Pages 1 through 5 of Exhibit 3A show the details of the cost increases by contract and type of claim.

Utilization & Intensity

To examine historical utilization trend patterns we first normalize for unit cost increases. We measure contract changes for the entirety of the experience period explicitly for each facility within our service area, as well as the three largest physician groups and independent labs.

We measure increases for fee schedules and other chargemasters by applying each schedule to a market basket of services. We define the market basket 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, we compare total allowed costs for the selected combinations of CPT and CPT modifier under each schedule to estimate the percentage increase. For contracts under Diagnosis Related Group (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.

Contracting changes for out-of-area services were derived from the Fall 2019 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

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We normalized claims to the December 2019 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 2019. We assume the derived trend for other claims to be continuous.

To ensure that random high claims did not skew the trend calculation, we removed all claims from members who exceeded \$500,000 in allowed medical claims in a calendar year. As the utilization component includes intensity, an increase in high cost claimants can disproportionately impact the year-over-over and regression calculations.

We have selected the following utilization trends:

Category	Annual Selected Utilization Trend
Facility	1.1%
Professional	2.2%
Medical Drugs	18.5%

The selection of utilization trend is a complex process that requires observations of historical patterns, statistical analysis and understanding of the different external forces that can influence claims costs in both the experience and projection periods. We analyzed each claim category separately and weighted the selected trends using experience period PMPM claims to derive an overall trend.

To adjust for the influence of benefit richness on the utilization of services as benefits vary over time, 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 2019.

Using SOA's report Health Care Cost - From Birth to Death factors, we calculated the average age-gender factors for the members included in the development. To normalize for the influence of changing demographics over time, we adjusted each month in to reflect the age-gender factor evident in December 2019.

Since early 2014, BCBSVT implemented many new programs to combat fraud, waste and abuse (FWA). As shown in the table below, the return of FWA programs has increased rapidly from 2015 to 2018. Due to BCBSVT's migration to a new operating platform, FWA programs slowed in 2019.

Calendar Year	Percent of claims recovered as part of FWA programs
2015	0.81%
2016	1.05%
2017	1.09%
2018	1.42%
2019	0.77%

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The change in recoveries could skew the trend calculation. We have therefore adjusted the claims to reflect 2019 recovery rates. Due to COVID-19, we have stopped some FWA programs in 2020, and it is unclear at this time when we will start them again. For this reason, we assume that the percentage of claims recovered through these programs will remain at approximately three-quarters of percent of total allowed claims over the next two years. We have accordingly not adjusted the trend for future improvements in FWA efforts.

We normalized the claims cost such that each month reflects the average number of working days per month in 2019, as defined by our reserving models.

The individual and small group population have very different claim levels, and the change in mix of these distinct populations skews the trend analysis. To adjust for this, we performed all calculations by market and blended the results based on in-force membership as of February 2020.

Exhibit 3B shows the calculation and resulting factors for these adjustments for each market.

Facility Claims

For facility claims, we select a 1.1 percent utilization trend.

Using the array of PMPM claims costs net of high claimants and adjusted for contract, benefits, aging, FWA programs, and number of working days, and weighted between the individual and small group markets using in-force membership, we performed 24-month regressions, 36-month regressions, 48-month regressions and time series calculations. Certain time series methods, such as those assuming no trend, those assuming that trend is dampening or those for which there is not sufficient historical data¹², are not included, as these are inappropriate for use in trend development and/or for the data available.

The year ended December 2019 over year ended December 2018 increase, after all the adjustments described above, is 0.9 percent. Logistic regressions using 24, 36 and 48 months calculate -0.1 percent, 0.9 percent and 1.2 percent trends respectively. The three time series that are appropriate to use give a similar range of projected trends (-0.5 percent to 1.9 percent).

¹² The seasonal additive, seasonal multiplicative, single moving average, and single exponential smoothing methods cannot be used since they assume zero trend. The dampened trend method already assume a slowdown of trend. The double moving average method requires three times the amount of historical data as projection periods, and therefore should not be used for this analysis.

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Method	Trend	RMSE	Theil's U
48 Months Logistic Regression	1.2%	21.84	
48 Months Linear Regression	1.2%	21.85	
Holt-Winters' Multiplicative 48 Monthly	1.3%	23.28	0.73
Holt-Winters' Additive 48 Monthly	1.4%	23.20	0.72
Double Exponential Smoothing 48 Monthly	-0.5%	24.49	0.81
36 Months Logistic Regression	0.9%	21.79	
36 Months Linear Regression	0.9%	21.79	
Holt-Winters' Multiplicative 36 Monthly	0.3%	27.48	0.90
Holt-Winters' Additive 36 Monthly	0.3%	27.48	0.90
Double Exponential Smoothing 36 Monthly	0.0%	23.16	0.71
24 Months Logistic Regression	-0.1%	21.73	
24 Months Linear Regression	0.0%	21.72	
Holt-Winters' Multiplicative 24 Monthly	0.5%	30.91	0.95
Holt-Winters' Additive 24 Monthly	0.5%	30.90	0.95
Double Exponential Smoothing 24 Monthly	1.9%	24.02	0.80
Year/Year	0.9%		

We selected 1.1 percent trend for facility claims. This is a 50/50 blend of the most recent year over year trend with the average of the 48-month regressions and Holt-Winter time series. The double exponential smoothing time series method has produced results that are wildly divergent from the other statistical methods, and we do not consider it in selecting a facility trend. We believe that using a longer view of facility trend is appropriate to smooth out monthly variability. Finally, we note that our selection is in very close proximity with the most recent actual year over year result.

Details on facility trends are shown on Exhibit 3C.

Professional and Ancillary

Professional claims utilization had been ramping up over the last few years but slowed down in 2019. The main driver of this reduction is the introduction of a lab benefit manager. To account for shift in site of care, we decided to change our methodology to look at services by provider grouping and adjust for historical cost trend to calculate the impact of changes in mix of services. We also experienced a higher than normal October in 2019, followed by a dampening of claims in December 2019. A low last data point skews regressions and time series, which is why we selected trends based on observation of recent patterns instead of statistical methods.

To analyze the number of services, we combined all provider groups except for labs processed through the lab benefit manager. For both individual and small group markets, we observed very stable rolling 12-month increases through August 2019 and then a sharp drop through the end of 2019, with December 2019 being abnormally low. We believe that the latter part of 2019 is a step down rather than a trend as we have already observed a leveling off in the early part of 2020. We are therefore adjusting 2019 to reflect a full year at the new level, and then trending

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at 2.9 percent for small groups and 3.6 percent for individuals, the year-ended August 2019 values.

For lab services, we contracted with a lab benefit manager as of August 2019. This drastically reduced both the fee schedule for independent laboratories and, through the application rigorous clinical protocols, the number of services that policyholders incurred. We adjusted the number of services going forward to reflect the level for the last four months of 2019 for calendar year 2021. Implicit in that adjustment is an assumption that ongoing clinical management will reduce utilization trend for these services to zero.

In this method, the intensity component is reflected by the mix of services. To quantify the impact of the changes in mix of services on professional trend, we first normalized the cost per service using the historical cost trend increases. We then measured the increase in cost per service. For services at BlueCard providers, we observed similar patterns for individual and small groups. In both markets, the mix trend increased in 2018 and returned in 2019 to levels experienced in 2017. We are therefore using a two-year average trend to project forward to eliminate the impact of an outlier year. For providers on the Community fee schedule, both hospital owned practices and independent practices, we believe that the recent declining trend in mix of services is due to the reallocation of site of care in 2019. We therefore normalize for site of care. A number of facilities upgraded their billing systems in the fall of 2019 and we experienced an elevated mix trend due to the transition¹³. We believe that this will continue until reaching a new equilibrium in 2020, and then level off through 2021. Finally, for providers associated with Dartmouth-Hitchcock we select different trends for the individual and small group market segments based on observed mix of services.

Finally, we blended the individual and small group trends using in-force membership to adjust for the changing mix between the two markets.

The resulting professional trend is 1.1 percent from 2019 to 2020 and 3.4 percent from 2020 to 2021.

This method of determining professional trend by fee schedule does not account for the potential changes between the different schedules. Based on historical patterns, we assessed historical movement between the community providers and academic medical center and it does not appear that an adjustment is necessary.

Exhibit 3D shows the number of services and adjusted cost per service by fee schedule and market.

¹³ We note that at least one hospital has cited the EMR impact on volumes as a leading driver of revenue shortfalls. See, for instance, <https://gmcboard.vermont.gov/sites/gmcb/files/Board-Meetings/NMC%20FY2020%20Mid%20Year%20Budget%20Adjustment%20-%20Narrative.pdf>

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Pharmaceuticals

As shown on Exhibit 3E, the year-over-year trend experienced in 2018 increased drastically from historical levels before returning toward a more typical increase in 2019. Ocrevus, a blockbuster drug for treatment of Multiple Sclerosis was the main driver of the high increase in 2018. Other drugs also experienced very high increases, and we expect some of these drugs to continue trending at very high rates.

With the help of the clinical staff at BCBSVT, we separately projected the expected cost and utilization increase for nine impactful drugs (see Exhibit 3E).

Based on the assumptions shown on Exhibit 3B, we project that annual total increases for drugs dispensed in a facility or office will be 18.0 percent. Using the average projected cost increase of 4.5 percent, we calculate a projected annual utilization increase of 12.9 percent. Over the past four years, the impact of new drugs ranged from 3 percent to 9 percent. Our clinical experts advise us that even with the COVID-19 pandemic, we can expect the impact of new drugs to increase trend by five percent, which was the impact of the pipeline for 2019. We therefore select an 18.5 percent utilization trend for pharmaceuticals.

Overall Medical Utilization Trend

Using the 2019 PMPM of the population used in the trend development as weights, we calculate a 3.6 percent overall medical utilization trend:

Category	Allowed Charge PMPM	Selected Utilization Trend
Inpatient	\$104.85	1.1%
Outpatient	\$209.47	1.1%
Pharmaceuticals	\$59.38	18.5%
Professional	\$148.18	2.2%
Total	\$521.88	3.6%

Cost Containment Strategy

BCBSVT transitioned to a new operating platform as of January 1, 2019, leading to a slowdown in claims payments for the first few months of the year as we worked through all the details of the transition. This delayed the start of the cost containment program that was aimed at reducing inpatient readmission and emergency room admissions. Employee turnover in the Integrated Health department further slowed the progress of this program. For these reasons, we did not meet our goal to reduce inpatient readmissions and emergency room visits for the VISG population for 2019. Cost containment programming came to a halt in March of 2020 due to COVID-19. With the continued uncertainty due to the pandemic and its impact on providers and members for the remainder of 2020 and 2021, we do not expect to focus on this programming in the time period considered by this filing.

For similar reasons, we have no plans at this time to expand the Convenient Care program that encourages home infusion therapy. The modest impact on the experience period of this program naturally flows through into projected trend as well.

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We are continuing our relationship with the lab benefit manager. The impact on 2019 claims experience, even with only five months of programming, was extremely positive. We have reflected an ongoing impact through 2021 directly within the professional trend described above.

3.4.7.2. Pharmacy Trend Development

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. 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. We then calculate the overall pharmacy trend by combining the separate projections.

Non-Specialty Drug Utilization

Similar to medical claims, we observe different levels of utilization of non-specialty drugs between the individual and small group markets. As described above, we adjust utilization trends for changes in benefits, aging and working days. Using the array of monthly PMPM claims after adjustments, we weighted the two markets using in-force membership. We then performed 24-month and 36-month regressions as well as time series, with appropriate underlying assumptions for trend and seasonality.

Exhibit 3F provides the monthly and the 12-month rolling data, along with the corresponding year-over-year and exponential regression trends and time series, for non-specialty drug utilization. We use the number of days supply, rather than the number of scripts, 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 24-month regression and time series results are higher than both the most recent year over year results and the 36-month regressions and time series. We observed a very high fourth quarter in 2019, which is skewing the 24-month statistics. The longer views also suggest that the most recent year-over-year trend may be artificially low. We select 3.0 percent, the average of the 36-month statistics and the most recent year over year results, as the non-specialty drugs utilization trend.

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Instead of projecting a generic dispensing rate, we separated the drugs into seven categories:

- Generics: Drugs that have been generic since at least January 2017
- New Generics: Generic drugs that have been in the market for less than 36 months (January 2017 to December 2019)
- Brands going Generic: brands that are expected to become available in generic form in the projection period, based on a list from our pharmacy benefit manager
- Vaccines
- Over the Counter (OTC)
- Compounds
- All other Brands

As shown on Exhibit 3I, all days supply is trended forward at the same rate of 3.0 percent.

Generic Cost Trend

To ensure that the generic cost trend is not skewed by the arrival of new generic drugs, we performed a 24-month regression on monthly Average Wholesale Price (AWP) per days supply on only those generic drugs that have been in the market for more than 36 months.

Brands that are going generic will be subject to the generic discounts. We do not expect that the AWP for these drugs will significantly change from the experience period due to the lack of generic competition for the main drugs in this category. We adjusted the price to reflect the different experienced effective discounts between brands and generics.

Exhibit 3G, page 1, shows monthly cost per days supply and the 24-month regression. We select 0.25 percent for the generic cost trend, which is the average of the 24-month regression and the year over year result. Though the AWP trend has increased in recent months, we consider a 0.25 percent to be a reasonable long-term outlook for generic cost trend. This selection is consistent with recent BCBSVT filings.

Brand Cost Trend

To ensure that the brand cost trend is not skewed by brands going generic, vaccines, over the counter, and compounds, we performed a 24-month regression on monthly AWP cost per days supply on the all other brand category only.

Compounds are one-off prescriptions that are constructed at the pharmacy from component ingredients. Because they are not sold on a wholesale basis, there is no official AWP. We select a 0.0 percent cost trend for compounds.

Vaccines cost have been increasing rapidly over the previous three years. We expect this to continue through 2021 and include a 20 percent cost trend for vaccines.

We also do not expect over-the-counter drugs to follow the overall Brand cost trend. Based on historical data, we select a *negative* 20 percent cost trend for OTC drugs.

Exhibit 3G, page 2, shows monthly cost per days supply and the 24-month regression. We select 10.0 percent for the brand cost trend, which is the average of the 24-month regression and the most recent year over year result. This selection is consistent with recent filings, and we consider it to be an adequate, yet not excessive, outlook of future trend.

Specialty Drugs

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In previous filings, the introduction of certain new specialty drugs required an adjustment to the specialty drug trend calculation. The impact of excluding certain specialty drugs has had an increasingly small impact on specialty trend. We no longer judge this impact to be material. Therefore, we combine all specialty drugs to develop trend. We will continue to monitor new specialty drugs and adjust our future methodology as necessary.

In January 2019, we amended our contract with our pharmacy benefit manager to reflect the new Accredo[®] Exclusive Specialty Program, which increased our discount off AWP for specialty drugs. We adjusted months prior to January 2019 to reflect the new contract.

For the same reasons stated in the medical trend section, we adjust each month to reflect aging. We did not adjust for working days, as nearly all retail specialty medications are provided through mail service, and the vast majority of prescriptions are refills. We did not adjust for benefits as there is no impact of induced utilization on high-cost specialty medicines. Again, we calculated PMPM arrays for individual and small groups and re-weighted the experience using in-force membership to adjust for the change in mix between the markets. Using the array of weighted PMPM claims costs after adjustments, we performed 24-month and 36-month regressions as well as two time series. Specialty drug utilization is not seasonal; therefore, we only use the double exponential smoothing method.

Exhibit 3H, Page 2 contains the results of the regressions and time series. The average of these five methods, including the year-over-year increase, is 20.5 percent. We select 20.5 percent, which is consistent with previous filings, as a reasonable and appropriate trend for specialty drugs.

Changes in Pharmacy Contracts

[REDACTED] To calculate this factor, we applied the contracted discounts and dispensing fees for each type of drug (Generic, Brand and Specialty) to calendar year 2019 claims for both the experience period and the projected period contract provisions. We apply to the projected pharmacy claims the contract adjustment factor for each type of drug, calculated by taking the ratio of the projected pharmacy claims under each contract (see Exhibit 3I for details). [REDACTED]

Overall Pharmacy Trend

Exhibit 3I summarizes the trends and calculates our total allowed pharmacy trend as 13.4 percent. Note that changes in pharmacy contracts are included in the cost trend component on Exhibit 3J.

3.4.7.3. Vision and Dental Trend Development

Dental Trend

The pediatric dental benefit is available to all members age 21 and under. The proportion of members age 21 and under is very different between the individual and small group markets. We therefore again analyze trend separately for each market and then combine the results using in-force membership.

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The allowed per child member per month (PCMPM) trend for the individual market increased in 2018 and decreased in 2019. For the small group market, there was a significant decrease in 2018 and another smaller decrease in 2019. Looking into the details, we can observe that classes III and IV¹⁴ are extremely volatile and skew the overall results.

Calendar Year	Individual Classes I and II PCMPM	Trend	Small Group Classes I and II PCMPM	Trend
2016	\$14.44		\$10.88	
2017	\$14.01	-3.0%	\$11.25	3.4%
2018	\$15.13	8.0%	\$10.38	-7.7%
2019	\$15.37	1.6%	\$10.30	-0.8%

We believe that 2018 was an outlier for each market and therefore select the most recent year-over-year increase for each market. After combining using the in-force membership, the overall dental trend is 0.7 percent. For the purpose of the index rate build-up, we included the total dental trend as utilization trend.

Vision Trend

The pediatric vision claims experience once again shows 2018 to be an outlier with much higher PCMPM than the other three years in the analysis.

Calendar Year	Individual PCMPM	Trend	Small Group PCMCM	Trend
2016	\$0.64		\$0.68	
2017	\$0.67	4.2%	\$0.64	-5.6%
2018	\$0.73	9.3%	\$0.74	15.8%
2019	\$0.67	-8.8%	\$0.63	-15.2%

We expect 2020 and 2021 to remain at the level experienced in 2017 and 2019; we therefore select a 0.0 percent overall vision trend.

3.4.7.4. Overall Total Trend

To calculate the overall trend, we apply the trend factors described above to the adjusted experience period allowed claims for EHB (Exhibit 5, line C), but exclude the adjustment for claims above \$1 million. The resulting factors (1+d₁ and 1+d₂ on Exhibit 5) are calculated as shown on Exhibit 3J.

	Row on Exhibit 5	Factor
Cost Trend Factor	1+d ₁	1.0999
Utilization Trend Factor	1+d ₂	1.0698

¹⁴ Class III dental services include major restorative care such as crown, bridges and implants. Class IV refers to orthodontia.

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3.4.8. COVID-19

The COVID-19 pandemic introduces unique and immense uncertainty into actuarial projections of 2021 claims costs. The underlying demand for services that is reflected in our baseline projections certainly exists; however, it is far from clear whether the supply of those services will be affected by the pandemic or its fallout, thereby impacting utilization. Furthermore, there is little to no clarity related to additional costs that should be expected due to COVID-19 and with respect to the deferral of non-emergent care while social distancing measures are in effect.

There are four main categories of considerations regarding the cost of health care services in 2021.

Direct costs of COVID-19 treatment: Information is emerging on the cost of treating a COVID-19 patient experiencing varying degrees of severity and in different settings. However, the overall infection rate remains murky. While the current wave of infection seems to be diminishing, it is possible that additional waves will follow when social distancing is relaxed, at the onset of the winter flu season, or even as a continual challenge fueled by a lower but steady rate of transmission. It is likely that infection will continue until a vaccine is available. The intermediate-term cost of follow-up care for patients who have recovered from an initial bout with COVID-19 could be considerable. These additional costs will be countered by additional deferrals of non-emergent care should social distancing measures become necessary into 2021. It cannot be predicted with any degree of certainty which directional impact will be greater in 2021.

Costs of COVID-19 preventive services: Most experts suggest that the fastest a vaccine could reach the market is within 12 to 18 months. This time frame would place vaccine availability squarely within calendar 2021. While there has been some speculation as to the potential cost of administering the vaccine, estimates vary widely. Current law would require that insurers cover these costs with no member liability. Depending upon their availability and the extent to which they play a role in the government response to the pandemic, antibody tests may be pervasively used as well. These, too, would be covered at zero cost share. Future government actions will dictate the extent to which these costs impact insurer liability in 2021.

Impact of the deferral of non-emergent care: Some portion of deferred care will be foregone altogether, while other services will have only been delayed. The timing of the return of the delayed care will depend upon the timing and severity of additional waves of infection and periods of social distancing. It seems likely that many providers will be operating at or above capacity for at least a portion, and perhaps a significant portion, of 2021 as they endeavor to meet demand and to make up for lost revenue during periods of social distancing. Furthermore, there are concerns about a worsening of the health status of the population following the delay or elimination of preventive and other care. Mental health is of particular concern given the additional stress generated by the health and financial crisis. It is clear that population health will worsen as a result of the pandemic, but the magnitude of the deterioration is difficult to predict.

Impact of economic factors: The covered population itself may change substantially from the enrolled 2020 population. It seems likely that continued unemployment will reduce the size of the small group market, but the same phenomenon is likely to increase the size of the individual

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subsidized population. There are selection concerns related to extended grace periods and the potential for individuals to elect to forgo coverage. Naturally, there is a revenue impact here as well, as uncollectible premium may increase. However, it is also possible that currently uninsured individuals, presumably healthier than the average VISG member, could sign up for coverage.

The various impacts of the COVID-19 pandemic will impact 2021 costs, and they will do so in both an upward and a downward direction. Based on information currently available, it is difficult to so much as predict an overall directional impact, particularly because future government actions will drive the timing and magnitude of many of the above considerations. We believe that it is entirely reasonable to forecast that the ongoing pandemic will increase 2021 claims costs beyond the levels projected within this filing. However, because of the margin guidance provided in Attachment C (as discussed in section 3.8.7.2), the addition of a COVID-related factor of any magnitude would be offset by a reduction in CTR of equal and opposite magnitude, resulting in no change to the premiums presented herein. Furthermore, based on information known at the time of filing, we see no reason to believe that the best estimate of the pandemic impact is a *decrease* in 2021 claims costs. We therefore include a COVID-19 impact of zero within the 2021 premium rates.

3.5. Credibility of Experience

BCBSVT's experience period had 520,581 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 claims.

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 \$714.23. We calculated this quantity by adjusting the Projected Index Rate (line F of Exhibit 5, \$778.04) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustment Transfer PMPM:

On March 25, 2020, CMS published an Interim Summary Report on Risk Adjustment for the 2019 benefit year¹⁵. The BCBSVT data included in the report represents claims incurred in 2019 and paid through December 31, 2019. We made the assumption that MVP's 2019 interim submission

¹⁵ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2019.pdf>

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includes the same incurred and paid data as BCBSVT, consistent with previous years' interim submissions. The final 2019 report will include the impact of supplemental diagnosis files and claims runout. The impact of claims runout and supplemental diagnoses for BCBSVT and MVP was estimated based on the average relationship of the plan liability risk score (PLRS) in the 2017 and 2018 Final Summary Report relative to the 2017 and 2018 Interim Summary Report.

The 2021 risk adjustment calculation starts with the estimated final 2019 risk adjustment and projects to 2021 based on projected membership changes, market-wide premium increases, PLRS adjustments due to model changes, and other factors impacting the transfer.

Market-Wide Premium Increases

We calculated the 2021 market-wide premium PMPM by applying the expected 2021 average rate increase to the estimated 2020 market-wide premium PMPM. The 2020 market-wide premium represents the weighted average of BCBSVT's billed premium as of February 29, 2020 and MVP's imputed premium PMPM from their 2020 URRT exhibit based on projected 2021 membership. See Exhibit 4, Table 1 for the statewide premium calculation.

Population Adjustments

We adjusted the PLRS for both BCBSVT and MVP for the impact of members migrating from BCBSVT's exchange market to MVP's, the impact of Association Health Plan (AHP) members re-joining the exchange markets, the impact of new members to BCBSVT and the impact of the 2021 model coefficients.

In order to estimate the impact of these items, we calculated risk scores for every BCBSVT exchange and AHP member in the 2019 experience period. We imputed a metal level for AHP members based on their benefit design. Comparing membership in force as of February 2020 to experience membership, we categorized members into "renew", "cancel" or "new" buckets. For the individual line of business we assumed that members in the new bucket would have a risk score that is proportional to their relative age-gender factor when compared to the age-gender factor and risk scores of the individuals in the renew bucket. We assumed that any member in the cancel bucket that left BCBSVT for reasons other than retirement, death, birth or transition to another BCBSVT line of business either switched to MVP or left the exchange market entirely. We observed that the overall individual market decreased by 414 members¹⁶. These members may have left the market due to a change in employment or residence or due to foregoing insurance altogether. Lacking better data, we assumed an equal proportion of each. We estimated the impact by imputing to this population the average of the risk score for total members either switching or leaving (representing those who left due to a change in employment or residence) and the risk score of the 414 lowest risk score adults who cancelled (representing those who dropped insurance altogether).

The small group analysis assumes that a new customer entering the BCBSVT market will have risk scores that are proportional to its average age-gender factor relative to that of the renewing small group members. Employer groups we have identified as cancelled are further sub-divided into several categories based on previous carrier, destination (if known), and group size. We separately identified one a sizable group established for a specific and temporary effort that is

¹⁶ <https://info.healthconnect.vermont.gov/sites/hcexchange/files/2020%20Individual%20and%20Small%20Group%20Enrollment%20Data.pdf>

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not expected to continue into 2021. We assumed if the previous carrier was MVP or if the customer has less than 20 enrollees¹⁷, the group has migrated to the MVP exchange market unless they are known to have joined another BCBSVT line of business.

Association Health Plan (AHP) customers and their calculated risk scores are categorized into three components: renewed in BCBSVT exchange, migrated to MVP exchange or renewed elsewhere. Like small group, we assumed if the carrier prior to AHP was MVP or the customer has less than 20 enrollees, they have migrated to the MVP exchange market unless they are known to have joined another BCBSVT line of business.



Model Changes

We considered the impact on risk scores of both BCBSVT and MVP of changes in the 2021 risk adjustment model coefficients. We focused our analysis on the following model coefficient categories: demographic, diagnosis, enrollment duration and cost-share reduction (CSR). In general, we observed a relative increase in the coefficients in platinum and gold plans and a relative decrease in silver and bronze plans. There appears to be a significant decrease in the demographic and enrollment duration factors and an increase in the diagnostic factors. Additionally, we observed a shift in plan mix from the 2019 experience period for both BCBSVT and MVP, as shown in the table below. BCBSVT is projecting to have fewer platinum members and more bronze members as a percent of total. We are projecting MVP to have a similar plan mix in 2021 as reported in 2020, which increases platinum and decreases bronze as a percent of total membership relative to the base year of 2019.

MVP ¹⁸	Platinum	Gold	Silver	Bronze
2019	8.5%	31.1%	34.4%	25.9%
2021	9.8%	35.2%	31.4%	23.6%

BCBSVT	Platinum	Gold	Silver	Bronze
2019	21.2%	28.1%	37.1%	13.5%
2021	18.3%	29.0%	35.9%	16.8%

Our model coefficient analysis addresses the change in the factors as well as the change in plan mix between the carriers.

¹⁷ The self-funded market is extremely limited in Vermont for very small groups. A number of self-funded alternatives do exist for groups of greater than 20 enrollees.

¹⁸ <https://info.healthconnect.vermont.gov/sites/hcexchange/files/2020%20Individual%20and%20Small%20Group%20Enrollment%20Data.pdf>



















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Applying the 2021 demographic factors for adults, children and infants to the projected 2021 BCBSVT membership mix, we calculate an updated demographic risk score of 0.266 compared to the 2019 BCBSVT demographic risk score of 0.349. The enrollment duration factors decreased in total like the demographic factors. We assumed the distribution of members by months of enrollment is the same in 2021 as that observed in 2019. Applying the 2021 plan mix to the 2021 duration factors produces a duration factor of 0.010, down from 0.022 in 2019.

The cost share reduction (CSR) factors are the same in 2021 as they were in 2019. The CSR component in the total risk score will vary based on the percentage of total membership in a CSR plan, the mix of CSR levels, and the relative base risk score (demographic, diagnosis, duration) of the CSR population relative to the non-CSR population. We assumed the base risk scores of the CSR population relative to the non-CSR population remain the same. BCBSVT’s projected 2021 membership assumes 12.9 percent of total membership will be in a CSR plan compared to 13.3 percent in 2019. The distribution of CSR levels is approximately the same; thus, we project the percentage of total 2021 risk score specific to the CSR component to be 1.1 percent, down from 1.2 percent in 2019.

The estimate of the 2021 diagnosis component assumes the same distribution of hierarchical condition categories (HCC) as that experienced in 2019. The 2021 model contains some additional HCC categories when compared to 2019, and so we considered only the HCCs that were in both the 2019 and 2021 diagnosis tables when calculating the impact of the new model¹⁹. The weighted average of the 2019 HCCs assuming the 2019 metal distribution across all categories produces an average diagnosis risk score of 2.778 (for those members with a diagnosis risk score). Updating to the 2021 model coefficients and applying 2021 metal distributions the average diagnosis risk score increases to 2.895, about 4.2 percent increase.

The table below illustrates the BCBSVT risk scores by component for the 2019 experience period, the adjusted risk scores after 2021 membership movement, and the projected 2021 risk scores including the impact of the model changes as well as the change in plan mix.

BCBSVT	Total	Demographic	Diagnosis	Duration	CSR
2019 Risk Scores	1.577	0.349	1.188	0.022	0.018
2019 distribution	100.0%	22.1%	75.3%	1.4%	1.2%
					
					
					
2021 Risk Scores (2021 Model)	1.541	0.266	1.248	0.010	0.018
2021 distribution (2021 Model)	100.0%	17.3%	81.0%	0.6%	1.1%

¹⁹ We made the same assumption for MVP; thus, any skewness that could result from the new HCCs being excluded will cancel out of the projection.

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We can observe that the projected 2021 risk score drops to 1.541 due to changes in the 2021 model and metallic plan mix. The next step was to develop comparable summaries of MVP's risk scores and determine the risk score ratio between BCBSVT and MVP after 2021 model and plan mix changes. Because BCBSVT has limited sightlines into MVP data, this necessitated a simplified approach.

BCBSVT has estimated MVP's 2019 experience risk score to be 1.237 by applying a two-year average completion factor to the 2019 interim risk adjustment report. [REDACTED]

[REDACTED] Starting with the CSR component, we observe the membership mix of total CSR and CSR level from the market wide enrollment report²⁰. We estimate MVP's CSR risk score to be 1.49 percent of their total risk score, or 0.018 as a factor. MVP's 2019 membership consists of 16.8 percent CSR members and their CSR plan mix has an average induced utilization factor of 1.083. BCBSVT by comparison has 13.3 percent of their experience in a CSR plan with an average induced utilization factor of 1.074. Given that MVP has a higher concentration of CSR members and richer CSR plans than BCBSVT their CSR risk score percent is higher as a percent of total. The estimate of the CSR component of MVP's risk score is therefore $(0.168 \times 1.083) / (0.133 \times 1.074) \times 0.012 = 1.49$ percent.

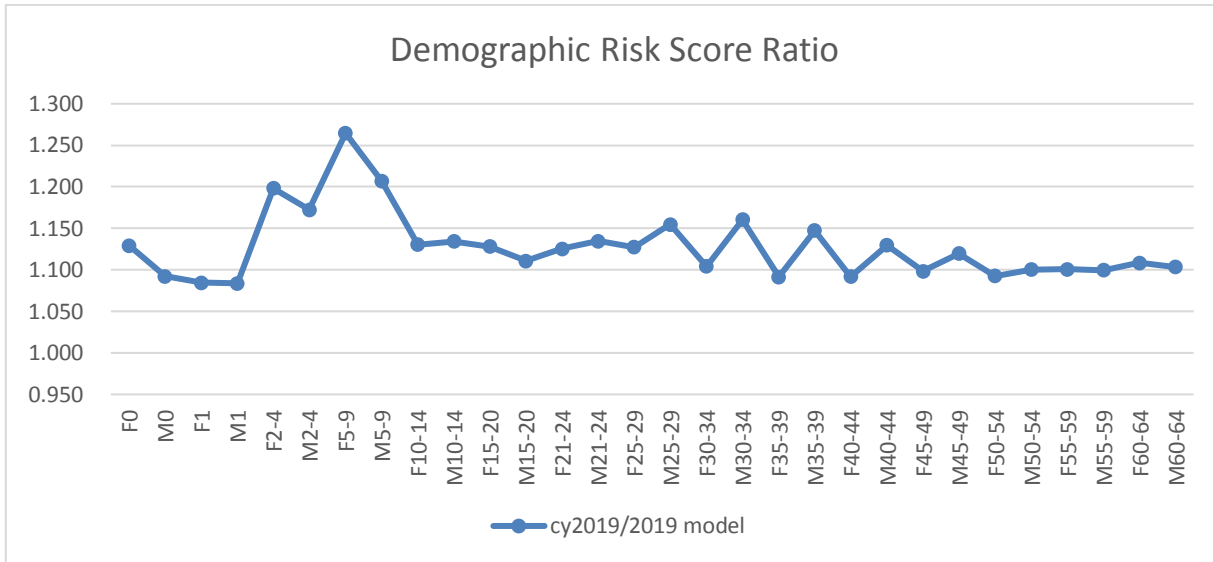
The enrollment duration factor for MVP starts with the assumption that they have a mix of membership with less than twelve months of enrollment comparable to that of BCBSVT. Applying MVP's 2019 metallic plan distribution across the 2019 duration factor table yields an estimate of 0.021. Since the enrollment duration factors apply only to adults, we made an additional adjustment to account for the difference in adults as a percent of total between each carrier. We estimate that 83.8²¹ percent of MVP's membership is an adult compared to BCBSVT's experience of 80.3 percent. Thus, MVP's 2019 enrollment duration risk score is estimated as $0.021 \times (0.838 / 0.803) = 0.022$.

The demographic factor varies by age, gender and metallic plan. Since we do not know MVP's age and gender distribution, we applied their metallic plan distribution across all age/gender buckets and compared those results to BCBSVT's metallic plan distribution applied across all age/gender buckets. The graph below illustrates the relationship between BCBSVT and MVP for each of the model's age/gender categories. Most of the data points fall between 1.10 and 1.15. The midpoint of this range, 1.125, is where the adults in the 21 to 49 aged data points are heavily concentrated. Since we believe that MVP has a higher proportion of adults relative to their total and presumably has proportionally younger adults, we have selected 1.125 as the demographic risk score ratio. MVP's 2019 demographic risk score component is therefore estimated as $0.349 / 1.125 = 0.310$.

²⁰<https://info.healthconnect.vermont.gov/sites/hcexchange/files/2020%20Individual%20and%20Small%20Group%20Enrollment%20Data.pdf>

²¹ Exhibit 4 of MVP's VT Exchange 2020 filing

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The diagnosis component is the difference between MVP’s total risk score and the demographic, enrollment duration and CSR components. This is calculated as $1.237 - 0.310 - 0.022 - 0.018 = 0.886$.

Adding in the migrating membership from the BCBSVT lines of business produces the following adjusted MVP risk score:

MVP	Total	demographic	diagnosis	duration	CSR
2019 Risk Scores	1.237	0.310	0.886	0.022	0.018
2019 distribution	100.0%	25.1%	71.6%	1.8%	1.5%
Membership Adjusted Risk Scores (2019 Model)				0.025	0.018
Membership Adjusted distribution (2019 Model)					

The risk score information in this table, along with BCBSVT’s projected 2021 risk scores, provides a basis to estimate the impact of the 2021 model coefficients and the projected 2021 metallic plan mix on MVP’s risk scores.

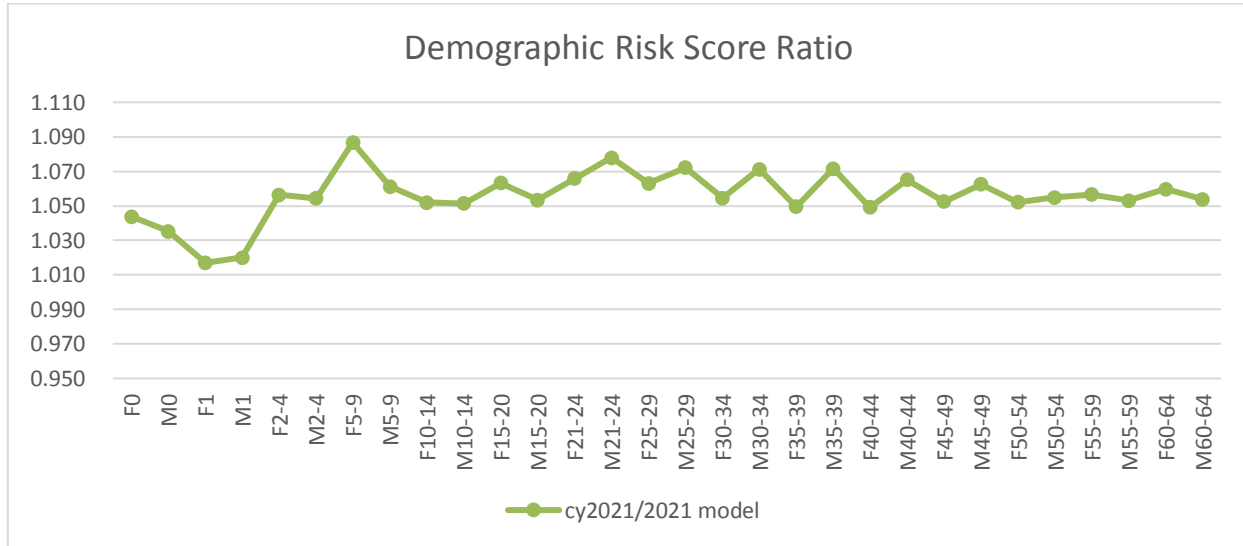
The 2021 CSR factor is estimated based on the CSR membership changes as a percent of MVP’s total as well as the change in CSR levels. We project MVP’s 2021 membership to include 13.6 percent in a CSR plan with an average induced utilization factor of 1.084. Comparing these figures to MVP’s 2019 experience attributes 1.20 percent of their 2021 risk score to the CSR component, calculated as $(0.136 \times 1.084) / (0.168 \times 1.083) \times 0.0149 = 0.0120$.

The enrollment duration factor for MVP’s 2021 estimate uses the simplifying assumption that the distribution of months of enrollment is the same as BCBSVT’s. The weighted average MVP’s 2021 metallic distribution on the 2021 model coefficients compared to MVP’s 2019 weighted average

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is 0.640. The 2021 enrollment duration factor multiplies this relational value to MVP’s adjusted risk score, calculated as $0.025 \times 0.640 = 0.016$.

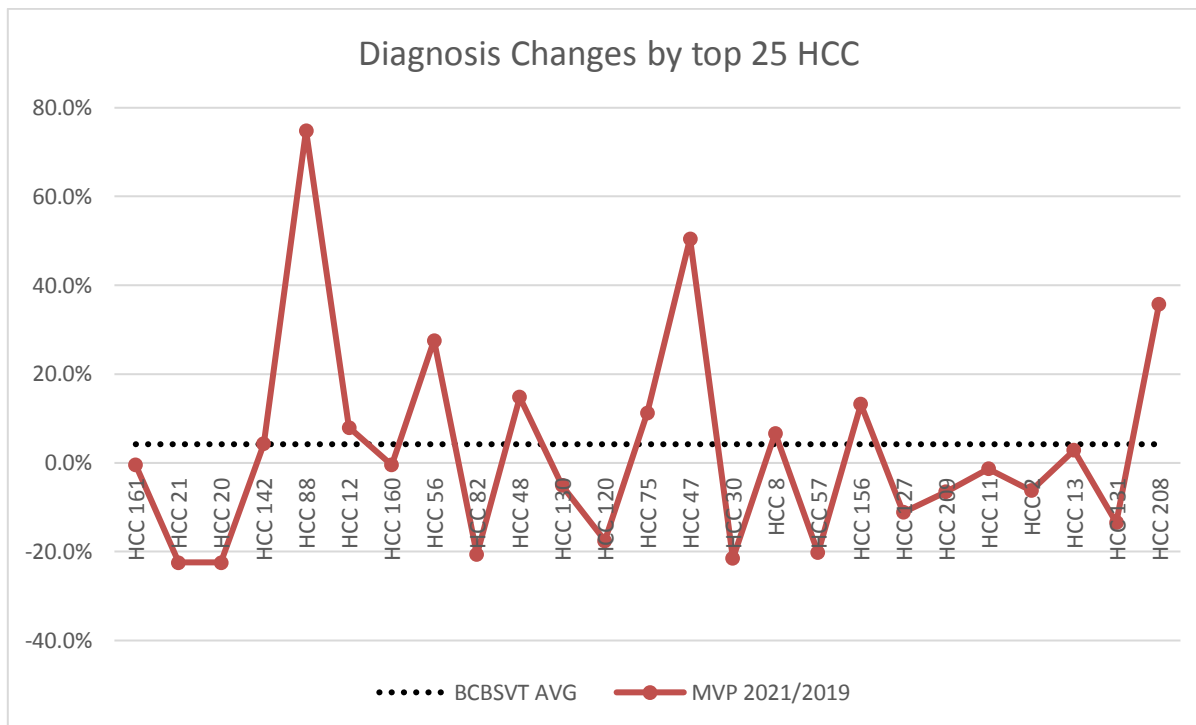
The 2021 MVP demographic factor uses a similar approach as 2019 since we do not have the age and gender distribution of MVP members. We applied MVP’s 2021 metallic distribution to each age/gender category and compared it to BCBSVT’s 2021 metallic distribution applied across all age/gender categories. As shown in the graph the relationship between BCBSVT and MVP for the demographic component has converged in 2021 compared to 2019:



Apart from the infant categories, the demographic risk score relationship between BCBSVT and MVP is concentrated mostly within the range of 1.05 to 1.07. We have selected the midpoint of the range as the assumption underlying MVP’s demographic score, calculating a demographic score of $0.266 / 1.06 = 0.251$.

The diagnosis component varies greatly from one HCC to the next. Some categories had decreases in the 2021 model compared to 2019 while others had increases. We have no insight into the distribution of HCCs underlying MVP’s experience, so we applied MVP’s 2019 metallic distribution to the 2019 model coefficients and compared those results to MVP’s 2021 metallic distribution on the 2021 model coefficients. The graph shows MVP’s increases and decreases for the 25 most common HCCs compared to BCBSVT’s average increase from 2019 to 2021 of 4.2 percent.

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Despite the volatility within this data we can still say that depending on MVP’s actual HCC distribution it is possible for them to experience an increase greater than BCBSVT’s 4.2 percent and it is also possible for them to experience an increase less than 4.2 percent. Therefore, the most reasonable assumption for MVP’s diagnosis component is to use that calculated for BCBSVT: 4.2 percent.

Compiling the 2021 MVP components for CSR, enrollment duration, demographics and diagnosis results in a total risk score of $1.265 = 0.015 + 0.016 + 0.251 + 0.985$. The risk score ratio between BCBSVT’s projected 2021 risk score, 1.541, relative to MVP’s risk score of 1.265 is 1.2181. The ratio of the adjusted risk scores prior to measuring the impact of the 2021 model and metallic distribution changes is 1.2182, meaning that we have estimated a model change impact of -0.01 percent. Since this result is vanishingly close to zero, we conclude that the impact of the 2021 model coefficient changes is nullified by the shift in metallic plans experienced by BCBSVT and MVP. Therefore, we make no adjustment to the risk score ratio for model changes.

Other Factors

The catastrophic plan adjustments were made to the 2019 estimated final risk adjustment for observed membership movements. Like the merged market, we assume a two-year average completion factor that was used to adjust the interim 2019 risk adjustment to the final 2019 risk adjustment for the catastrophic market. Overall, we expect that BCBSVT will have approximately 96 percent of the catastrophic market in 2021, comparable to the 2019 interim risk adjustment report. We assume that risk scores for new BCBSVT members are proportional to their age-sex factors relative to those of renewing catastrophic members. The impact of this movement is a slight decrease in BCBSVT’s catastrophic risk score since the new members are projected to have modestly lower risk scores than the members no longer with BCBSVT. We

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assumed that MVP's catastrophic risk scores would not have a material change; thus, the catastrophic risk score ratio is expected to be slightly lower in 2021.

Other factors impacting the risk adjustment transfer include the actuarial value (AV), induced demand factor (IDF) and allowed rating factor (ARF). The AV and IDF factors change from the estimated final 2019 calculation as a result of the metallic distribution changing in 2021. We assume the ARF is unchanged from 2019. These results are shown in Exhibit 4, Table 3.

The 2021 transfer amount PMPM is partially offset by the projected charges and payments for the High Cost Risk Pool (HCRP) program. HHS published the final 2018 Risk Adjustment Summary Report on June 28, 2019, which clarified that the actual 2018 high-cost risk pool charge was 0.21 percent for merged market plans. Because trend leverage for a constant attachment point will increase the charge as a percent of total premium, we estimate the 2021 charge to be 0.25 percent of premium, or \$1.69 PMPM. Because the methodology described in Section 3.3.1 nets projected reinsurance payments from projected claims, we effectively assume HCRP payments of zero.

Since the Market Adjusted Index Rate is on an allowed claims basis, we adjusted the net projected risk adjustment payment by the average paid-to-allowed ratio (from Exhibit 6C). The overall market-wide adjustment (line g₁ of Exhibit 5) for the risk adjustment program is -\$63.97 PMPM as shown on Exhibit 4.

3.7.2. Exchange User Fees

BCBSVT does not expect Vermont Health Connect to charge a user fee for 2021.

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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 informed by two factors:

- Benefit Richness Adjustment
- Paid-to-Allowed Ratio

The paid-to-allowed ratio comes from the federal actuarial value calculator (AVC) and is adjusted for benefit items that are not supported by the calculator as well the impact of aggregate and stacked deductibles. The adjustments to the federal AVC come from BCBSVT's internal re-adjudication model. The experience used to calculate the adjustments to the-paid-to allowed ratio is our calendar year 2018 data trended to calendar year 2021 using the trend factors described in section 3.4.7. The model re-adjudicates claims by starting with the allowed charges and applying appropriate cost sharing for each service. The model generates the projected average paid claims for each benefit based on what the AVC can support as well as what the model cannot support. The relationship between these outputs from the BCBSVT based model is applied to the federal AVC paid-to-allowed ratio. The BCBSVT re-adjudication model is calibrated to 2018 experience and able to reproduce the experience paid-to-allowed ratio to within 0.1 percent.

The benefit richness adjustment reflects the expected changes in utilization due to different levels of cost sharing. This adjustment is based on the 2020 adjusted federal AVC. The 2021 federal AVC was not used as the basis because the updates made to the AVC produced counterintuitive results across metal levels. The AVC, while not developed as a pricing tool, is used here to set the relativities between the plans because it represents the best approximation of a total market distribution free from selection bias. The adjustment described in section 3.8.6 ensures that the total premium collected is appropriately based on BCBSVT's re-adjudication model and experience, and not the federal AV calculator.

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. We applied the HHS Induced Utilization formula ($IU=AV^2-AV+1.24$) to each plan's paid-to-allowed ratio described in the section above.

These factors were normalized using the projected membership to ensure that the total adjustment is 1.000. The plan-level adjustment for benefit richness is calculated by applying the benefit richness adjustment by base benefit and applying a factor of 1.000 for non-system claims and market-wide adjustments. See Exhibit 6B for details.

3.8.1.2. Paid-to-Allowed Ratio

The paid-to-allowed ratio as seen in Exhibit 6C reflects the expected portion of total claims BCBSVT will pay. To calculate these ratios, we utilize the standard population within the federal AVC. Two adjustments are made to the federal AVC: 1) impact of benefit items not supported by the AVC, and 2) the impact of family deductible and family out of pocket on the paid-to-allowed

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ratio. The result is a paid-to-allowed ratio based on a standard population that reflects the BCBSVT plan designs, including the family deductible and out of pocket maximum arrangements.

3.8.2. Silver Loading:

The silver loading plan level adjustment represents the impact of the defunding of the federal cost share reduction (CSR) program. Each base silver plan measures the impact of the 73%, 87%, 94% and 100% CSR plans by running each plan design through the BCBSVT re-adjudication model and observing the projected paid-to-allowed ratio differences. These plan specific differences are multiplied through by projected CSR membership. Projected CSR membership is assumed to be equal to the observed February 29, 2020 CSR membership. The total impact of the silver loading is \$5.4 million. Please see details in Exhibit 6C.

3.8.3. Provider Network, Delivery System and Utilization Management adjustment:

Not applicable.

3.8.4. Adjustment for benefits in addition to the EHBs:

We trended our 2019 experience period non-EHB claims using the medical trends described in section 3.4.7, which produced an average allowed charge of \$0.09 per member per month. Applying the same paid-to-allowed ratio to this benefit as to the EHB benefit, we calculate plan level factor adjustments that range from 1.0001 to 1.0005, as shown on Exhibit 6A.

3.8.5. 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 adjustments are based on the eligible population. The eligible population includes Vermont residents who are under age 30 and residents age 30 and over who are granted a hardship exemption by Vermont Health Connect. We used our current enrollment in the catastrophic plan as a proxy for eligibility and adjusted the projected members who would qualify under the hardship rule to account for the increase in premiums. [REDACTED] 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 (qualifying by age or hardship) and re-adjudicating for the catastrophic benefit. Using the projected eligible members as weights, we calculate that the overall expected allowed charges are 0.5187 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 0.9467.

These factors were applied to the EHB portion of the Projected Period Index Rate. Because this adjustment has no impact on 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 0.4469. See Exhibit 6D for details.

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3.8.6 Impact of Selection

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 6E). 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 left section of Exhibit 6E shows the build-up of paid claims from allowed charges using actual plan-level adjustments described in Section 3.8 of this memorandum. The right section of the same exhibit demonstrates the impact on total paid claims of using benefit richness adjustments that instead reflect actual 2019 single risk pool 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. The total impact of selection is 1.0871, as shown in Exhibit 6E.

3.8.7. Adjustment for distribution of the administrative costs

3.8.7.1. Administrative Expense Load:

BCBSVT did not initially calculate the administrative expense load as a percent of premium adjustment. This adjustment is the sum of the following fees:

BCBSVT Base Administrative Charges

We use calendar year 2019 data from both individual and small group members to develop the Base Administrative Expenses PMPM. The starting PMPM for the base administrative charges is \$45.87 PMPM. The single risk pool population is comprised of individuals who can choose to enroll through the Vermont Health Connect (VHC) website or directly with BCBSVT, and small groups that enroll directly with BCBSVT. The experience period base administrative expenses for individuals was \$51.05 PMPM compared to \$41.90 PMPM for members in small groups.

We removed expenses incurred due to one-time, non-recurring events, as these fees are not expected to continue into the projection period. These primarily consist of transitional costs associated with the conversion to a new technology platform. We have reflected transitional savings of \$0.46 PMPM in 2021 for the VISG line of business.

The remaining charges (\$45.41 PMPM) are projected to 2022 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 2020, over the projection period. We assumed that other operating costs remain flat. We calculated that 73.2 percent of our administrative costs are for salaries and benefits. The decline in this percentage from previous years is largely due to software depreciation increases due to the new operating platform along with a reduction in consulting services. We therefore increase our projected administrative expenses by the weighted average of 2.2 percent per annum.

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Administrative trend calculation		Percent of Total BCBSVT Administrative Costs CY 2019
Employee costs:	$A = a_1 + a_2$	56.7%
Purchased services	B	22.5%
Other operating costs	C	20.8%
Total Administrative Expenses	$D = A + B + C$	100.0%
BCBSVT Personnel Cost	$E = A / (A + C)$	73.2%
Projected Personnel Cost Increase	F	3.0%
Projected Administrative Cost Increase	$G = (E \times (1+F) + (1-E)) - 1$	2.2%

Overall enterprise membership decreased significantly in 2020. To adjust for membership losses, we calculate PMPM admin charges with 2019 enrollment and projected 2020 enrollment. Using the lower 2020 enrollment increases the PMPM by 6.0 percent. Cost accounting exercises suggest that variable costs represent half of total administrative expenses. BCBSVT is committed to providing insurance coverage for our members at the most affordable rates possible; as a result, even though it is impractical to react to enrollment shifts by immediately right-sizing staff, we nonetheless remove from our projection the entirety of variable costs associated with the reduced enrollment. We therefore apply an increase of 3.0 percent to the base PMPM charges to account for the reduction in membership. The table below demonstrates the calculation.

Average Monthly 2019 Enrollment	A	187,261
Projected Monthly 2020 Enrollment	B	176,610
CY 2019 enterprise PMPM with 2019 enrollment	C	\$36.63
Projected CY 2020 enterprise PMPM with 2020 enrollment	$D = A \times C / B$	\$38.84
Reduced Projected CY 2020 enterprise PMPM to reflect 50% variable cost	$E = C + (D-C)/2$	\$37.73
Impact of Membership Losses	$F = E/C$	1.0302

To calculate the projected base administrative charges, we multiplied the experience PMPM, net of non-recurring expenses, by 2.2 percent for two years for trend.

Projected Administrative Charges Calculation		PMPM
Experience Base Administrative Charges	A	\$45.87
Exclusion of non-recurring expenses	B	(\$0.46)
Trend Projection (2 years)	C	1.0444
Impact of Membership changes	D	1.0302
Projected Base Administrative Charges (Exhibit 7A)	$E = (A-B) \times C \times D$	\$48.85

The projected base administrative charges PMPM of \$48.85 is 7.2 percent of premium.

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VHC Billing

Carriers will be taking over premium billing for VHC enrolled members for plan year 2022. BCBSVT must enhance its billing technology capabilities, hire customer service staff and be ready to process transactions by October 2021 for open enrollment. Expenses in plan year 2021 related to the transition of VHC billing are estimated at \$0.94 PMPM. These are added to BCBSVT projected base administrative expenses.

Debit and Credit Card Fees

Starting in plan year 2021, BCBSVT will offer members the opportunity to pay their premiums via debit and credit cards. Currently, BCBSVT only offers direct debit and check payments. Banks charge fees as a percent of the transaction for debit and credit card payments. To estimate the average fee, we relied on our banking partners for the projected average fee per transaction. Their estimate, based on an average cost for debit card transaction of 0.7 percent, average cost for credit card transaction of 2.35 percent, and known banking fees of \$0.15 and 0.25 percent per transaction, is 2.3 percent of premium. Currently, approximately 25 percent of BCBSVT VISG small groups and individuals directly enrolled with BCBSVT use our online platform to pay their premium via direct debit transactions. We expect that 40 percent of policy holders who currently use direct debit will switch to debit or credit card payment. We also project that the percentage of policyholders that use the online platform will grow to 40 percent, and that 70 percent of the new accounts will elect to pay via debit or credit card. Using these input items, we calculate an estimated fee of 0.4715 percent of premium.

Charges for Outside Vendors

- **CBA Dental and VSP Vision**
Dental and vision benefits are administered by third parties. The administrative fees are charged for eligible members only. We assume that these fees will not increase from those in the experience period, and therefore add a charge equal to the experience period PMPM.
- **HRA/HSA Integration Services**
All single risk pool members are eligible for HRA and/or HSA integration services. For plans with an HSA-compatible benefit design, we offer a service to integrate with the mechanics of depositing monies into and paying claims out of Health Savings Accounts (HSAs). All plans are also eligible for this service in connection with Health Reimbursement Accounts (HRAs). 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 the single risk pool in the first quarter of 2020.

The total of all administrative charges outlined in this section is 7.91 percent of premium. The details of the administrative charges are on Exhibit 7A.

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Reconciliation to the Supplemental Health Care Exhibit

The Supplemental Health Care Exhibit (SHCE) is on a statutory accounting basis (as promulgated by the NAIC), while the administrative charges in this filing were developed based on GAAP accounting.

In the SHCE, administrative expenses are included in lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4. Line 1.5 also includes an allocation of federal income taxes that are not part of administrative expenses. Those must be excluded to reconcile to statutory basis administrative expenses (note that BCBSVT had an income tax benefit, or negative income tax expense, for 2019). Statutory and GAAP accounting treat some expenses differently, mainly related to ITS fees and pension costs. For the filing, we start with GAAP administrative expenses and then exclude from the base administrative charges federal and state fees and assessments (Federal Insurer Fee, PCORI, HCCA and GMCB billbacks) and certain fees paid to outside vendors, as those are added back into the premium separately. As described above, we also excluded from the experience expenses that were due to one-time, non-recurring events. The following chart demonstrates a reconciliation of the SCHE to base period administrative charges used in this filing:

		Individual and Small Group
SCHE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	\$26,846,448
Less taxes in SCHE 1.5 that are not admin	B	(\$1,138,520)
Total administrative charges - STAT basis	C = A - B	\$27,984,968
Differences in STAT and GAAP treatment	D	(\$2,102,889)
Total administrative charges - GAAP basis	E = C + D	\$25,882,079
Federal and State fees	F	(\$1,557,213)
Fees for outside vendors	G	(\$231,635)
Exclusions*	H	(\$214,973)
Total base administrative charges	I = sum(E:H)	\$23,878,258
Member months	J	520,581
Experience base administrative charges PMPM	K = I / J	\$45.87

* The exclusions include the transitional savings and other one-time, non-recurring events.

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

Contribution to Policyholder Reserves

As directed by BCBSVT management, the filed rates include a 1.5 percent contribution to reserves (CTR). A contribution to policyholder reserves is required in order to maintain an adequate level of surplus. Surplus, or policyholder reserves, is a critical consumer protection that is required by the Vermont Department of Financial Regulation. In the event of unforeseen adverse events that may otherwise impact BCBSVT’s ability to pay claims, surplus allows subscribers to receive needed care and providers to continue to receive payments.

A memo from BCBSVT senior management regarding the requested level of CTR can be found as Attachment C.

Other Risk Margin

Under the ACA, enrollees who are receiving Advance Premium Tax Credits (APTC) have a three-month grace period to pay premiums, while enrollees who are not receiving APTC have a one-month grace period. For both these populations, the State requires the insurer to pay for claims incurred in the first month of the grace period even if premium is never collected. This uncollected premium is considered bad debt. To ensure that BCBSVT collects enough premium from the total pool to cover the grace periods, it is necessary to include a risk margin for bad debt. We have added a margin of 0.10 percent, which is both the 3-year average and the actual amount of uncollected premium due to the grace periods in each of the previous four years.

	Unpaid 30-day Grace Period Premium	Total Billed Premium	Percent of Billed Premium
2016	\$207,098	\$386,247,850	0.1%
2017	\$415,186	\$408,055,901	0.1%
2018	\$276,549	\$342,711,239	0.1%
2019	\$232,289	\$309,718,620	0.1%
Total	\$924,024	\$1,446,726,734	0.1%

Every year since the inception of VHC, BCBSVT has been left with outstanding account receivables for premiums expected from VHC for members enrolled through their system, excluding the 30-day grace amounts. Through 2016, these accounts receivable were paid by VHC through a settlement process. BCBSVT has incurred losses in 2017, 2018 and 2019 totaling \$1.9 million for these unpaid premiums.

	Uncollected Premium	Total Billed Premium	Percent of Billed Premium
2017	\$582,126	\$408,055,901	0.1%
2018	\$585,831	\$342,711,239	0.2%
2019	\$704,553	\$309,718,620	0.2%
Total	\$1,872,510	\$1,060,465,687	0.2%

BCBSVT is including a 0.2 percent risk charge for uncollectable VHC premium in the 2021 rating. Therefore, the total risk charge for bad debt is 0.3 percent.

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

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3.8.7.3. Taxes and Fees:

The proposed rates include on average 1.43 percent in taxes and fees. These taxes and fees are imposed by both the state and federal government.

Green Mountain Care Board Billbacks

BCBSVT is assessed a billback from the Green Mountain Care Board. In 2019, \$787,708 was allocated to the VISG market. To calculate the increase to this fee, we used the increase in BCBSVT invoice from FY2019 to FY2020 and applied to the portion allocated to VISG in 2019. The BCBSVT total invoice increased by 48.6 percent. We therefore calculate the projected 2021 billback allocated to BCBSVT VISG products as \$1,170,718, or \$2.54 PMPM.

Health Care Claims Tax

The Health Care Claims Tax (HCCT) levied by the State of Vermont totals 0.999 percent of claims. This consists of 0.8 percent of claims for the HCCA tax and 0.199 percent of claims for the VITL assessment. Act 73 of 2013 sunset the 0.199 percent assessment for the Health IT-Fund. A two-year extension was approved by the Vermont legislature in Act 41. Given that this fee has routinely been extended close to its sunset date, we continue to include it in the calculation for the full calendar year.

Patient-Centered Outcomes Research Institute Fee

This fee is part of the Affordable Care Act and applies to all plan years through October 1, 2029. We estimate that the fee will be \$0.24 PMPM for the plan year ending December 2021.

Federal Insurer Fee

The Federal Insurer Fee (also known as the Health Insurer Tax, or HIT) funded some provisions of the Affordable Care Act. H.R.1865 ended this fee after 2020.

Risk Adjustment User Fees

Per the 2021 proposed Notice of Benefits and Payment Parameters (85 FR 7088), the risk adjustment user fee is \$0.19 per billable member per month. Using the projected relationship of 0.9326 billable months per member month from the risk adjustment transfer calculation, we included \$0.18 PMPM for the risk adjustment user fees.

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

3.8.8. Calibration

Age, Tobacco, and Geographic factors are not allowed in Vermont. Therefore no calibration is required.

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3.8.9. Projected Loss Ratio

The MLR calculation will be performed at the combined market level with a minimum requirement of 80 percent. We project that the overall Loss Ratio, using the federally prescribed MLR methodology for the combined market, will be 90.8 percent. See Exhibit 8 for details.

3.9. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium rates are displayed on Exhibit 9B. Since rate factors for age, tobacco and geography are not allowed in Vermont, the only adjustment is the application of rating tier factors. Vermont has predetermined the tier factors for plans for Individuals and Small Groups.

We observed that using the same contract conversion factor on all plans does not produce the same total premium when multiplying members and PMPM and when multiplying contracts and rates. This is due to not all plans having the same distribution in each tier and not all plans receiving the same annual rate increase.

To correct this discrepancy, we calculate the contract conversion factor in two steps using projected membership. First, we calculate preliminary rates by tiers by using the simple ratio of average number of members to subscribers to calculate average tier factors for all plans except the catastrophic plan. We then compare the total premium from multiplying members by PMPM to the premium totaled by multiplying contracts by rates, and adjust the contract conversion factor to ensure that we collect the total required annual premium. We calculate a contract conversion factor specifically for the catastrophic plan and one for all other plans.

Please see Exhibit 9A for details calculation of the contract conversion factor.

The Consumer Adjusted Premium Rates are shown on Exhibit 9B.

3.10. Small Group Plan Premium Rates

All Small Groups must renew on January 1, 2021 according to the combined market rules. BCBSVT will not file small group rates for Q2-Q4 2021.

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4. ADDITIONAL INFORMATION

4.1. Terminated Products

BCBSVT is terminating the Blue Rewards deductible plans and replacing them with the Vermont Preferred plans as of January 1, 2021. The table below includes the mapping to the new plans.

Market	Terminated Plans		New Plans	
	2020 Name	2020 QHPID	2021 Name	2021 QHPID
Small Group	Blue Rewards Gold	13627VT0360001	Vermont Preferred Gold	13627VT0360005
Small Group	Blue Rewards Silver	13627VT0360002	Vermont Preferred Silver	13627VT0360006
Small Group	Blue Rewards Silver - Reflective	13627VT0360004	Vermont Preferred Silver - Reflective	13627VT0360008
Small Group	Blue Rewards Bronze	13627VT0360003	Vermont Preferred Bronze	13627VT0360007
Individual	Blue Rewards Gold	13627VT0380001	Vermont Preferred Gold	13627VT0380005
Individual	Blue Rewards Silver	13627VT0380002	Vermont Preferred Silver	13627VT0380006
Individual	Blue Rewards Silver - Reflective	13627VT0380004	Vermont Preferred Silver - Reflective	13627VT0380008
Individual	Blue Rewards Bronze	13627VT0380003	Vermont Preferred Bronze	13627VT0380007

4.2. Plan Type

The plan type is EPO.

4.3. Act 193 Information

The table below shows the percentage of the 2021 proposed PMPM premium for generic, brand, and specialty drugs. The percent of premium rate was calculated by applying the brand, generic and specialty weights from Exhibit 3G to the total pharmacy projected allowed PMPM from Exhibit 5, adjusted for non-trend factors in the Projected Index Rate and adjusted for the plan level adjustment. Pharmacy rebates were weighted based on projected brand and specialty paid claims. We are assuming that the plan level adjustments apply to each category equally.

Drugs Processed Under the Pharmacy Benefit	
Type	Percent of premium
Generic	3.1%
Brand	6.0%
Specialty	9.9%

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The table below shows the change in allowed charge PMPM from calendar year 2018 to calendar year 2019 and the annualized projected increase to 2021, including the impact of contract changes.

Drugs Processed Under the Pharmacy Benefit		
Type	CY 2018 to CY 2019	CY 2019 to CY 2021, Annualized
Generic	3.0%	4.1%
Brand	9.1%	7.4%
Specialty	15.2%	20.5%

The increase in drug spending compared to other premium components is below:

Premium Increases	
Component	Increase
Rx Claims	8.5%
Medical Claims	5.8%
Non-Claims Components	-6.4%

Information about BCBSVTs National Performance Formulary is located on our website, <https://www.bcbsvt.com/pharmacy/drug-lists/national-performance-formulary-npf>. BCBSVT's benefits do not have a specialty tier. All brand drugs, specialty or not, are included in the preferred brand or non-preferred brand tiers.

Drugs administered in an outpatient setting and covered by the medical benefit represent 13.2 percent of the projected 2021 premium PMPM.

BCBSVT's pharmacy benefits are administered by Express Scripts (ESI). ESI manages claims processed through the pharmacy benefit but not claims processed through the medical benefit for use in a facility.

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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, Principal and Senior Consulting Actuary and Brittney Phillips, ASA, MAAA, Consulting Actuary with Wakely Consulting. (Attachment A)

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the plans that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to offer to the Vermont individual and small group market in 2020. 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 and Reflective plan offered by BCBSVT in 2021, the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, that the Index Rate is developed in accordance with federal regulations, and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

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

In my opinion, the projected Index Rate is in compliance with all applicable State and Federal Statutes and Regulations (including 45 CFR 156.80 and 147.102), has been developed in compliance with the applicable Actuarial Standards of Practice, is reasonable in relation to the benefits provided and the population anticipated to be covered, and is neither excessive nor deficient. The calculations and results are appropriate for the purpose intended.

The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

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

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

The COVID-19 pandemic introduces uncertainty far greater than that present in a typical rate development. Scientific knowledge of the pathogen and its treatment continues to evolve. Furthermore, future governmental action in response to the pandemic will have a material impact on costs. As the health care ecosystem continues to rapidly change, new developments may call into question the adequacy or excessiveness of the premium rates discussed herein.

**BLUE CROSS BLUE SHIELD OF VERMONT
2021 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING
ACTUARIAL MEMORANDUM**

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 A. Schultz, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont
May 8, 2020