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July 9, 2019

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

Re: Blue Cross and Blue Shield of Vermont
2020 Vermont Health Connect Individual and Small Group Rate Filing
SERFF# BCVT-131936226

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2020 Individual and Small Group Filing for Blue Cross and Blue Shield of Vermont (BCBSVT) and to assist the Green Mountain Care Board (GMCB or Board) in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation that provides individual coverage, small and large group coverage to employers, and Medicare Supplement coverage in Vermont. This filing develops premiums for BCBSVT's Qualified Health Plans (QHPs) to be offered on Vermont Health Connect (VHC), beginning January 1, 2020.

2. This filing addresses BCBSVT individual members and small groups. There are 43,939 members enrolled in plans affected by this filing. Enrollment in these plans has decreased in recent years, as demonstrated in the following table:

Coverage Year	Members	Change
2015	67,050	--
2016	70,423	5.0%
2017	70,035	-0.6%
2018	53,664	-23.4%
2019	43,939	-18.1%

3. As required by law, VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters at certain income levels who will pay a limited premium as a percentage of their income. These plans include funding to offset the loss of federal CSR payments. In addition to the Silver plans offered on VHC, carriers began offering "Silver Reflective" plans outside of VHC in

2019 and will continue to do so in 2020. Silver Reflective plans do not include funding to offset the loss of the federal CSR payments. So, while the VHC premiums for Silver plans are substantially higher than the Silver Reflective premiums, most or all members in these plans in 2020 will not pay higher premiums due to their receiving federal premium subsidies.

4. The overall impact of this filing is a proposed average rate increase of 15.6%, which is $89.39 on per member per month (PMPM) basis. This average increase is broken down by metal level in the next table. The following table illustrates the final premium rate changes after the 2019 QHP filing.

2020 Proposed Rate Changes

Plan Type	Avg. 2019 Premium PMPM	Avg. 2020 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$243.55	$277.63	14.0%	$34.08	0.7%
Bronze	$455.54	$515.44	13.2%	$59.90	13.5%
Silver Loaded	$625.43	$712.28	13.9%	$86.85	16.9%
Silver Reflective	$507.29	$587.54	15.8%	$80.25	20.8%
Gold	$567.96	$658.92	16.0%	$90.95	27.5%
Platinum	$691.11	$810.92	17.3%	$119.81	20.6%
Overall	***$573.04***	***$662.43***	***15.6%***	***$89.39***	***100.0%***

2019 Proposed and Approved Rate Changes

Plan Type	Proposed Percent Change	Approved Percent Change	Approved PMPM Change	Percent of Membership
Catastrophic	1.2%	-0.6%	($1.53)	0.5%
Bronze	4.9%	2.9%	$12.70	12.7%
Silver Loaded	16.0%	15.6%	$84.59	20.6%
Silver Reflective	4.0%	5.2%	$24.94	20.80%
Gold	5.0%	2.9%	$15.78	26.1%
Platinum	6.8%	4.6%	$30.69	19.3%
Overall	***7.5%***	***5.9%***	***$31.86***	***100.0%***

Standard of Review

Pursuant to 8 V.S.A. § 4062, 18 V.S.A. § 9375(6), and Green Mountain Care Board Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the methodology used to calculate the proposed 2020 individual and small group premiums. The Company provided exhibits which quantitatively supported each component of the premium development, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees.

Exhibit 3 provided support for the proposed pharmacy and medical trend factors. Historical claims costs were provided for the prior three years.

For pharmacy cost, the combined utilization for non-specialty drugs was projected and then split into seven categories to separately model unit cost by category. Specialty drugs are analyzed on a PMPM basis, rather than by utilization and unit cost separately, due to the relative infrequency and high cost nature of these drugs.

For medical services, the total projected allowed cost trend is 5.9% per year[1]. The unit cost portion of the trend applicable to medical charges is projected to be 2.6% annually based on recent contracting and provider budgetary changes. The utilization and intensity portion of the total trend, including the impact of cost containment measures, is projected to be 3.2% annually.

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

Exhibit 8 demonstrated the development of expected loss ratios, which produced a traditional loss ratio of 88.1% (when adjusted for risk adjustment transfer payments) and a federal Medical Loss Ratio (MLR) of 91.2%[2], which exceeds the minimum MLR requirement of 80.0%.

Exhibit 9A showed the impact of the single conversion factor. Exhibit 9B showed the proposed premiums, the requested rate increase by plan, and the calculation of the average proposed rate increase of 15.6%.

L&E Analysis

The average proposed increase of 15.6% versus the 2019 premiums is attributed to several factors, including trend, updated membership assumptions, and changes to state and federal programs, as illustrated in the table below. To create a consistent comparison for both companies filing QHP products, L&E categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

[1] The filing as submitted by BCBSVT includes cost containment measures as a trend provision in some exhibits but not all. For the sake of clarity, this report will state trend net of cost containment expenses, unless stated otherwise. This is why the 5.9% allowed medical trend described in this report differs from the allowed trend shown at the top of Exhibit 3H.

[2] The initial filing memorandum stated that the projected MLR was 91.8%, which was an error.

Component[3]	Percentage Change[4]	PMPM Change
1. 2018 Actual/Projected Claims Experience	3.8%	$23.16
2. Difference in Trend from 2018 to 2019	-0.1%	($0.71)
3. Trend from 2019 to 2020	7.6%	$44.38
4. Changes to Population Morbidity Adjustment	5.3%	$31.28
5. Demographic Shift	3.5%	$20.51
6. Plan Design Changes	0.6%	$3.81
7. Changes to Other Factors	-1.8%	($10.74)
8. Manual Rate Impact	0.0%	$0.00
9. Changes due to Reinsurance	0.0%	$0.00
10. Changes to Risk Adjustment	-2.9%	($17.01)
11. Changes in Exchange User Fees	0.0%	$0.00
12. Changes in Actuarial Value	-4.4%	($25.53)
13. Changes in Administrative Costs	-0.1%	($0.31)[5]
14. Changes in Taxes & Fees	2.6%	$15.04
15. Changes in Contribution to Reserves	1.2%	$6.95
16. Changes in Single Contract Conversion Factor	-0.2%	($1.44)
Total Proposed Rate Increase	**15.6%**	**$89.39**

1. *2018 Actual/Projected Claims Experience:* The actual 2018 claim experience was 3.8% higher than the 2018 costs as expected at the time of last year's filing, which was about $593 PMPM.[6] Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate. This impact is partly mitigated by an increase in risk adjustment receivables, which is discussed in another section.

[3] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies between the URRT and the Company's rating approach; therefore, a direct comparison is not appropriate.

[4] The percentage changes are multiplicative and may not sum to the requested 15.6% premium increase.

[5] This summary considers all rate components to be multiplicative factors of the final premium. Administrative costs are remaining fairly constant as a percentage of premium; therefore, they are displayed as a near-zero change. It should be noted that the actual change in administrative cost is a PMPM increase of about $6 PMPM.

[6] Because the 2019 filing and URRT (United Rate Review Template) did not differentiate between the two years of trend, L&E allocated those two-year trends evenly between both years. The new 2020 URRT has separate inputs for the two years of trend, so where applicable the trend from 2018 to 2020 is reported on a year-by-year basis.

2. *Difference in trend from 2018 to 2019:* The assumed annual trend of 6.5% from 2018 to 2019 in the 2020 URRT is 0.1% lower than the assumed trend from 2018 to 2019 in the prior URRT. The 6.5% trend assumption going from 2018 to 2019 is consistent with the trend projection from 2019 to 2020, and differs due to differences in hospital budget increases, mix of cost by facility, and cost containment impacts.

   The underlying assumptions behind the trend projections are discussed further in the next section.

> GMCB HOSPITAL BUDGET REVIEW
>
> The overall unit cost medical trend of 2.6% includes: 1) a trend of 2.8% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and 2) a trend of 2.4% for other medical facilities and providers that are not subject to the Hospital Budget Review.

3. *Trend from 2019 to 2020:* The Company projected an overall utilization trend of 3.1% and an overall unit cost trend of 4.3% from 2019 to 2020. The combined allowed trend is approximately 7.6%. These trends are higher than the corresponding values from 2018 to 2019. After a review of the overall trend over the two-year period, the allocation of that trend between the two years has no influence on the proposed rates. The overall annual trends from 2018 to 2020 are shown in the table below:

Cost Category	Unit Cost Trend	Utilization / Intensity Trend	Total Allowed Trend	Share of Total Cost
Medical	2.6%	3.2%	5.9%	81%
Pharmacy	10.6%	1.2%	12.0%	19%
Total	***4.2%***	***2.8%***	***7.1%***	***100%***

- *Medical Trend:* The Company is projecting an allowed medical trend of 5.9%, which is comprised of 2.6% for unit cost changes and 3.2% for utilization and intensity changes.

  Unit Cost Trend
  For the BCBSVT service area, the Company analyzed recent changes to provider contracts as the starting point for the 2020 unit cost trend estimates. Approximately 50% of medical costs are related to facilities impacted by the GMCB's Hospital Budget Review process. L&E reviewed the assumed increases for each of these hospitals and determined that the assumptions made in this filing are generally consistent with the actual budget increases approved by the GMCB.

  The assumed unit cost increase for hospital-based charges differs from the Board's Vermont-wide projections for several reasons:
  - BCBSVT's costs are distributed differently from the entire commercial market producing a different average across all facilities.
  - Approximately 50% of medical services are provided by hospitals not subject to the GMCB hospital budgeting process.

- The hospital budgets are not effective on a calendar year basis, while the proposed rates are for calendar year 2020.
- Additional contract changes were ordered after the 2019 hospital budget negotiations were finalized.
- There are a small number of facilities where BCBSVT assumes that 2019 and/or 2020 increases will differ from the approved 2018 budget increases. These assumptions are immaterial in the development of the proposed rates.

For providers outside the BCBSVT service area, the Company used the Fall 2018 Blue Trend Survey conducted by the Blue Cross Blue Shield Association.

BCBSVT's analysis resulted in a unit cost trend of 2.3% increase for 2019 and 2.9% for 2020, which produces a two-year average of 2.6%.

Utilization Trend and Intensity

To estimate utilization and intensity trend, the Company normalized historical allowed costs to remove the impact of unit cost changes. The data was also adjusted to remove the impact of changes in induced utilization, population aging, and the impact of the Fraud, Waste and Abuse (FWA) program that began in 2014.

The Company performed: 1) regression analyses over multiple historical periods, and 2) year-over-year analyses, for the portion of medical trend related to the utilization and intensity of services.

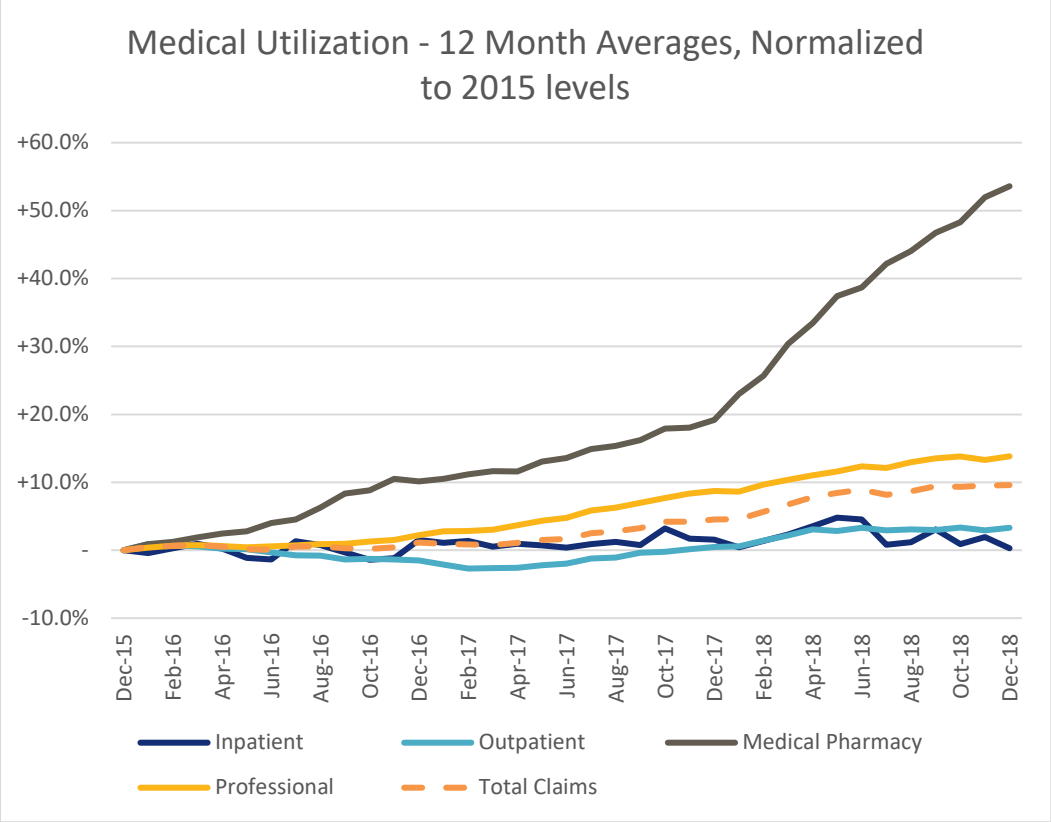
To mitigate the impact of volatile, short-term fluctuations resulting from high-dollar claimants, BCBSVT removed claims for members who exceeded $500,000.

After the above-mentioned adjustments, the observed year-over-year utilization trend since 2015 is:

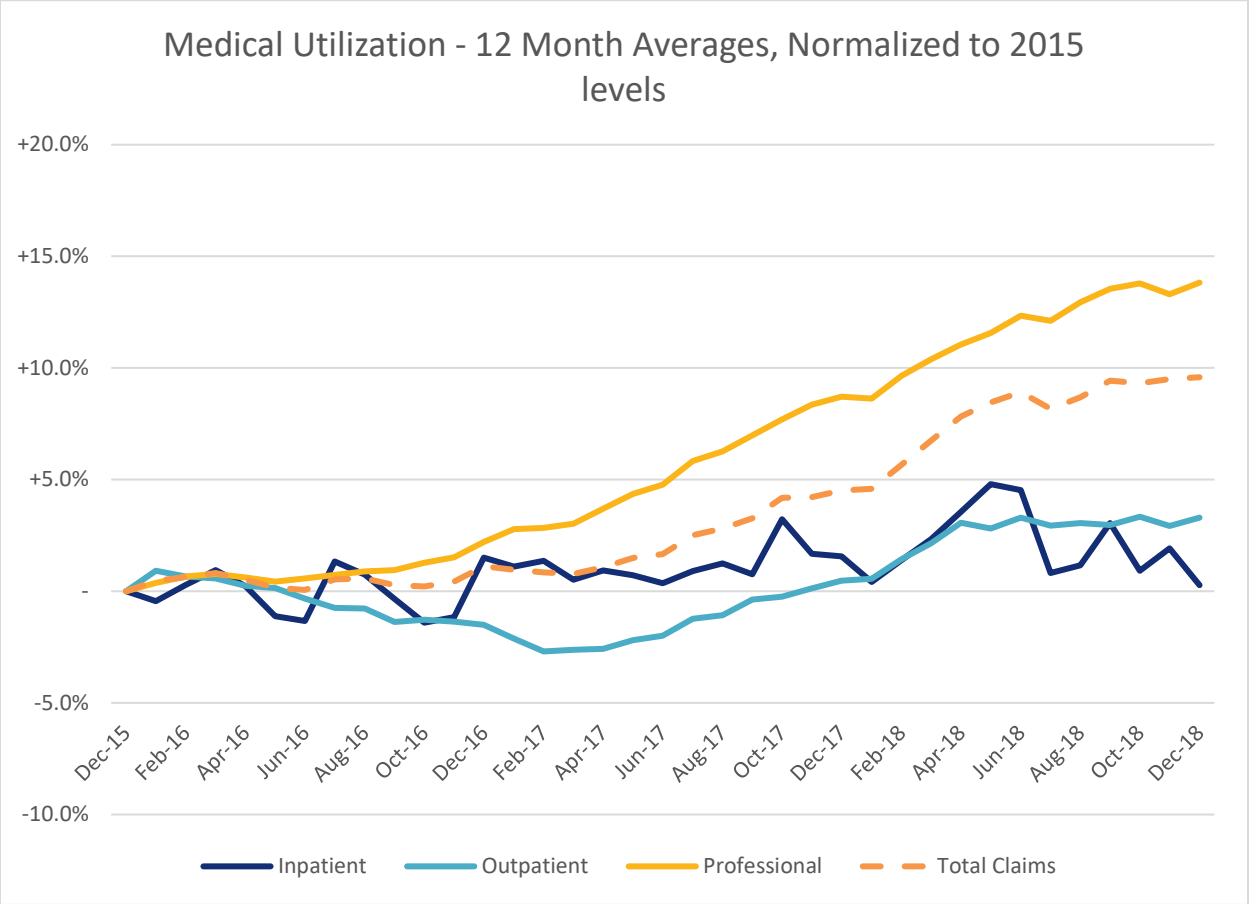
Year	Utilization / Intensity Trend
2015 to 2016	1.1%
2016 to 2017	3.4%
2017 to 2018	4.8%
Two Year Average	4.1%
Three Year Average	3.1%

Utilization trend has been materially positive and increasing since 2015; however, it has been volatile. Since there are other factors which have not been controlled for in the above analysis, BCBSVT analyzed the utilization trend in further detail, particularly by splitting the data into the following benefit categories: inpatient, outpatient, professional, and medical Rx.

The following exhibits demonstrate recent utilization trends by benefit category normalized to 2015 cost levels. Note that both of the following graphs utilize the same data; however, the second graph excludes Medical Rx so it is easier to visualize the trends in the other benefit categories.



Both medical pharmacy and professional claims have experienced sustained, consistent increases in utilization since 2015. BCBSVT assumed a 5% annual increase for professional services and a 15% annual increase in medical pharmacy services. Both assumptions appear in line with long-term trends and appear reasonable.



Since 2015, inpatient and outpatient hospital claims have not exhibited a clear pattern of trend. While outpatient services have increased in recent months, overall utilization during 2017 appears in line with 2015 utilization.

BCBSVT assumed a 0% trend for inpatient services, which appears consistent with the above graph. Due to the recent upswing in outpatient claims, BCBSVT assumed a 2.5% trend for outpatient services.

The weighted average of the above utilization trend assumptions by benefit category is 4.1%. It should be noted that this is equal to the two-year average of the overall observed utilization trend illustrated in the table above.

BCBSVT's analysis assumes that observed utilization changes are primarily the result of an underlying trend in utilization. That is, they do not believe the increase in utilization can be explained by the loss of low-utilizing members. While BCBSVT did normalize the data for changing age and induced utilization since 2015, these adjustments alone do not appear to address significant changes in the underlying membership since 2015.

Since 2017, BCBSVT has lost approximately 37% of its membership. Generally, the members that migrated were healthier than the members that stayed with BCBSVT. While

BCBSVT did exclude some 2018 small groups who migrated to another block, actual risk adjustment results clearly indicate that the members staying with BCBSVT are materially higher-risk than the members who left. Therefore, a portion of the observed utilization increases in the dataset could be the result of anti-selection.

Two analyses were performed to assess whether anti-selection was present. First, L&E requested that BCBSVT compare the increased utilization to the increase in risk scores over the same period. Based on the data provided, it was clear that risk scores have increased faster than utilization. This data is provided below.

Year	Allowed PMPM	Risk Score	Risk-Normalized Allowed PMPM
2016	$458.65	1.168	$392.66
2017	$476.78	1.242	$383.82
2018	$508.44	1.319	$385.55

At first glance, this data would suggest that utilization trend has been negative over the last few years. In their response to the request, BCBSVT correctly pointed out that the increase in risk scores is partly due to coding efforts, which would have little or no impact on actual claims utilization.

BCBSVT provided data showing that the continuously-enrolled population from 2016 to 2018 experienced risk score increases of 7.2% and 11.0% in 2017 and 2018, respectively. BCBSVT concluded that this change, because it substantially exceeds the effect of that population getting older, must be the result of improved diagnosis coding rather than heightened morbidity. However, as some events leading to coded diagnoses are anticipated by the member during open enrollment, L&E sees it as plausible that the risk score increases could result from durational anti-selection rather than just coding efforts. The observed CTR in 2017 and 2018 does not seem to suggest that BCBSVT has received the additional revenue that would result from such rapid increases in coding.

The second analysis sought to decompose observed trend into distinct morbidity and utilization components by using market wide utilization data, i.e. a combination of utilization data from both QHP carriers. The goal of the analysis was to observe market wide utilization trends while mitigating the impact of enrollment shifts. Even though there have been significant enrollment shifts since 2017, the aggregate QHP population has been relatively stable. The following table summarizes recent utilization trends based on the market wide data[7].

[7] It should be noted that blending data from two carriers introduces certain limitations to the analysis. To the extent that the data is reported differently between carriers or there are discrepancies in either Company's normalization of the historical data, such discrepancies may materialize as apparent positive or negative trend in the combined analysis. L&E has made every effort to control for such concerns and relied on this analysis only as one data point among many.

Timeframe	Utilization / Intensity Trend Per Year
24 Months	4.2%
36 Months	2.0%
48 Months	1.3%

The 24-month market wide estimate of 4.2% is substantially similar to the previously stated BCBSVT-only estimate of 4.1%. However, the 36-month market wide estimate of 2.0% is materially lower than BCBSVT's observed estimate of 3.1%. Since the market wide study produced long-term trends lower than BCBSVT's observed long-term trend, the results suggest that anti-selection by members transitioning between carriers may have distorted the data underlying BCBSVT's trend development process.

L&E performed a series of independent trend calculations using market wide utilization data from 2015 to 2018. The Vermont QHP market has undergone several changes in recent years[8] that creates a wide range of results when different analysis methods are used. Additionally, substantial year-over-year volatility makes it difficult to assess trend levels. In both the BCBSVT-only and market wide datasets, there was a material increase in utilization trends in 2018 versus 2017 and 2016. This raised concerns over whether this is a short-term fluctuation or the evolution of a long-term trend. After assessing all the market wide results, L&E believes that a reasonable range for market wide utilization trend to be 1% to 4%.

BCBSVT's large group block, which has experienced less volatility in recent years, has exhibited a utilization trend of approximately 3.5% per year.

Based on an analysis of GMCB's recent hospital data, Vermont insurance carriers are experiencing higher medical facility cost trends compared to the revenue trend recently experienced by Vermont hospitals. One contributing factor is that there has been an increase in members seeking medical treatment outside of the GMCB's jurisdiction. In 2016, 54% of BCBSVT's medical claims were impacted by the GMCB hospital budget review process. In 2018, that proportion has decreased to 51%. This means that, over a two-year period, BCBSVT's costs grew approximately 6% faster than costs associated with facilities affected by the hospital budget process. An even more pronounced shift from GMCB facilities to non-GMCB facilities has been observed in the other carrier's data.

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

[8] The most notable change is the shift in enrollment from BCBSVT to the other QHP carrier. BCBSVT's QHP market share has decreased from over 90% in 2016 to approximately 60% in 2019. This shift has been particularly pronounced among small group members, contributing to changes in the mix of members within each carrier.

Additionally, BCBSVT is assuming that 2020 costs will be reduced by approximately 0.5% due to network changes, including shared savings agreements with providers, and by offering in-home infusion therapies to reduce facility costs and the risk of infection. The impact of these strategies is shown in Exhibit 3C.

The cost containment strategies have the effect of reducing the 2018 to 2020 medical utilization trend from a projected 4.1% to 3.2% per year. BCBSVT is assuming that they will be able to reduce medical utilization trend below historical levels through care management efforts.

Based on all data available for review, L&E recommends BCBSVT's utilization trend assumption be reduced to 2.5% per year, including the impact of cost containment. L&E's recommendation is based on the following:

- L&E notes that the outpatient utilization trend has oscillated in recent years and has leveled off in late 2018.
- The reduced assumption is consistent with market-wide data.
- L&E believes this assumption strikes a better balance between whether risk score increases are due to coding efforts or morbidity increases.

The impact of reducing medical utilization trend from 3.2% to 2.5% is a rate decrease of approximately 1.1%.

Total Allowed Medical Trend

Combining the Company's proposed unit cost trend of 2.6% with the utilization trend of 3.2% results in an allowed medical trend of 5.9%. L&E believes that actual allowed medical trend will likely fall in the rage from 3.5% to 6.5% per year. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market.

L&E's independent calculation of a medical trend estimate produced a wide range of possible outcomes due to: 1) significant enrollment and morbidity shifts between carriers, 2) recent material increases in utilization versus prior years, 3) unquantifiable differences in managed care effectiveness between carriers, 4) population aging, and 5) diagnosis coding improvement.

Using L&E's recommended change to utilization trend, the allowed medical trend reduces from 5.9% to 5.2% per year.

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost assumption underlying the 2020 premium rate calculations.

- *Pharmacy Trend:* The Company is requesting an allowed pharmacy trend of 13.0% per year.

Multiple methods can be used to determine the reasonableness of these trend assumptions. A typical approach analyzes the historical pharmacy claims costs on a PMPM basis; however, this approach does not account for other factors such as, 1) the slowing growth of the generic dispensing rate, 2) drugs losing their patents in the projection period, as well as 3) the adjustments to the future contract terms with the Company's Pharmacy Benefit Manager.

The Company's approach accounted for pharmacy changes, including:

- Adjusted historical experience for changes in benefits and aging population;
- Cost and utilization trends for Brands, Generics, and Specialty drugs; and
- The transition of some drugs to generic status, and the resulting reduction in unit costs for those drugs.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total Trend	Portion of Rx Spend
Generic	0.7%	1.2%	2.0%	17%
Brand Converting to Generic	-56.6%	1.2%	-56.1%	3%
Brand	10.6%	1.2%	12.0%	33%
Specialty[9]	-	-	20.0%	47%
Total	-	-	**13.0%**	**100%**

The Pharmacy trend assumptions are supported in Exhibits 3D through 3G in the initial filing. Exhibit 3D addresses utilization trend among non-specialty drugs. Members often have a choice of utilizing a brand drug or a generic version of the same compound. For this reason, the utilization trend is measured across all non-specialty drugs. BCBSVT fits a regression to the historical claims after normalizing for induced utilization, age/gender factors, and the number of working days per month. As noted in the memorandum, seasonality in the recent claims causes the trendline to suggest higher increases than a smoothed version of the data. In particular, the very last month of the trend period is December 2018, and that month exhibited a significant spike in utilization. That spike is unlikely to reflect the pattern of a new long-term trend, but it heavily influences the regression calculation. The observed increase in utilization of non-specialty drugs after these normalizations was 0.5% in 2018 and 2.8% in 2017. The average increase over the last two years is therefore 1.6% per year. BCBSVT's assumption for non-specialty utilization trend is 1.2% per year, which is lower than the two-year average and the regression estimates. L&E finds this assumption reasonable.

BCBSVT's methodology for generic cost trend reflects L&E's recommendation from the recent large group filing. BCBSVT has separated historical generic claims into drugs which were generic over the entire trend period, and those which became generic

[9] Specialty drug cost is projected on a PMPM basis and is not analyzed separately for utilization and unit cost trends. L&E believes this is reasonable.

during the trend period. This methodology avoids miscalculations in the generic cost trend because new generics are often more expensive per 30-day supply than existing generic drugs. The generic cost trend calculated in this manner is 0.7% using a 24-month regression and 1.0% using a 36-month regression. BCBSVT has opted to use the lower value of 0.7%, which L&E finds reasonable. The brand cost trend is calculated in a similar manner, with regression estimates of 10.6% and 10.9%, respectively. Again, BCBSVT elected to use the lower value, and L&E finds this assumption reasonable.

Specialty drug costs are dependent on a relatively small number of very high-cost drugs, and BCBSVT elects not to analyze utilization and unit cost components separately. Specialty drug costs have increased by 6.5%, 28.7%, and 32.3% in the past three years. 24- and 36-month regressions produce trend estimates of approximately 30%-31% per year. BCBSVT also considered several time-series methods of projecting trend, which produced estimates ranging from 3.7% (a clear outlier) to 15.6%. In light of all these methods, BCBSVT elected to assume a 20% per year increase in specialty drug cost. L&E finds this assumption reasonable.

L&E reviewed the overall drug cost assumptions against aggregate historical data to ensure that the decomposition into generic, brand, unit cost, and utilization did not create an inaccurate picture of the overall trend in cost. Based on the most recent three years of monthly data, L&E estimated a historical trend rate of 15.3% per year. The overall Pharmacy trend assumption of 13.0% appears reasonable in relation to historical data.

4. *Change to Population Morbidity Adjustment:* The Company is estimating that the projected 2020 population morbidity will be 7.4% higher than the experience period morbidity.

   The increase is itemized below:

Source of Change	Impact on Morbidity
AHP Impact	+1.4%
Pool Morbidity	+0.4%
Newly Insured	-1.9%
Selection	+7.1%
Individual Mandate Penalty	+0.5%
Total Morbidity Change	**+7.4%**

   The 2019 rates already reflect BCBSVT's expectation of 2019 morbidity increases, so the assumed morbidity change will not generate a full 7.4% premium increase. The rate increase

associated with morbidity changes is 5.3% after morbidity changes assumed in the 2019 filing are considered.

- *Association Health Plan Impact*: BCBSVT assumed that small groups electing to join association health plans (AHP) in 2020 would be disproportionately healthy, thereby resulting in a deterioration in the health status of the QHP risk pool. The assumed rate impact was a 1.4% increase to premiums, counteracted in part by a risk adjustment component discussed later in the report. The net impact to rates assumed in the initial filing, considering morbidity and risk adjustment, was approximately a 1.0% increase to rates.

  On March 28, 2019, the United States District Court of DC vacated key portions of the DOL's guidance on AHPs. The DOL released frequently asked questions that they will not pursue enforcement actions on AHPs through the remainder of the plan year or contract term, whichever is longer. The DOL is currently appealing the court ruling. As of the date of this report, it appears that these AHP's will not be permitted to continue into 2020 in Vermont. This is supported by the GMCB's recent disapproval of the AHP rate filing. Therefore, these healthy members are not expected to leave the QHP market.

  Many of the Company's original pricing assumptions removed AHP members from the calculations completely, or separate adjustments were made to account for this population. As a result, there are small changes to several assumptions in this filing due to the members now assumed to stay in the QHP market.

  L&E requested an illustration from BCBSVT of the overall rate impact of the Board's decision regarding AHPs. BCBSVT responded that, of the small groups which left the QHP market and enrolled in an AHP in 2019, they assumed that only the sicker groups will return to the QHP market, while it was assumed that the healthier groups will elect to self-insure their major medical coverage. As a result, BCBSVT's projection as provided on July 3rd suggests that the Board's decision will have an impact of less than 0.2% on BCBSVT's proposed rates.

  BCBSVT's analysis relies on the assumption that small groups will compare the cost of self-insurance with BCBSVT's QHP rates. However, particularly for bronze plans, MVP Health Plan's (MVP) QHP rates are materially lower. Therefore, L&E believes that some of these groups could possibly return to the QHP market and elect coverage with MVP. This outcome would increase BCBSVT's risk score relative to the market and produce additional revenue.

  L&E recommends that the filing be modified such that the overall impact of AHP groups be a 0.7% increase, net of any risk adjustment impact, over 2018 rate levels. L&E does not have the data group-level data necessary to calculate each of the factors related to AHP's in the filing; however, L&E expects this overall rate impact would be reasonable. This change would have an impact of -0.3% on 2020 premiums. L&E notes that BCBSVT may need to reflect these changes across multiple assumptions due to the complexity of this issue.

- *Changes in Pool Morbidity*: +0.4%
  The claims that underlie this projection are from 2018. Since this filing was submitted after the 2019 Open Enrollment Period, BCBSVT knows which of the 2018 members remained in the block and which left. The Company separates the 2018 experience into those members who remained in 2019 and those who left in 2019. In prior years, this analysis was performed only on individuals, as it was assumed that new small groups would be added to the block to replace any small group which left. However, since BCBSVT has witnessed recent high cancelations in the Small Group market, this analysis has been updated to include small groups as well.

  The small groups which left BCBSVT in 2019 were very low-cost in 2018. While BCBSVT also lost a significant number of relatively high-cost bronze members, their impact is outweighed by the loss of the healthy small groups. BCBSVT's calculations considered the impact to future claims of these groups leaving; however, the calculations did not explicitly consider the impact on risk adjustment. BCBSVT is implicitly assuming that these members likely left the risk pool in 2019 and will not produce additional risk adjustment revenue for BCBSVT. Given the visible decrease in QHP enrollment across both the individual and small group markets in 2019, this assumption is reasonable.

- *Impact of the Health Status of the New Members*: -1.9%
  BCBSVT separately analyzes the impact of new, young members and the impact of the aging of existing members. This factor reflects the impact of a new cohort of members, often in their twenties. BCBSVT used a Society of Actuaries study on the relationship between age and healthcare costs to estimate the impact these members will have on the average costs for members of this program. The review of this factor was performed in conjunction with BCBSVT's "demographic shift" factor, which considered only aging and not the impact of new young members. The review of these factors is contained in Section 5 below.

- *Impact of selection:* +7.1%
  Healthy members generally select low benefit, low premium plans, while less healthy members tend to choose plans with the richest benefits. The Affordable Care Act does not allow carriers to reflect this consumer selection at the plan level. Therefore, the Company has included the impact of selection equally to all plans.

  Also included within this calculation is a true-up of the expected paid-to-allowed ratio to the Actuarial Values (AVs) calculated by the federal AV Calculator. As discussed later in this report, BCBSVT chose to use AV factors from the federal AV Calculator, which are lower on average than what is suggested by BCBSVT's actual data. This approach primarily reflects the correction for the AV difference and does not reflect a change in morbidity. For this reason, L&E recommends that BCBSVT move this factor from morbidity into the Pricing AVs. This would have no rate impact, but it would more accurately reflect the reasons and justification for the rate increase.

- *Removal of the Penalty for the Individual Mandate:* +0.5%
  The Company estimated the impact of the removal of the individual mandate penalty by assuming that all individual members that had no claims or only had preventive claims in the 2018 individual market and did not receive premium assistance would not purchase an QHP policy in 2020. It should be noted that the individual mandate was included as an "Other" factor in the prior filing but as a morbidity increase in this filing. The individual mandate assumption made in this filing is lower than what was assumed in the prior filing.

  The Company noted that some members have left BCBSVT in 2019. This led the Company to assume that the remaining members meeting the criteria described in the previous paragraph would leave in 2020, resulting in a rate increase of 0.5%. Because those members were assumed to have left the market entirely, the Company did not make a counter-acting adjustment to the risk score projections.

  It is the Company's position that whether these members left for MVP or left the market entirely is irrelevant to the rate setting for BCBSVT. However, because these members have very low risk scores, L&E expects that those individuals' presence in the market has an impact on rates for both carriers. Because migration of low-cost members to MVP will result in additional risk-adjustment revenue to BCBSVT, L&E does not believe the 0.5% claims increase assumed in relation to the individual mandate to be appropriate. L&E recommends removing this factor, which will reduce the rates by approximately 0.5%. This would still allow the 0.3% increase from 2019 dis-enrollments in full. Therefore, this effectively represents a partial mitigation of the overall 0.8% enrollment drop assumed by BCBSVT. This is consistent with L&E's expectation that most members who would leave the market due to the repeal of the individual mandate penalty will have already done so in 2019.

The above factors combine to reflect an assumed morbidity increase of 7.4% between 2018 and 2020. In the 2019 filing, the overall morbidity assumption was a 2.0% increase, reflecting primarily the impact of healthy members and groups terminating coverage in 2018. The difference between the prior morbidity factor and the proposed morbidity factor produces the 5.3% increase related to morbidity.

After the implementation of the above recommended changes, L&E considers the morbidity adjustments reasonable and appropriate. With those changes, the morbidity factor would reduce from +7.4% to -0.5%. However, it must be emphasized that this includes the removal of the selection load, which should not be removed from morbidity without also being added to the Pricing AVs. L&E has also assumed here that the change in AHP assumptions is reflected entirely in morbidity. The 0.5% reduction in morbidity relates to the impact of new members, which will be discussed further in the Demographic Shift section of this report. The effective rating impact of the morbidity recommendations in this report is a reduction in rates of 0.8%.

5. *Demographic Shift:* This factor represents the expected change due to the aging of the population. The Company's approach produced an expected 3.5% increase to premium rates in 2020 resulting from the aging impact.

It is important to note that BCBSVT reports this factor separately from the impact of new young members, which is discussed in the morbidity section of the report. These two assumptions are closely linked and should be assessed in the aggregate to measure the overall impact of changes to the age and gender of the population. The demographic change is calculated based on a study by the Society of Actuaries regarding the relationship between age and healthcare cost to estimate the impact of demographics. Combining the new young members and the aging of existing members, the projected demographic change is a 1.5% increase between 2018 and 2020.

The Company acknowledged the utility of analyzing these factors together and demonstrated that this demographic change is consistent with recent years. The past three years have exhibited average age factor increases of 1.3%, 1.6%, and 1.8%, respectively. Therefore, L&E believes that the assumed demographic shift factor is reasonable.

In the course of L&E's review, it was discovered that the calculation does not reflect the impact of newborns born during the middle of a plan year. BCBSVT estimated that if the methodology were changed to reflect those newborns, the rate increase would be increased by a factor of 0.6%. L&E believes this reflects only the increase in claims and does not consider the potential revenue increase that would come with new family-tier premiums and/or risk adjustment. Therefore, a change is not recommended at this time.

L&E reviewed the Company's supporting documentation for these adjustments, and L&E considers the Demographic Shift to be reasonable and appropriate.

6. *Plan Design Changes*: The Company estimated the change in the average utilization of services due to the change in the average cost sharing is +0.6%. This accounts for an anticipated increase in induced utilization because members are expected to choose plans with lower cost sharing in 2020 compared to 2018.

   L&E agrees with this methodology in general but notes that part of the increase is due to BCBSVT's reasonable assumption that AHPs could draw membership disproportionately from low-benefit plans. On July 3rd, BCBSVT indicated that the subset of current AHP members expected to move back to the QHP market in 2020 would have richer benefits, on average, than the 2019 AHP population. L&E does not have the group-by-group data needed to replicate this projection. L&E does not recommend any changes to this factor. However, L&E does note that a small change to this factor would likely be a component of the 0.3% rate reduction recommended in relation to AHPs.

7. *Changes to Other Factors*: This filing contains a 0.1% decrease in rates due to a variety of factors described below. The prior filing included a 1.7% increase in rates for the removal of the individual mandate, resulting in a combined effect of a 1.8% decrease in rates relative to 2019.

   - *Impact of the Medicare Part B Requirement*: -0.7%
     Some members in this block are eligible for Medicare. The computer system BCBSVT used to administer claims in 2018 was unable to properly enforce the requirement that these

members enroll in Medicare, which would place primary claims responsibility on Medicare. BCBSVT now has that capability, meaning that the amount paid for professional claims for Medicare-eligible members is decreasing. L&E notes that the Company's calculation assumes Medicare pays 80% of all Part B claims and does not consider the impact of the Part B deductible. L&E believes that the Part B deductible should be included; however, the impact would be an immaterial increase to premiums. L&E does not recommend any changes and considers the Company's estimate reasonable.

- *Impact of the Accountable Care Organization (ACO)*: -0.4%
  In 2018, BCBSVT had a shared-risk agreement with OneCare that covered many of the policyholders in this block. This agreement limited the risk faced by BCBSVT by transferring some claims liability to healthcare providers. The 2018 settlement was equal to 0.2% of claims, which reduced the projected liability for 2020.

  In 2019 and 2020, BCBSVT anticipates that the number of participating providers (and therefore the number of attributed members) will increase. The inclusion of more members in the ACO program is expected to decrease claims by another 0.2%. The calculation of this factor appears reasonable.

  The combination of 2018 settlement receipts and the expansion of the ACO program in 2019 and 2020 result in a total reduction to projected claims of 0.4%. These savings are relative to 2020 cost in the case where no ACO agreement was in place.

- *Non-System Claims:* +1.0%
  This includes changes to pharmacy rebates, Blueprint payments, Interplan Teleprocessing System (ITS) fees[10], Vaccine payments, and net cost of reinsurance. All non-system claims projections appear reasonable.

- *Leap Year Adjustment*: +0.3%
  Premium rates are calculated on a per-member-per-month basis using 2018 experience. 2020 is one day longer than 2018 due to it being a leap year. BCBSVT applied an increase of 0.3%[11] to reflect the extra day of coverage in 2020. This factor is calculated correctly and appears reasonable.

- *Changes in Pharmacy Contract*: -0.4%
  BCBSVT contracts with a Pharmacy Benefit Manager (PBM) to purchase prescription drugs and handle certain aspects of offering a prescription drug benefit. The terms of this contract are changing in 2020, resulting in a 0.4% decrease to premiums.

L&E does not recommend any changes to the "Other" factors described above.

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

[11] This adjustment is equal to 366 divided by 365, minus one.

8. *Changes to Manual Rating Adjustment:* The Company did not use a manual rate because the 629,988 member months of experience was considered fully credible. L&E considers this to be reasonable and appropriate.

9. *Changes to Reinsurance*: The U.S. Department of Health and Human Services (HHS) implemented a nationwide reinsurance program for high-cost enrollees, which is outlined in the Notice of Benefit and Payment Parameters. Carriers with individuals who have claims exceeding $1,000,000 will be reimbursed 60% of the costs exceeding $1,000,000 in the individual and small group markets. The cost of this program will be collected from each carrier such that the program will be budget neutral to the carriers and HHS at the national level.

   The filing assumes a 0.5% increase related to federal reinsurance costs. As noted in the filing, HHS commented that the cost would be "less than 0.5%". HHS published the final 2018 Risk Adjustment Summary Report on June 28th, which clarified that the actual 2018 high-cost risk pool charge was 0.21% for merged market plans. L&E recommends that this assumption be reduced to 0.25%, reflecting the impact of trend on the unchanging $1 million threshold. This would have a rate impact of approximately -0.25%.

10. *Changes to Risk Adjustment:* As noted above, BCBSVT paid more in claims during 2018 than anticipated; however, this was due in part to having a higher-morbidity population than in 2017. Therefore, a portion of the higher claims was offset by an increase in the amount received under the federal Risk Adjustment program. This created a 2.9% decrease in the proposed rates. BCBSVT projected the 2020 risk adjustment based on the most recent data available, which was the interim report[12] published by Centers for Medicare and Medicaid Services (CMS) in early April 2019. Based on the interim report, BCBSVT estimated that final 2018 risk adjustment receivable would be $13,016,863.

    L&E requested that both carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports in order to compile them confidentially and to provide both carriers with an updated risk adjustment estimate. This calculation indicated that BCBSVT's 2018 risk adjustment receivable would be $15,926,203. This approximate $3 million increase in receivables over BCBSVT's expectations corresponds to approximately a $5 decrease in premiums PMPM.

    On June 28th, CMS released the 2018 Summary Report on Permanent Risk Adjustment Transfers[13], which confirmed L&E's preliminary calculation of the 2018 risk adjustment amount.[14]

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

[13] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf

[14] The actual risk adjustment payment differed from L&E's estimate by $64 out of a total nearly $16 million.

L&E recommends revising the risk adjustment calculation such that each carrier begins with the same 2018 value. L&E recommends that each company use a 2018 estimate of $15,926,267 based on the final report from CMS.

L&E calculated the projected 2020 risk adjustment receivable for BCBSVT, using approved 2019 premium increases and proposed 2020 premium increases, as $33.08 PMPM. This estimate did not consider the impact of member migration in 2020 related to AHPs. The impact of these changes is greater than BCBSVT's projection calculated on the same basis. The impact of this change would be an expected 0.6% reduction to rates.

Additionally, L&E performed a study on the diagnosis and enrollment data from both carriers and determined that changes to the 2020 risk adjustment model will have a material impact on Vermont risk adjustment transfers. The 2020 risk adjustment model is expected to have a larger multiplicative impact on lower-risk bronze members than higher-risk platinum members. Because BCBSVT has a disproportionate share of higher-risk and higher-benefit members, L&E projects that the 2020 model will produce a risk adjustment receivable for BCBSVT of $38.16 rather than $33.08. Reflecting this change would decrease rates by 0.8%. The impact of all risk adjustment changes combined is a reduction to rates of 1.4%. L&E notes that this value is before any consideration of changes related to AHPs.

L&E notes that BCBSVT included the federal high-cost member program as part of the risk adjustment calculation. Because these programs are administered in tandem, L&E believes this is reasonable. For clarity in this report, the high-cost member program is discussed in the Reinsurance section. The recommended risk adjustment amount above does not reflect the high-cost member provision of the rates, which must be included for the rates to be actuarially sound. For the recommendation regarding the high-cost member program, see the "Reinsurance" section of the report.

2020 Risk Model Coefficient Changes

The calculated risk score for each covered member is calculated by a model developed by the US Department of Health and Human Services (HHS). HHS has proposed changes to the coefficients in the model that will be used in 2020. L&E used both the current and the 2020 models to calculate risk scores for the Vermont QHP population and to estimate the impact this model change will have on the population. L&E is recommending that rates for both carriers in the QHP market reflect the anticipated impact. Generally, this involves increased transfer payment from Bronze members to Platinum members.

11. *Changes in Exchange User Fees*: This is not applicable to Vermont in 2020, as Vermont operates its own Exchange and does not charge users a fee.

12. *Changes in Actuarial Value:* The change in the Actuarial Value (AV) assumption is -4.4% relative to the 2019 filing. This reflects Pricing AV changes such as changes in Metal AVs and changes in

the projected enrollment distribution by plan. For 2020, BCBSVT changed their methodology for calculating the Pricing AV by plan. The Pricing AV reflects the portion of total medical costs that the plan will cover. In the past, BCBSVT based this factor on an analysis of their own claims; however, because they have a distinctly higher-risk than average population, this caused atypical results. In particular, it suppressed the rate differential between platinum and bronze plans. This caused BCBSVT's rates to be less competitive on bronze plans. In consideration of this distortion, BCBSVT updated their methodology to base Pricing AVs on the output of the federal AV Calculator, which is a standardized tool distributed by HHS.

Using the AV Calculator mitigated the distortion between platinum and bronze premiums; however, it understated the average proportion of claims paid by BCBSVT. Therefore, BCBSVT included an approximate 7% load to the index rate to counteract the impact of using the AV Calculator data. L&E believes the updated calculation is reasonable, but L&E recommends that the loads be included in the Actuarial Value calculations rather than in the index rate. Since the apparent reduction in rates due to Actuarial Value is directly related to the +7% selection load, L&E believes the filing is clearer if they are presented together as a combined part of the AV calculation. BCBSVT acknowledged this as a plausible method and submitted revised exhibits that display the index rate in this manner.

With the selection load moved, the overall AV change is +2.8% instead of the filed -4.4%. This is an increase of 7.1%. However, this change corresponds to a decrease in morbidity factor of 7.1%. Combined, there is no premium impact. L&E believes the proposed AV calculations produce a reasonable impact on premiums.

13. *Changes in Administrative Costs:* The PMPM administrative costs are projected to increase by about 15% over the administrative costs that were projected in the prior filing. Since administrative costs are projected to increase at a similar rate as claims, the administrative costs are projected to remain nearly constant as a percentage of premiums. The overall rate impact is -0.1% even though the administrative costs are increasing from the prior filing from $40.26 to $46.54 PMPM.

    The 2020 projected administrative cost is based on the 2018 administrative cost, which is then adjusted for expected changes. These adjustments include:

    - Non-Recurring Expenses: -$1.06 in administrative costs
      The Company removed all expenses incurred due to one-time, non-recurring events.

    - Trend: +2.5% in administrative costs each year for two years
      The Company increased the base administrative costs for trend to project the 2020 administrative costs, using an annualized trend of 2.5%. This trend is based on a 3% increase to personnel costs, which make up 83.4% of administrative costs, and a 0% change to other operating costs. L&E has previously reviewed the historical increases in personal income per capita in Vermont and the 3% increase is consistent with the average increase over recent years.

    - Loss of Membership: No change to administrative costs

While the relative rate levels of the two carriers may cause BCBSVT to lose membership in 2020, BCBSVT has not assumed an increase in administrative costs PMPM for the QHP block. As there are other blocks of business to spread the cost, L&E believes this to be reasonable.

In addition to reviewing each of the specific modifications proposed by BCBSVT, L&E also compared BCBSVT's administrative costs for the individual and small group markets to other nationwide BCBS plans. The comparison was based on a review of the 2018 National Association of Insurance Commissioners (NAIC) Annual Statements. BCBSVT's administrative costs on a percentage of premium basis ranked 55th out of 63 plans analyzed. BCBSVT's administrative costs on a PMPM basis ranked 50th out of 63 plans analyzed. That is, BCBSVT has lower expenses than approximately 50 of the 63 Blues plans assessed. This implies that BCBSVT had lower expenses than approximately 80% of the Blues plans who sold individual and small group products.

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

14. *Changes in Taxes & Fees:* The total taxes and fees increased from 1.3% in 2019 to 3.5% of premium due to the Federal Health Insurer Fee being reinstated for 2020. The other taxes consist of GMCB Billbacks, the Health Care Claims Tax and the Patient Centered Outcomes Research Institute Fee. The change in taxes and fees increases the premium by 2.6%.[15] This portion of the proposed rate increase is considered reasonable and appropriate.

15. *Changes in Contribution to Reserves (CTR):* The Company's proposed CTR is 1.5%. This is consistent with the requested CTR in the prior filing. The proposed CTR is an increase from the 0.5% CTR that was ordered by the Board for 2018. Additionally, the Company also incorporated a 0.1% load into the rates to reflect uncollected premiums. This provision is consistent with observed bad debt in both 2017 and 2018.

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

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

[15] The reason that the rate impact is greater than the difference between the 2019 and 2020 assumptions is that all non-claims rate components are treated as fixed percentages of premium within this report. The difference between the 2019 and 2020 tax assumptions is leveraged over the traditional loss ratio to arrive at the 2.6% premium impact.

Year	Company Expected	Company Actual
2014	-0.1%	1.0%
2015	1.0%	-1.4%
2016	0.8%	-3.2%
2017	1.0%	-0.4%
2018	-3.8%	-4.1%
Average	**-0.2%**	**-1.8%**

As a reasonableness check of the proposed CTR provision, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs). In 2019, there were 777 Single Risk Pool (QHP) Filings (individual and small group) filed across the country. Across the 777 filings, the average submitted CTR was 2.95% and the median submitted CTR was 3.15%. Based on the 2019 filings, an assumed CTR of 1.5% would rank 629th out of 777 filings. That is, over 82% of the filings had assumed CTRs higher than 1.5%.

In 2018, there were 836 Single Risk Pool Filings filed across the country. Across the 836 filings, the average submitted CTR was 2.66% and the median submitted CTR was 2.75%. Based on the 2018 filings, an assumed CTR of 1.5% would rank 655th out of 836 filings. That is, over 79% of the filings had assumed CTRs higher than 1.5%.

Based on L&E's evaluation of BCBSVT's CTR compared to the assumed CTR levels underlying every QHP filing submitted 2018 and 2019, L&E believes that BCBSVT's proposed CTR is reasonable in light of its underlying risks and L&E believes that is allows the Company to offset the impact of trend and other potential adverse events with appropriate consideration given to maintaining the CTR at an adequate long-term level.

In addition to reviewing the CTR assumption, L&E reviewed BCBSVT's Risk Based Capital (RBC)[16] percentage relative to other BCBS plans as a comparison for reasonableness. L&E analyzed the 2018 NAIC Annual Statements of 63 Blues plans. Of these 63 plans, the average RBC percentage was approximately 900% and the median RBC percentage was approximately 800%. This implies that BCBSVT's current target RBC range of 590% to 745% falls in the bottom half of actual RBCs for BCBS plans nationwide.

Of the 63 Blues plans reviewed, 33 had RBC percentages that were larger than the top end of BCBSVT's target RBC range.

BCBSVT's actual 2018 RBC percentage is ranked 59th out of 63. That is, only 4 Blues plans had lower RBC percentages than BCBSVT.

As a result of the 2017 Tax Cuts and Jobs Act, BCBSVT is expected to receive $17.9 million in 2019 in the form of an Alternative Minimum Tax (AMT) refund. By adding this refund to

[16] "Risk-Based Capital" is a framework that helps measure the potential of an insurer becoming insolvent. A low RBC can indicate a high risk of an insurer becoming unable to meet its financial obligations.

BCBSVT's capital and surplus account, BCBSVT's RBC percentage rank would increase to approximately 48th out of 63 if all other assumptions stayed the same; however, it should be noted that other Blues plans will also realize AMT refunds. Therefore, BCBSVT's surplus position is likely not to materially increase relative to other Blues plans.

As stated previously, due to the required grace period under the Affordable Care Act, the Company included an additional risk margin provision for bad debt of 0.1% to pay for the claims for members for which premiums are never collected. The average amount of non-paid premiums due to the grace period provision over the last several years was 0.1%. L&E notes that the Board required that this margin for bad debt be removed in the 2019 filing. However, it appears that BCBSVT has provided adequate support to demonstrate that such costs will continue into 2020 at a similar level. Therefore, L&E believes this provision is reasonable.

L&E believes the CTR assumption is reasonable and does not recommend any changes to the CTR. In addition to L&E's review, L&E recommends that any solvency analysis performed by the Department of Financial Regulation be considered. Based on BCBSVT's recent financial results, L&E believes that any reduction in the CTR could produce rates that do not protect BCBSVT's solvency position.

16. *Changes in Single Contract Conversion Factor:* A conversion factor[17] adjustment is used to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single conversion factor is decreasing by 0.2% from the prior filing, resulting in a 0.2% decrease in rates. This corresponds roughly to a slight decrease in the number of covered children per policy and is based on actual membership data emerging in 2019. This is considered reasonable and appropriate.

Recommendations

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

- *Medical Utilization Trend:* L&E recommends that the medical utilization trend, net of cost containment measures, be reduced to 2.5% per year. This will have a rate impact of approximately -1.1%.

- *Cost Trend from 2019 to 2020*: If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends updating the assumed unit cost trends in the 2020 premium rate calculations. The impact of such a change cannot be estimated at this time.

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

- *AHP Morbidity Impact*: L&E recommends reducing the AHP morbidity load on claims and making any associated changes to risk adjustment and plan change factors, such that the projected premiums are reduced by approximately -0.3%.

- *Impact of Selection:* L&E recommends that the selection and Actuarial Value factors, which are a combined 7.1%, be moved from an index rate adjustment to a Pricing AV adjustment. This would have no impact on rates.

- *Individual Mandate Morbidity Impact*: L&E recommends removing this 0.5% load. This will reduce rates by approximately -0.5%.

- *High-Cost Member Program:* L&E recommends that the assumption for the federal high-cost member program be reduced by -0.25%.

- *Changes to Risk Adjustment*: L&E recommends that the projected risk adjustment transfer reflect the most recent data available, L&E's modeled impact from implementing the 2020 risk adjustment coefficients, and the turnover of AHP expansion rules. The combination of these adjustments would result in a projected 2020 risk adjustment transfer of $38.16 PMPM[18]. This should be the starting point, before adjustments for the high-cost member program or changes relative to the 2018 market due to AHP's and shift to self-insurance. L&E's calculations suggest this change would reduce rates by -1.4%.

After the modifications, the anticipated overall rate increase will reduce from 15.6% to approximately 11.4%.[19]

Metal Tier	BCBSVT Proposed Overall Rate Change	L&E Recommended Overall Rate Change	Percent of Membership
Catastrophic	14.0%	9.9%	0.7%
Bronze	13.2%	9.1%	13.5%
Silver Loaded	13.9%	9.8%	16.9%
Silver Reflective	15.8%	11.6%	20.8%
Gold	16.0%	11.8%	27.5%
Platinum	17.3%	13.1%	20.6%
Overall	***15.6%***	***11.4%***	***100.0%***

[18] As noted elsewhere, L&E's calculated risk adjustment transfer does not consider the high-cost member program.

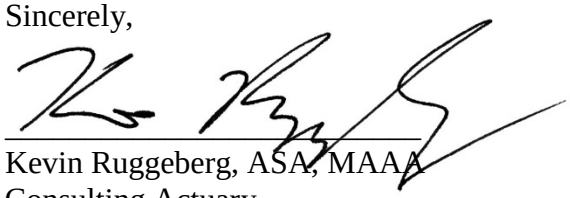
[19] Due to the complexity of the premium rate development and the possible interdependency of the assumptions modified, the actual implemented rate change may vary from the estimate.

A breakdown of L&E's recommendations is provided below:

Component	Filed Change	L&E Recommended Change
1. 2018 Actual/Projected Claims Experience	3.8%	No change
2. Difference in Trend from 2018 to 2019	-0.1%	-0.7%
3. Trend from 2019 to 2020	7.6%	7.0%
4. Changes to Population Morbidity Adjustment	5.3%	-2.4%
5. Demographic Shift	3.5%	No change
6. Plan Design Changes	0.6%	No change
7. Changes to Other Factors	-1.8%	No change
8. Manual Rate Impact	0.0%	No change
9. Changes due to Reinsurance	0.0%	No change[20]
10. Changes to Risk Adjustment	-2.9%	-4.7%
11. Changes in Exchange User Fees	0.0%	No change
12. Changes in Actuarial Value	-4.4%	+2.4%
13. Changes in Administrative Costs	-0.1%	No change
14. Changes in Taxes & Fees	2.6%	No change
15. Changes in Contribution to Reserves	1.2%	No change
16. Changes in Single Contract Conversion Factor	-0.2%	No change
Total Rate Change	**15.6%**	**11.4%**

[20] For the purpose of this exhibit, the recommended changes related to the high-cost member program is included in the risk adjustment line item.

Sincerely,



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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[21], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[22], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Kevin Ruggeberg, ASA, MAAA, Consulting Actuary at L&E.
- David M. Dillon, FSA, MAAA, MS, Senior Vice President & Principal at L&E.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at L&E.

Identification of Actuarial Documents

The date of this document is July 9, 2019. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 9, 2019.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness; however, not every aspect of the data has been audited. Neither L&E nor the responsible actuaries assume responsibility for the items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed.

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

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

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

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

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

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

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