June 7, 2019

Mr. Kevin Ruggeberg, A.S.A., M.A.A.A.
Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 05/30/2019 Questions re:
Blue Cross and Blue Shield of Vermont
2020 Vermont Individual and Small Group Rate Filing
(SERFF Tracking #: BCVT-131936226)

Dear Mr. Ruggeberg:

In response to your requests dated May 30, 2019, here are *your questions* and our answers:

1. *Explain why the market-wide average $31.92 risk-adjustment payment is used to develop the expected claims cost for the catastrophic population in Exhibit 6D, when this population is both known to have different risk characteristics than the primary risk pool and has a separate risk adjustment payment.*
We have used the market-wide average risk adjustment PMPM in this filing and in previous filings in the calculation of all plans, as it is our understanding of the rating rules that the market-wide adjustment should be the same for all plans.

   We believe that another allowable method for the catastrophic plan only may be to adjust for the risk adjustment transfer of that plan specifically instead of using the average transfer PMPM. Based on historical information, which varies widely around zero, tour best estimate of the catastrophic risk adjustment transfer would be zero. This methodology would increase the catastrophic premium by 13.2 percent as compared to the filed rates.

2. *The actuarial memorandum explains that actual 2018 risk adjustment receipts are expected to be higher than assumed in prior rate development. This would suggest that BCBSVT's relative risk position has increased in recent years. This would seem to suggest that the utilization trend calculation, which does not consider the morbidity of the included population, includes the impact of increasing morbidity. Address the concern that this increase is already funded by the increased risk adjustment and would be further funded by risk adjustment if it continued.*
First, we disagree with the premise that increasing risk adjustment receivables are necessarily indicative of a changing morbidity position. The transfer is also impacted by external factors, most notably including model changes and changes in provider coding patterns (i.e. "coding creep"). In order to investigate the possible impact of changing morbidity on trend, we conducted a great deal of analysis as we prepared the filing.

To begin, we calculated the risk scores of all members in 2016, 2017, and 2018 using the 2018 CMS-HHS model. Simply adjusting the experience, excluding groups that left BCBSVT in 2018 or joined an AHP in 2019, leads to the following annual increases:

Year	Allowed PMPM	Risk Score	Normalized PMPM	Increase
2016	$458.65	1.168	$392.66	
2017	$476.78	1.242	$383.82	-2.3%
2018	$508.44	1.319	$385.55	0.4%

This would suggest a medical utilization around zero percent, which contradicts results of other analyses. We therefore pursued additional strategies in an attempt to confirm the legitimacy of the incongruous result when adjusting for risk score.

Using a closed cohort, where members were enrolled for at least six months in each of the experience years, we calculated the impact of coding growth and health status deterioration with age:

Year	Risk Score of Closed Cohort	Increase
2016	1.137	
2017	1.220	7.2%
2018	1.354	11.0%

We estimated the impact of coding creep by comparing the derived risk score adjustment to a pure benefit and aging adjustment for the closed cohort. While risk scores will change for certain acute conditions, normalizing for population changes should produce a result that across a broad population closely approximates an aging adjustment. We found that the risk score adjustment is significantly higher than a pure aging adjustment, and conclude that significant coding growth is impacting risk score results.

There are a number of reasons to expect significant coding growth in the Vermont health care environment. UVMMC implemented a new electronic medical record (EMR) platform as of January 2018. We observed a significant improvement in risk coding as a result of this implementation, as demonstrated by the 2018 risk transfer results as well as through our work with OneCare Vermont on the 2018 shared risk/savings program. The ACO itself encourages better coding, as its internal measurement of medical service areas is impacted by risk score. This is a new influence in Vermont, as practitioners have had little exposure to risk-adjusted reporting and results historically. Finally, BCBSVT has engaged with providers throughout our service area to improve coding and capture more complete information on claims submissions.

We calculated the CY 2018 over CY 2017 trend for the closed cohort and compared the result to our base populations described in the actuarial memorandum. We found that the year over year trend was *higher* for the closed cohort when adjusting only for aging and benefits, and also when adjusting for coding growth:

CY2017 / CY 2018		All VISG	Excluding Groups that left in 2018 or joined an AHP in 2019	CLOSED COHORT
TOTAL	Allowed PMPM	10.5%	8.9%	15.3%
	Intensity and Utilization (I/U)	8.2%	6.7%	13.0%
	Cost	2.1%	2.1%	2.0%
Benefit and Aging	Intensity and Utilization	8.2%	6.7%	13.0%
	Benefit and Aging Adjustment (B/A)	-1.9%	-0.7%	-3.3%
	(I/U) after (B/A) Adjustment	**6.1%**	**5.9%**	**9.3%**
Risk Score	Intensity and Utilization	8.2%	6.7%	13.0%
	Risk Score Adjustment (RS)	-8.2%	-5.8%	-9.9%
	(I/U after (RS) adjustment	-0.7%	0.5%	1.8%
	Coding Growth	7.3%	7.3%	7.3%
	Trend after adjusting for Coding Growth	**6.6%**	**7.8%**	**9.3%**

These results lead us to the conclusion that the zero trend calculated by adjusting for raw risk score without considering coding growth was an outlier and not supported by additional analysis. All other methodologies, including the approaches discussed in the actuarial memorandum, observing a closed cohort adjusted for aging, and observing a closed cohort adjusted for risk score and coding growth (even if we assume a coding growth of 5 percent, typical in an environment where coding optimization efforts are underway), produce similar trends. We therefore discard the incongruous results calculated by using unadjusted risk scores, and conclude that the other methodologies – which all converge to similar results – are sounder. We chose to use the trends with exclusion of certain groups rather than the closed cohort because it is a larger population base that is easier to work with mechanically than the closed cohort.

3. *Factor b9 on Exhibit 5 reflects the loss of healthy "Members in Groups that are no longer with BCBSVT". The actuarial memorandum describes this as a change in pool morbidity, and no corresponding adjustment to risk adjustment is assumed. Would these members not be assumed to transition to other carriers in the market, potentially increasing the risk adjustment receivable to BCBSVT?*
It is true that a change in pool morbidity will correspond to an increase in PLRS for BCBSVT, but it is also possible that these migrating members could increase the other carrier's PLRS and thus net out all or some of the change in expected risk adjustment receivable.

For instance, from the interim 2018 risk adjustment data we calculated the average BCBSVT plan liability risk score (PLRS) to be 1.499 and MVP's to be 1.188. We looked at the member specific risk scores of those small group members that left BCBSVT and estimated that their specific PLRS was 1.393. Therefore, moving these members out of BCBSVT to MVP will result in an increase in PLRS for both BCBSVT and MVP. The table below illustrates how the baseline PLRS is impacted after being adjusted for the transitioning small group members:

Carrier	Baseline PLRS	Adjusted PLRS
BCBSVT	1.499	1.501
MVP	1.188	1.196
BCBSVT/MVP	**1.262**	**1.255**

The risk adjustment receivable will ultimately depend on the relationship of PLRS between the carriers. The impact of reflecting the change in population as above would be a reduction in risk adjustment receivable to just over $17 million, which would increase premiums by 0.2 percent.

4. *Similarly, demonstrate how the risk adjustment projection considers the following factors, all assumed to impact the morbidity of the BCBSVT insured pool: aging, AHP and its associated shift towards platinum plans, members exiting due to removal of mandate penalty, low-cost small groups leaving BCBSVT, "impact of different benefit plans", and "impact of selection."*
We assumed that morbidity items such as aging, individual mandate and impact of different benefit plans would impact both carriers proportionally and would not add or subtract any value to the risk adjustment receivable. The impact of selection factor has no impact on the risk scores since the plan selected is already accounted for in the risk score model. Furthermore, the impact of selection factor is not an actual adjustment to projected allowed charges but an adjustment to projected paid claims to ensure that BCBSVT projected paid claims reflect the total projected paid claims for the single risk pool. This factor is included in the buildup of the index rate as it is our understanding of the rating rules that we cannot have a plan level adjustment that varies by plan. The impact of low-cost small groups leaving BCBSVT is discussed in our response to question 3.

We did make explicit assumptions for the AHP shift since BCBSVT contributed a higher proportion of membership than MVP to the AHP market. The BCBSVT member specific risk scores within the 2018 interim data suggest that the PLRS associated to the migrating members was 1.409 compared to the BCBSVT total PLRS of 1.499. Therefore, removing these members from the market will increase BCBSVT's PLRS by approximately 0.4 percent. MVP's 2019 URRT template shows their 2017 experience period to have a higher small group allowed charge PMPM than their individual market. We assumed that the PLRS would have a similar relationship as their allowed charges. Thus, by MVP losing small group membership to the AHP market we expect this to lower their average risk score and increase the PLRS differential between the carriers by roughly 0.1 percent. Lastly, we increased the PLRS differential for the shift towards platinum plans by taking the weighted average PLRS of projected members before and after the platinum shift and estimated the impact to be about 0.2 percent. Overall, we increased the PLRS differential between the carriers by approximately 0.7 percent for the impact of AHP and its associated shift towards platinum plans.

5. *The actuarial dataset states that 17,993 of 26,981 contracts will have a rate increase of 15% or more. However, Exhibit 9B suggests that only 16,937 contracts will have an increase of 15% or more. Please clarify.*

The actuarial dataset was not updated with the final rate distribution. The table should read as follows:

Annual Rate Change Distribution	Impacted # of Contracts	Impacted # of Members	Impacted # of Groups
Reduction of 15.00% or more	0	0	0
Reduction of 10.01% to 14.99%	0	0	0
Reduction of 5.01% to 10.00%	0	0	0
Reduction of 0.01% to 5.00%	0	0	0
No Change	0	0	0
Increase of 0.01% to 5.00%	0	0	0
Increase of 5.01% to 10.00%	1,743	2,454	123
Increase of 10.01% to 14.99%	8,301	13,755	1,365
Increase of 15.00% or more	16,937	27,730	2,830
Total	26,981	43,939	4,318

6. *The actuarial memorandum states that the projected federal MLR is 91.8%. The actuarial dataset states that this value is projected to be 91.2% and Exhibit 8 agrees with this latter value. Please clarify.*

The MLR figure listed in the actuarial memorandum is incorrect. The projected MLR on Exhibit 8 of 91.2 percent is the correct answer.

7. *Exhibit 2C calculates a selection factor based on a static population. Explain why this selection impact is not already reflected in the underlying experience claims, which reflect a similar selection environment.*

The experience period does come from a similar selection based environment as our projected period. What the selection factor in Exhibit 2C represents is the relationship between HHS based IU and AV factors relative to BCBSVT's expected IU and AV factors that are influenced by selection. This factor is unique from other factors in that it does not represent an adjustment to the experience period but rather an adjustment to projection period claims to ensure that the projected claims using HHS based factors yields the same result in total (not by plan) as the BCBSVT factors based on selection and experience. Since this is an adjustment to projected claims, the selection factor uses the static projected membership as the weights within the calculation.

At issue is the disconnect between a rating methodology that requires that plan selection cannot be considered in conjunction with an observation that, on average, healthier individuals select plans with lower actuarial values. The adjustment illustrated in Exhibit 2C is necessary to correct for this disconnect while not violating rating rules that preclude plan-level selection adjustments (even if the projected membership distribution exactly matches the membership distribution in the experience period).

8. *Explain the difference between the two fields labeled "Pricing Actuarial Value" in Exhibit 2C (called "Exhibit 2D" in the actuarial memorandum.)*
The first use of "Pricing Actuarial Value" under the "Using HHS Induced Utilization Factors" heading represents the paid-to-allowed ratio of the 2020 plan designs using the standard population underlying the federal actuarial value calculator as the basis. The second use of "Pricing Actuarial Value" under the "Using BCBSVT Induced Utilization Factor" heading represents the paid-to-allowed ratio of the 2020 plan designs using BCBSVT's experience as the base with consideration of the impact that member selection and morbidity have on each plan's paid-to-allowed ratio.

9. *Explain the following statement regarding the development of the normalized Pricing AV values: "The change in method is worth approximately three quarters of the total factor."*
If we were to calculate the impact of selection (c_6) using the same methodology as previous years the c_6 factor would have been 1.0189 (please see attached worksheet, *Responses to BCBSVT 2020 VISG Inquiry 2.xlsx – Q9 tab* for an illustrative version of Exhibit 2C under the previous methodology). Thus, the estimated impact specific to methodology change is 1.0508 = 1.0707/1.0189, or roughly three quarters (~72%) of the total 7.07 percent impact of selection. As stated in the Actuarial Memorandum, there is an offset within the plan level adjustments such that the net overall rate impact is zero. This change in methodology was in response to the analysis done by L&E[1] wherein it was stated that a 4 percent gap in actuarial values for bronze plans "is a potential source of future VHC instability."

10. *It appears that the paid-to-allowed ratios are generally higher using BCBSVT's data than using the Federal AVC. This contributes to the 7% selection factor applied in item c6 which is applied to the index rate. Explain how it is appropriate to increase the index rate, which is on an allowed basis, in response to a decrease in paid-to-allowed factor.*
The plan level adjustments per the ACA (HHS) guidelines cannot reflect differences due to health status. In practice we have observed that healthier people tend to select leaner plans and unhealthier people tend to select richer plans. The c_6 factor quantifies the shortfall that occurs from using HHS-compliant plan level adjustments to project claims relative to the observation that health status does play a role in a member's plan selection. Due to this discrepancy, projected claims will ultimately differ from projections based on HHS factors, as illustrated in Exhibit 2C. Since we cannot apply health status at the plan level we must therefore apply the c6 factor as a market-wide adjustment.

We included this adjustment as part of the index rate calculation as the result of a conversation with our actuarial review team for the 2017 VISG filing. We believe that it could alternatively be included as a market-wide adjustment that is consistent across plans if that were the new guidance of our actuarial reviewers.

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[1] Provided by email to BCBSVT on December 6, 2018.

11. *Please reconcile the projected index rate on the URRT of $788.92 to the Projected Index Rate in Exhibit 5 of $789.49.*
Worksheet 1 of the URRT was not updated with final factors. The projected index rate on the URRT should have been $789.42. The projected index rate on Exhibit 5 includes non-EHB claims. Those are removed before calculating the Market Adjusted Index Rate in row g_4 of Exhibit 5.

Please see revised Worksheet 1 in *Responses to BCBSVT 2020 VISG Inquiry 2.xlsx – Q11 tab*. We will revise the URRT at the end of the review process.

12. *Regarding factor b7 regarding the elimination of the individual mandate penalty:*
    a. *The base period data is from 2018. The actuarial memorandum describes 0.8% of membership leaving between 2018 and 2020, with only a nominal change in cost. Explain then why the factor is a 0.5% adjustment rather than a 0.8%.*
    We believe that the ultimate impact of the individual mandate will be 0.8 percent and that this factor will be fully realized by 2020. As of March 2019, we have observed a premium impact of about 0.3 percent for those expected to leave the market due to the removal of the individual mandate penalty and who have actually done so. The remaining 0.5 percent are expected to leave the market over the next year.

    b. *If the removal of the penalty in 2019 resulted in only a third of this population leaving in that year, explain why BCBSVT is assuming this cohort will uniformly decide to leave the insurance pool in 2020.*
    We believe that the impact of the removal of the individual mandate penalty may have been far less in Vermont than anticipated because the individual mandate enacted in Vermont allowed the legislature to subsequently create an associated penalty. Members may have remained in the risk pool in 2019 due to the anticipated penalty, or because it was unclear that Vermont had enacted a mandate but no immediate penalty.

    In the past few months there has been much press coverage of Vermont's legislative discussion of the individual mandate and an associated penalty. The final version of H.524[2] does not include a penalty for failing to meet the requirement to maintain minimum essential coverage. We therefore believe that we will see additional members leave the single risk pool during the 2020 open enrollment period now that it is widely known that there will be no penalty. We approximate this impact by measuring the impact on premium of the remainder of the members forgoing insurance in 2020 who had no claims or had preventive care only claims within the individual market in 2018 and who do not receive premium assistance. The total impact of departures in both years is assumed to be less than half of the low end of the range of a study commissioned jointly by the GMCB and DFR in early 2018.

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[2] An act relating to health insurance and the individual mandate:
https://legislature.vermont.gov/Documents/2020/Docs/BILLS/H-0524/H-0524%20As%20Passed%20by%20Both%20House%20and%20Senate%20Unofficial.pdf

13. *Explain why the Interplan Teleprocessing System fees are treated as Allowed costs, when they appear to be costs incurred in the processing and payment of claims.*

Interplan Teleprocessing System (ITS) fees are included in our medical claims data within our data warehouse. We treat these fees as claims for our internal IBNR calculations and GAAP financial reporting, which is why we have identified these fees as claims in the Index Rate. For purposes of MLR (Exhibit 8) or statutory financial reporting, ITS fees are not considered claims because these fees represent costs of processing and administering claims. It is not unusual for items to be treated differently for these purposes; for instance, health care quality improvement expenses are treated as claims for MLR purposes.

14. *Explain why pharmacy rebates are trended forward using only cost trend, and not utilization trend as well.*

We calculate the utilization trend for all non-specialty days supply to account for the shift from brand to generic. When separately calculating utilization trends for brands and generics, the results are +1.5 percent for generic and -1.0 percent for brands.

Summary of Days Supply in Exhibit 3G

Category	Experience Period	Projection Period	Annual Trend
Generic	16,611,665	17,127,494	1.5%
Brand	2,306,747	2,260,849	-1.0%
Total Non-Specialty	18,918,412	19,388,343	1.2%

In practice, BCBSVT works closely with ESI to continually enhance rebate contracts in order to balance out the negative brand utilization trend. We have reflected those efforts by applying only brand cost trend to the rebate projection.

15. *Factors b3 and c3 are closely related, as they reflect the impact of young new members joining as well as the aging of existing members.*
    a. *Does factor c3 consider the impact of older members exiting the pool?*
    b. *The combination of these factors implies that changes in population age will result in a population with morbidity 1.5% higher than in 2018. Support this implicit assumption and confirm that it does not double-count the assumed market exits related to the removal of the individual mandate penalty.*
    c. *Was consideration given to the possibility that c3 could reflect the same change as b9, in that groups which left BCBSVT may have had disproportionately younger members?*

An overall 1.5 percent morbidity increase over two years is a reasonable increase and tracks well with our historical patterns, as shown in the table below. Note that the experience average age-gender factor was calculated after excluding the groups that left BCBSVT in 2018 or joined an AHP in 2019.

Period	Average Age-Gender Factor	Annual Increase	Two-Year Impact
CY 2015	1.2661		
CY 2016	1.2763	1.0081	
CY 2017	1.2889	1.0098	1.018
CY 2018	1.2969	1.0062	1.016
March 2019	1.3057	1.0068	1.013

In response to your request, we took a deeper dive into our rating methodology to verify that we were appropriately accounting for each segment of the population. We found certain small segments that were in more than one factor, but also other segments that did not appear at all. The net impact of all the changes described below is a 0.5 percent upward adjustment to rates.

First, retired members, defined as members who canceled when age 65 or over and members who aged into one of our Medicare Supplement products, should more appropriately be included in the category of members who voluntary cancel in the calculation of the change in pool morbidity factor (b9).

This reduces the factor from 1.0037 to 1.0020.

Revised Table from Page 17 of the Actuarial Memorandum	Voluntary Cancelation in the Individual Market	Members in Groups that are no longer with BCBSVT	All Other Members (excluding groups that joined an AHP)	Total
Experience Period Allowed	$37,784,218	$9,553,059	$323,191,619	$370,528,896
Member Months	60,248	17,761	502,727	580,736
PMPM	$627.14	$537.87	$642.88	$638.03
Experience Period Average Induced Utilization	0.960	1.006	1.006	1.000
PMPM after normalization for induced utilization	$653.17	$534.89	$639.32	$638.03

In order to normalize for all other adjustments, the impact of the changes in demographics should compare in-force members, excluding new members, to the experience period demographics of the individual members and groups who continued their enrollment with BCBSVT. This will account for regular employee churn and aging of a closed population on the individual market.

This change increases the impact of demographics (c3) factor from 1.0350 to 1.0353:

	Average Age-Gender Factor
Experience Period, excluding groups that subsequently joined an AHP	1.2967
Inforce, excluding new members	1.3194
Demographic Adjustment	= $(1.3194 / 1.2967)^2$ = 1.0353

Finally, we noted that we were not adjusting our demographic factor to account for new newborns in the projection period. By aging the inforce membership, any impact of newborns is removed. Based on the experience period, newborn claims are expected to increase the overall PMPM by 1.0059.

All of the adjustments described above are captured in the table below:

Factor	As Filed	Updated
1+b9	1.0037	1.0020
1+c3	1.0350	1.0353
Impact of newborns	1.0000	1.0059
Total Impact	**1.0388**	**1.0434**

Finally, the impact of the individual mandate is separated into two pieces. First, we have the observed 0.3 percent that is already accounted for in the change in morbidity (b9). Second, we have the additional impact of members enrolled in 2019 but expected to leave in 2020. That impact of 0.5 percent is independent of the other demographic and morbidity changes.

16. *Provide more detail on any case where "recent information from... early negotiations" caused BCBSVT to use medical trend assumptions which differ from the Board-approved 2018 increases.*
No recent information from early negotiations for GMCB-regulated providers was incorporated into the unit cost trend. In 2018, increases at certain facilities varied to reflect the result of negotiations applied to the BCBSVT Managed Care contract relative to other contracts. Additionally, the increase at one facility varied to reflect a change in the contract's effective date. These were one-time adjustments, and subsequent increases reflect the aggregate ordered 2018 or 2019 increase.

Additionally, we erroneously reflected the total contracted increase of one hospital's October 2018 rate change in the unit cost development, instead of the inpatient and outpatient increases. The 2019 and 2020 increases correctly reflect the actual inpatient and outpatient increases. Correcting the 2018 increase would have an immaterial upward impact on premiums.

17. *Explain any discrepancy between the annual cost trend by year between the actuarial memorandum and the confidential exhibit provided in your previous response.*

As noted in our response to question 2 of your questions dated May 14, 2019, certain hospitals reflected erroneous contracted increases due to a reference error in the unit cost development underlying the cost trends on Exhibit 3H. The 2019 and 2020 increases in the confidential responses provided on May 16, 2019, were updated to reflect the actual estimated increases. This change results in an increase of 0.04 percent within the unit cost trend. There was also a typographical error in the actuarial memorandum for the total annual cost trend for other facilities and providers. The table on page 26 should read:

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in Experience	Cost Trend from 2018 to 2019	Cost Trend from 2019 to 2020	Total Annual Cost Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	51.1%	2.8%	2.9%	2.8%
Other facilities and providers	48.9%	2.0%	2.9%	2.4%
Total	100.0%	2.4%	2.9%	2.6%

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

Sincerely,

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

Chief Actuary

BLUE CROSS AND BLUE SHIELD OF VERMONT
2020 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

Responses to BCBSVT 2020 VISG Inquiry 2

			Projected Paid Claims - Using HHS Induced Utilization Factor					Projected Paid Claims - Using BCBSVT Induced Utilization Factor				
			Projected FFS Allowed Charges - Without Selection	Benefit Richness Adjustment	Pricing Actuarial Value	For Catastrophic Plan only - Impact of the specific eligibility	Projected Paid Claims	Projected FFS Allowed Charges - Without Selection	Benefit Richness Adjustment	Pricing Actuarial Value	Projected Paid Claims	Projected Membership
NON-STANDARD PLANS	GOLD	Blue Rewards	$751.07	1.0108	83.33%	1.0000	$632.58	$751.07	1.1008	84.01%	$694.57	883
	GOLD	Blue Rewards CDHP	$751.07	0.9922	80.13%	1.0000	$597.11	$751.07	1.1008	81.25%	$671.76	4,811
	SILVER	Blue Rewards	$751.07	0.9717	76.16%	1.0000	$555.83	$751.07	1.0232	75.05%	$576.77	1,523
	SILVER	Blue Rewards CDHP	$751.07	0.9709	76.01%	1.0000	$554.25	$751.07	1.0232	74.74%	$574.38	115
	BRONZE	Blue Rewards	$751.07	0.9446	69.73%	1.0000	$494.67	$751.07	0.5679	67.79%	$289.17	408
	BRONZE	Blue Rewards CDHP	$751.07	0.9467	70.30%	1.0000	$499.86	$751.07	0.5679	67.11%	$286.27	1,662
STANDARD PLANS	PLATINUM	Deductible	$751.07	1.0755	92.61%	1.0000	$748.14	$751.07	1.4436	93.63%	$1,015.16	8,732
	GOLD	Deductible	$751.07	1.0190	84.65%	1.0000	$647.88	$751.07	1.1008	84.90%	$701.93	5,615
	SILVER	Deductible	$751.07	0.9693	75.67%	1.0000	$550.90	$751.07	1.0232	75.12%	$577.30	4,634
	SILVER	CDHP	$751.07	0.9827	78.36%	1.0000	$578.37	$751.07	1.0232	77.37%	$594.60	1,130
	BRONZE	Deductible	$751.07	0.9452	69.91%	1.0000	$496.32	$751.07	0.5679	66.48%	$283.59	1,811
	BRONZE	CDHP	$751.07	0.9510	71.44%	1.0000	$510.30	$751.07	0.5679	67.90%	$289.64	1,412
	BRONZE	Integrated	$751.07	0.9531	71.95%	1.0000	$515.05	$751.07	0.5679	69.40%	$296.05	274
	Catastrophic	Blue Rewards	$751.07	0.9499	71.15%	0.4940	$250.76	$751.07	0.2093	68.72%	$108.01	293
REFLECTIVE PLANS	SILVER	Blue Rewards	$751.07	0.9717	76.16%	1.0000	$555.82	$751.07	0.6960	71.59%	$374.25	655
	SILVER	Blue Rewards CDHP	$751.07	0.9706	75.93%	1.0000	$553.54	$751.07	0.6960	70.60%	$369.06	349
	SILVER	Deductible	$751.07	0.9693	75.67%	1.0000	$550.89	$751.07	0.6960	71.92%	$375.99	4,948
	SILVER	CDHP	$751.07	0.9826	78.36%	1.0000	$578.29	$751.07	0.6960	74.44%	$389.16	2,429
	Total						**$606.30**				**$617.77**	**41,684**

1+c6 under Previous Method = $617.77 / $606.3   **1.0189**

Unified Rate Review v5.0

To add a product to Worksheet 2 - Plan Product Info, select the Add Product button or Ctrl + Shift + P.

To add a plan to Worksheet 2 - Plan Product Info, select the Add Plan button or Ctrl + Shift + L.

Company Legal Name:	Blue Cross and Blue Shield of Vermont	State:	VT
HIOS Issuer ID:	13627	Market:	Combined
Effective Date of Rate Change(s):	1/1/2020		

To validate, select the Validate button or Ctrl + Shift + I.

To finalize, select the Finalize button or Ctrl + Shift + F.

Market Level Calculations (Same for all Plans)

Section I: Experience Period Data

Experience Period: 1/1/2018 to 12/31/2018

	Total	PMPM
Allowed Claims	$388,253,552.55	$616.29
Reinsurance	$0.00	$0.00
Incurred Claims in Experience Period	$326,400,534.41	$518.11
Risk Adjustment	$13,016,547.37	$20.66
Experience Period Premium	$342,711,238.59	$544.00
Experience Period Member Months	629,988	

Section II: Projections

Benefit Category	Experience Period Index Rate PMPM	Year 1 Trend		Year 2 Trend		Trended EHB Allowed Claims PMPM
		Cost	Utilization	Cost	Utilization	
Inpatient Hospital	$104.55	1.023	1.029	1.029	1.035	$117.25
Outpatient Hospital	$244.43	1.023	1.029	1.029	1.035	$274.11
Professional	$130.67	1.023	1.029	1.029	1.035	$146.54
Other Medical	$28.12	1.021	1.028	1.027	1.034	$31.36
Capitation	$8.08	1.023	1.029	1.029	1.035	$9.06
Prescription Drug	$100.37	1.116	1.012	1.116	1.012	$128.09
Total	$616.23					$706.42

Morbidity Adjustment		1.074
Demographic Shift		1.035
Plan Design Changes		1.006
Other		0.999
Adjusted Trended EHB Allowed Claims PMPM for	1/1/2020	$789.42

Manual EHB Allowed Claims PMPM	$0.00
Applied Credibility %	100.00%

			Projected Period Totals
Projected Index Rate for	1/1/2020	$789.42	$394,874,199.36
Reinsurance		$0.00	$0.00
Risk Adjustment Payment/Charge		$41.64	$20,828,661.12
Exchange User Fees		0.00%	$0.00
Market Adjusted Index Rate		$747.78	$374,045,538.24

Projected Member Months	500,208