Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
2023 Association Health Plan Rating Program Filing
Actuarial Memorandum

1. Purpose

Blue Cross and Blue Shield of Vermont (Blue Cross) performs association health plan (AHP) rating on a case-by-case basis. We accomplish rating through a formulaic approach that blends recent AHP experience with a manual rate according to a credibility formula. We may adjust formula results for underwriting judgment and/or management decisions. This filing establishes the formula, manual rate, and accompanying factors that we will use to rate Pathway 1 AHPs beginning upon approval of this filing. The formula and factors in this filing apply to Pathway 1 AHPs only.

Once approved, we will use this filing for insured AHPs until superseded by a subsequent filing. In the event that we require factors with effective dates or experience periods beyond those explicitly presented in this filing, we will calculate appropriate factors using the same base data and methodology used in this filing. This filing will apply beginning with rates communicated within seven business days after the date of its approval and continuing until at most seven business days after the date of approval of the next Blue Cross AHP Rating Program filings. The term "communicated," for this purpose, means a written proposal delivered to an association health plan account.

2. Overview and Rate Impact

2.1. Overview

This filing includes a description of the rating formula and the development of each of the factors used in it. Blue Cross projects that this filing will affect 1,434 members (959 subscribers) in one AHP. These totals are as of December 31, 2021.

We will describe in detail the formula and factors applicable to all insured association health plans. The factors in the build-up of the projected claims cost include the trend factors, benefit relativities, manual rate, and large claims factors. In addition to the projected claims cost, we will explain the calculation of administrative charges, the net cost of reinsurance, contribution to reserve, and state and federal assessments, all of which are included in the rate development.

2.2. Historical Financial Results

Below is the combined medical and pharmacy experience for calendar year 2021. In 2019, Blue Cross had two AHPs, neither of which was a Pathway 1 AHP. The financial results of those AHPs are not relevant to this filing.

Insured Association Health Plan Experience							
Year	Incurred Claims	Administrative Charges	Earned Premium	Gain/(Loss)	Loss & Expense Ratio	Target Loss and Expense Ratio	Member Months
2021	$8,560,484	$1,175,528	$10,844,842	$1,108,830	89.8%	98.5%	18,558

The incurred claims, administrative expenses, and earned premium are from Blue Cross GAAP financials. The claims include capitations, fee-for-services claims, certain assessments, and other claims expenses.

2.3. Impact of Formula and Factor Changes

To compute the impact of changes to the rating formula and the various factors in this filing on AHP premium rates, we use the concept of a "pure manual premium," which is the premium that can be developed for the manual rate base using none of their own experience data. Two renewals are developed for the manual rate base: the first renewal applies the approved factors currently in force (BCVT-132760913) with an effective date of January 1, 2022. The second renewal uses the factors and formulas detailed in this filing with a January 1, 2023 effective date. By nature of the differing effective dates, the latter renewal includes an additional year of health care cost trend.

Impact of Formula and Factor Changes				
Renewal and Filing Year	**2022**	**2023**	**Component Increase**	**Premium Impact**
Manual Claims (a)	$631.02	$688.92	9.2%	8.6%
Projected Rebates	-$37.95	-$38.45	1.3%	-0.1%
Pediatric Vision & Dental	$2.24	$1.88	-16.1%	-0.1%
Admin	$50.41	$54.94	9.0%	0.7%
Reserve	$10.11	$11.06	9.4%	0.1%
Mandates and Assessments	$14.88	$15.37	3.3%	0.1%
Additional Items (b)	$3.06	$3.59	17.3%	0.1%
Total	$673.77	$737.31		9.4%

(a) The manual claims increase is the change in the manual rate as described in section 6.1.

(b) Additional Items include net cost of reinsurance, Cost Plus stop loss, broker commissions, the OneCare Coordination Fee, and fees paid to outside vendors.

The above approach has been used to generate a proxy increase for a hypothetical AHP that is renewing with zero experience credibility, exactly average demographics and industry, and no underwriting judgment or management discretion applied to the proposed or in-force rates. The actual rate increase experienced by any specific AHP will be based on the AHP's own circumstances, including its claims data, demographic makeup, large claims experience, and so forth.

This total 9.4 percent impact of formula and factor changes should not be interpreted as the premium increase for any specific AHP.

3. Formula Description

We develop rates for active and Medicare Primary subscribers separately based on their own experience. Both the formula and factors described in this filing are the same for both populations except where noted.

Benefit-Adjusted Projected Single Claims Rate

Exhibit 1A contains a sample calculation of the benefit-adjusted single claims rate. Page 1 of the exhibit applies to active members and page 2 applies to Medicare Primary members. For each case, we start the rating with a twelve-month experience period with at least two months of runout[1]. We develop the experience rate for medical and pharmacy claims separately. We determine a pooling point based on the size of the case at the end of the runout period and split the experience period claims (line A) into amounts above (line B) and below (referred to as capped claims, line D) the pooling point. We exclude certain COVID-19 related claims (line C) from the development. Exhibit 6C contains a list of excluded primary diagnosis and procedure codes, which we will update as new information becomes available. Section 6.7 provides further details on the exclusion of COVID-19 related claims.

We apply completion factors (line E) developed from the monthly financial reporting process (best estimates before margin) to capped claims to produce completed capped claims (line F). We use the formula and factors described in Milliman's 2021 *Health Cost Guidelines – Reinsurance* to calculate expected claims above the pooling limit (line G). We add the expected claims above the pooling limit to the completed capped claims to produce large-claim-adjusted experience period claims. Medicare Primary members generally do not have claims near the pooling point, so we do not pool their claims.

We then multiply the large-claim-adjusted experience claims by an adjustment factor (line H) to reflect structural changes between the experience period and the rating period. This adjustment modifies the experience to reflect such things as mandated benefit changes, contractual provision changes, etc., that, in the judgment of the underwriter, are necessary to make the experience appropriate for the estimation of the expected claims in the rating period.

We divide the result (line I) by the number of member months during the experience period (line J) to produce the adjusted experience period claims per member per month (line K).

We then divide the adjusted experience period claims per member per month (PMPM) by a seasonally-adjusted benefit relativity value to neutralize any effect of seasonality and benefits on the paid claims. To determine this factor, we first determine a benefit relativity factor for each benefit plan (using the factors described in section 5) and contract tier type (single, 2-person, family, etc.). Based on the seasonal patterns observed as part of the reserving process for each calendar month, we determine seasonal factors for CDHPs and for non-CDHPs and normalize them so that they total to 12. We combine these factors to calculate seasonal benefit relativity factors for each combination of benefit plan, contract tier type, and month. We apply these factors to the number of contracts for each benefit plan, contract tier type, and month in the experience period. We total the results and divide the resultant sum by the number of member months in the experience period. We apply the seasonal factors regardless of the length of experience period, but if there is a 12-month experience period and there are no changes in benefits or enrollment, the normalization of the seasonality factors would cause the seasonal adjustment to be 1.000. This produces the average experience period seasonally-adjusted benefit relativity factor (line L).

[1] For first year renewals where twelve months of experience is not available, we typically use claims incurred in nine months with no runout.

We adjust for any change in the demographics of the AHP between the experience period and the rating period by calculating the average demographic factor for each period and applying the ratio of projection to experience (line M). We multiply the adjusted experience period claims PMPM (line K) by the demographic normalization factor and divide by the average experience period seasonally-adjusted benefit relativity factor (line L) to produce the benefit-adjusted experience period single claims rate (line N), which is the expected cost for a single contract in the experience, neutral of benefit and seasonality. We then multiply this by a trend factor (line Q, as discussed in section 4) to project the claims from the experience period to the rating period.

We blend the projected single contract rate (line R) with the adjusted manual rate (line S, as described in section 6.1) using the credibility formula described below.

We calculate the credibility factor (line T) as follows:

$$Credibility = \sqrt{\frac{Member\ Months}{Upper\ Bound}}$$

The pooling point determines the upper bound. We base the pooling limit on the AHP's membership in the current month. Please see the abbreviated table below for details. The underwriter may apply discretion in the event the current month's membership is not appropriate for determining a pooling limit (e.g. a significant change in enrollment due to an acquisition or layoff).

Membership (Current Months)	Pooling Point	Upper Bound Member Months
Medicare Primary		8,325
0 to 299	$70,000	14,002
300 to 499	$90,000	16,127
500 to 999	$110,000	17,923

If member months are greater than the upper bound, the credibility factor will be 1. Exhibit 6A provides a complete list of upper bound member months by pooling point, while Exhibit 6B details pooling points by current month membership.

To blend the projected single contract rate with the adjusted manual rate, we use the following equation:

$$Benefit\text{-}Adjusted\ Projected\ Single\ Claims\ Rate = Projected\ Single\ Contract\ Rate \times (Credibility) + Adjusted\ Manual\ Rate \times (1 - Credibility)$$

Multiple Experience Periods

Blue Cross uses multiple experience periods (when available) to develop the benefit-adjusted projected single claims rate. Following the methodology described above, we calculate an experience rate for the first and second year preceding the experience period. We then apply the credibility formula recursively

to the residual portion of the rate. The table below provides a demonstration of the application of the credibility formula for an AHP with 50 percent credibility in each experience year.

Experience Period	Proportion of Rate
YE 202206	50.0%
YE 202106	25.0%
YE 202006	12.5%
Manual Rate	12.5%

Three years of experience is the maximum that we will use. In the absence of extenuating circumstances, all renewals will use the maximum number of years available. In the event we do not consider historical experience appropriate or reliable for rating periods (e.g. a significant change in enrollment due to an acquisition or layoff), the underwriter will use fewer years of experience and document the rationale for such a change.

Exhibit 1B provides a detailed sample calculation of the benefit-adjusted projected single claims rate using three years of experience.

If the credibility of the first year of experience is in excess of 66.67%, the underwriter shall develop rates using a 3-2-1 blend of experience periods and not utilize the manual rate.

Required premium by Plan, Tier Type

Exhibit 1C provides a sample calculation of premium. For each plan and contract tier type anticipated in the rating period, we calculate projected claims (line B1) as the product of the benefit-adjusted projected single claims rate (S) and the benefit relativity factor (as described in section 5) for the plan and contract tier (line A). For any premium components that are exclusively applicable to either active or Medicare Primary members, we only include the component in the respective rate tier(s) to which it applies.

We use the members per contract tier during the last month of the runout period as the basis for the projected members per tier in the rating period. The underwriter will adjust this ratio if, in their opinion, the result is not representative of the expected values in the rating period.[2]

Underwriting Judgment Adjustments

If, in the underwriter's professional judgment, the standard formula would not produce appropriate rates for the case being rated, the underwriter will make such modifications as needed to produce appropriate rates. The underwriter will document in the case file the reason(s) for the adjustment(s) and the method of determining the appropriate adjustment(s).

[2] E.g., the number of contracts in a particular tier may be small (or even 0). In such instances, the underwriter should use appropriate values based on total block of business or other appropriate sources.

Management Discretionary Adjustments

For marketing or other reasons, management may decide to modify the rates on a specific case or block of cases. The underwriter will document in the case file the adjustment(s) made, along with a description of the nature of the adjustment(s).

4. Trend Factors

The source of data for trend development is the Blue Cross data warehouse, except where noted below. To ensure the accuracy of claims information, we reconcile the data used against internal reserving, enrollment, and other financial reports. The data includes claims from Blue Cross Cost Plus groups, Blue Cross ASO groups of under 1,001 members, Blue Cross insured large groups, Blue Cross insured small groups with more than 10 members, Blue Cross insured association health plans with more than 10 members, and TVHP insured large groups. The data also excludes insured large groups with much higher costs than average that have left Blue Cross in 2020 and 2021. The above lines of business cover substantially similar populations under similar benefit packages. Combining these homogeneous populations creates greater consistency and credibility within the trend factor development.

We exclude large ASO groups and ASO groups with special pricing arrangements. Blue Cross experienced large membership movement out of the small group market during the trend experience period. Due to significant changes in membership, we exclude all membership from small groups that were not continuously with Blue Cross throughout the trend experience period. We exclude claims from Medicare Primary members. Medicare Primary trend is discussed in section 4.5. We exclude compounds, vaccines, and over-the-counter drugs from the pharmacy cost trend development.

We use claims incurred from September 1, 2017 to August 31, 2021, paid through October 31, 2021. We apply completion factors to estimate the ultimate incurred claims for each period shown in the exhibits.

4.1. Medical Trend Development

Medical trend is composed of three pieces: cost, utilization, and intensity. In our analysis, we combine utilization and intensity within the utilization metric and analyze the unit cost separately. For fee-for-service claims, we combine plan payment with member cost sharing to calculate the allowed charges. For claims under a capitation arrangement, we combine a fee-for-service equivalent amount with the member cost sharing to calculate allowed charges.

4.1.1. Unit Cost

Observations of recent contracting and provider budgetary changes are the main source of unit cost trends. During the year ended August 2021, roughly 52 percent of total claims dollars were provided by Vermont facilities and providers directly affected by the hospital budget review process of the Green Mountain Care Board (GMCB). For hospitals under the jurisdiction of GMCB review, we start with the assumption that the GMCB will approve hospital budgets for the 2022 cycle that support identical commercial increases as those approved for the 2021 cycle. For hospitals that requested a midyear increase in the spring of 2022, we assume that their next approved budget will be higher than the 2021 cycle by the annualized proportion that was not granted as a midyear adjustment.

[redacted]

Based upon the above assumptions concerning hospital budget and fee schedule changes, the provider contracting and actuarial departments worked together to assess the impact such an increase would have on contract negotiations for the Blue Cross Managed Care and Blue Cross Non-Managed Care contracts. For marketing reasons, Blue Cross negotiates different unit cost increases for each of the two contracts. To reflect these differences, we calculate a cost trend for each contract.

We assumed for other providers within the Blue Cross service area that overall 2022 and 2023 budget increases would be identical to those implemented during the 2021 cycle, with the exception that we have reflected any more recent information gleaned from our early negotiations with providers. Again, the provider contracting and actuarial departments worked closely together to assess the impact these assumptions would have on contract negotiations for the Blue Cross Managed Care and Blue Cross Non-Managed Care contracts.

Finally, we derive unit cost increases for providers outside the Blue Cross service area from the Fall 2021 Blue Trend Survey, which is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

Exhibit 2A shows the details of the cost increases by contract and type of claim. We use the expected increases to trend the contract-normalized claims to the projection period.

The chart below summarizes the results of the analysis:

Medical Unit Cost Trend – CY 2022		
	Blue Cross Managed Care	Blue Cross Non-Managed Care
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	6.4%	6.6%
Other facilities and providers	5.5%	5.7%
Total	6.0%	6.2%

Medical Unit Cost Trend – CY 2023		
	Blue Cross Managed Care	Blue Cross Non-Managed Care
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	10.1%	10.1%
Other facilities and providers	5.7%	5.7%
Total	8.0%	8.0%

4.1.2. Utilization & Intensity

We use the utilization trend factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

4.1.3. Total Medical Trend

The total medical trend factors are the product of the utilization trend and the unit cost trend factors.

Annual Medical Trend – BCBSVT Managed Care				
Category	Facility	Professional	Pharmaceuticals	Total
Unit Cost	7.4%	5.1%	7.3%	
Utilization	2.4%	1.8%	1.9%	
Total Medical Trend	9.9%	6.9%	9.3%	9.0%

Component	BCBSVT Managed Care	BCBSVT Non-Managed Care
Total Annual Medical Trend	9.0%	9.2%

These represent the annualized trend from year-ended August 2021 to calendar year 2023. Due to the non-uniform trend assumptions for facility and all other professional services, we will apply monthly trend factors to bring the renewal experience period through the rating period. The monthly factors are shown on Exhibit 2G.

4.2. Retail Pharmacy Trend

We use the retail pharmacy trend factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

4.3. Overall Total Trend

Using the claims experience[3] for the groups included in the manual rate (see section 6.1), we calculate the overall allowed trend as follows:

Category	Allowed PMPM	Allowed Trend
Medical	$577.50	9.0%
Pharmacy	$129.05	9.9%
Total	$706.55	9.2%

4.4. Leveraged Trends

We use the leverage formulas from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

Applying the leverage factors for benefits present in the year ended August 2021 for the groups included in the manual rate, we calculate the following paid trends:

[3] We use claims incurred September 1, 2020 through August 31, 2021, projected to calendar year 2023.

Category	Paid PMPM	Paid Trend
Medical	$474.54	10.5%
Pharmacy	$116.24	10.7%
Total	$590.78	10.5%[4]

4.5. Medicare Secondary Trends

We use the Medicare Secondary trend factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

4.6. Vision Trend

AHP benefits must include pediatric vision benefits that are analogous to those offered in the individual and small group marketplace. We use the vision trend of 0.0 percent from the Blue Cross 2022 Vermont ACA Market - Small Group Rate Filing (SERFF: BCVT-132829562) since we expect the covered population to be substantially similar to the ACA Small Group population.

4.7. Dental Trend

AHP benefits must include pediatric dental benefits that are analogous to those offered in the individual and small group marketplace. We use the dental trend of 0.0 percent from the Blue Cross 2022 Vermont ACA Market - Small Group Rate Filing (SERFF: BCVT-132829562) since we expect the covered population to be substantially similar to the ACA Small Group population.

4.8. Prior Experience Period Trend Factors

We trend prior experience periods to the most current experience period using observed trends and apply the trend factors in section 4 to trend from the most current experience period to the rating period. Exhibit 2G contains the trend factors applicable to prior periods. For months following our trend base (that is, after August 2021), the observed trend is set to the trend factors in section 4. There are separate observed trend factors for active medical, Medicare Primary medical, and pharmacy.

To develop the observed medical trend factors, we calculate a monthly utilization trend. We apply actual cost increases to calculate the total observed medical trend. The observed pharmacy trend is the allowed claims trend of the trend experience base described in section 4. Historical trend factors for Medicare Primary medical claims are the approved trends for prior periods from the 2022 TVHP Medigap Blue Rate Filing (SERFF# BCVT-132956934).

5. Benefit Factors

5.1. Models for Active Employees

We use the models for Active Employees from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

[4] The paid trend without the pharmacy contract adjustment is [redacted].

5.2. Tier Factors

We use the tier factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

5.3. Models For Age 65+ Medicare Secondary Plans

We use the models for Models For Age 65+ Medicare Secondary Plans from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

5.4. Formulary & Pharmacy Options

Blue Cross offers AHPs a selection of formularies. AHPs can select either the Blue Cross Formulary or the National Performance Formulary. AHPs electing the National Performance Formulary receive greater rebates than those on the Blue Cross Formulary. To calculate the impact of the change, we identify rebate-eligible claims for the groups in the manual rate base. We calculate rebate totals under the contracted terms of each formulary. For AHPs changing formularies, we apply the below factors to projected rebates. We adjust the factors proportionately if the experience period includes a mix of formularies.

Experience Formulary	Rating Formulary	Rebate Multiplier
Blue Cross Formulary	National Performance	[redacted]
National Performance	Blue Cross Formulary	[redacted]

The National Performance Formulary covers different drugs than the Blue Cross Formulary. To reflect the difference in covered drugs between the two formularies, we apply a factor to the drug BRV for the Blue Cross Formulary. Using the claims in the drug BRV model, we compare the average cost per script, including the impact of brand and generic dispensing rates, for both formularies. We compare the cost per script for each formulary to the cost per script for all claims in the model to calculate adjustment factors for each formulary.

Formulary	Adjustment Factor
Blue Cross Formulary	[redacted]
National Performance Formulary	[redacted]

5.5. Riders

Blue Cross files riders with the Vermont Department of Financial Regulation (DFR) that allow AHPs to add or modify covered services. These riders include, but are not limited to, the Benefit Enhancement Rider, Acupuncture Benefits Rider, and Wellness Drug Rider. For riders that modify covered services, we use the benefit relativity model to price the rider. For riders that cover an optional service, we develop allowed charges from groups offering that coverage and adjust to the AHP's benefit or use a reasonable approximation of allowed charges if no experience data exists. If, in the underwriter's professional judgment, the election of a rider will create material anti-selection, the underwriter will modify the rate as necessary to reflect appropriate rates for the rider being rated, as described in section 3.

5.6. Rate Smoothing Charges

We use the rate smoothing charges from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

6. Other Factors Applicable to All Association Health Plans

6.1. Manual Rate

The AHP manual rate for active members is the medical and pharmacy paid claims PMPM incurred between November 1, 2020 and October 31, 2021, paid through December 31, 2021, for Blue Cross insured large groups, Blue Cross Cost Plus groups, TVHP insured large groups, Blue Cross insured association health plan member groups, and Blue Cross insured small groups. We only include in the manual rate experience groups where the average number of monthly subscribers exceeded 25, and where the group had active enrollment throughout the manual rate experience period. We consider the above lines of business to be representative of the expected membership of association health plans to be covered under this filing. We use claims from these groups, trended to calendar year 2023 using the trends and pharmacy contract adjustments described in section 4. We cap claims at $145,000[5] and add expected claims above $145,000. We calculate the expected large claims using the method described in section 6.2.

We calculate a separate manual rate for Medicare Primary members using the paid claims PMPM from the BRV experience period, trended to calendar year 2023 using the Medicare Primary trends described in section 4.5 and the pharmacy contract adjustments described in section 4.2. There are not enough Medicare Primary members in association health plans to develop a credible manual rate with only association health plan experience, so we base the Medicare Primary manual rate on the larger set of claims in the BRV experience, which includes Medicare Primary members from ASO groups as well as large groups. We make no adjustments to the Medicare Primary manual rate for large claims.

[5] Selected using the highest level a group in the manual rate membership base would be pooled at using the table in Exhibit 6B.

Calculation of the Manual Rate (Actives)			
Claim Type		Medical	Pharmacy
Incurred and Paid Experience Paid Claims, capped at $145,000	A	$52,500,140	$14,168,435
COVID-19 Related Claims	B	$2,953,431	$144,782
Estimated IBNR	C	$287,197	$869
Expected Claims above $145,000	D	$7,202,262	$516,735
Experience Adjustment Factor	E	1.0000	1.0000
Demographic Normalization	F	1.0034	1.0034
Overall Paid Trend Factor	G	1.2371	1.2450
Projected Total Paid Claims	H = (A - B + C + D) x E x F x G	$70,801,538	$18,165,609
Total Member Months	I	129,140	129,140
Medical/Pharmacy Manual Rate	J = H / I	$548.25	$140.67
2023 Manual Rate	**$K = J_1 + J_2$**	**$688.92**	
Q3 2021 Approved Manual Rate	L	$631.02	
Manual Rate Increase	M = K / L -1	9.2%	

We use the Medicare Primary manual rate from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

Changes in the experience base, an update to the trends detailed in this filing, and an additional year of trend cause the change in the active manual rate. As noted in the trend section, the ”Update Experience Base” component results in a decrease to the manual rate due to claims being lower than expected due to COVID-19. We expect an increase to unit cost and utilization trend, which results in an increase in the ”Update Trend” line. Lastly, we trend the claims underlying the manual rate from 2022 to 2023.

Manual Rate Development	PMPM	PMPM Change	Impact
2022 Manual Rate	$631.02		
Update Experience Base		$(39.90)	-6.3%
Update Trend		$25.74	4.1%
Trend to 2023		$72.06	11.4%
2023 Manual Rate	$688.92		

We adjust the manual rate to reflect a group’s particular characteristics, as demonstrated in Exhibit 4A. We make an adjustment for the average age/gender factor (line B) of the group. For active and Medicare primary members, we use factors from the SOA’s report *Health Care Costs – From Birth to Death*[6]. We normalize the factors such that the membership in the manual rate experience period has

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

an age/gender factor of one. We assign an industry factor (line C) to each group based on the Standard Industrial Classification code. See Exhibit 4B for the schedule of industry factors. We normalize the industry factors such that the manual rate has a factor of one. We do not apply an industry adjustment to the manual rate for Medicare Primary members. We then multiply the manual rate by an adjustment factor to reflect structural changes between the experience period to the rating period. This adjustment modifies the manual claims to reflect such things as mandated benefit changes, contractual provision changes, etc., that, in the judgment of the underwriter, are necessary to make the manual rate appropriate for the estimation of the expected claims in the rating period.

Finally, we calculate a contract conversion factor (line D) based on member distribution and tier factors in order to convert from a PMPM to a single rate basis. This factor is necessary because the rating formula blends the adjusted manual rate (line S of Exhibit 1A) with the projected single contract rate (line R of Exhibit 1A), which is not on a PMPM basis.

6.2. Large Claims Factors

We use the large claims factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

6.3. Administrative Charges

We use the administrative charge schedule from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

6.4. Net Cost of Reinsurance

We use the net cost of reinsurance charges from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

6.5. Pharmacy Rebates

We calculate pharmacy rebates by taking the experience period rebates and trending them using the total trend for brands eligible for rebates using the factors from the Q3 Large Group Filings (BCVT-133154621 and BCVT-133154563) as approved by the GMCB on May 18, 2022.

We subject the trended rebates to the minimum guarantees for the rating period. There is a lag between the receipt of pharmacy rebates and the time of the original claims. For months in the experience for which we do not have detailed rebate information, we include an estimated rebate amount in the calculation.

The factors for the age curve are in Chart 1 (for actives) and Chart 21 (for Medicare Primary) of the databook linked on the page.

6.6. Pediatric Vision and Dental

AHPs must offer pediatric dental and vision benefits that are analogous to those offered in the individual and small group marketplace. To develop the projected claims, we use small group claims and trend from the Blue Cross 2022 Vermont ACA Market - Small Group Rate Filing (SERFF: BCVT-132829562).

Projected Pediatric Vision and Dental Claims			
		Dental	Vision
Base Data (CY 2020)	A1	$1.39	$0.10
Adjustment for Deferred Care	A2	1.2756	1.0000
Adjusted Base Data	A = A1 x A2	$1.78	$0.10
Annual Trend	B	0.0%	0.0%
Months of Trend	C	36	36
Projected Claims	D = A x (1+B)^(C/12)	$1.78	$0.10

6.7. OneCare Coordination Fee

Blue Cross pays OneCare Vermont a care coordination fee for attributed members. This payment directly supports ACO providers, including community providers, as they deploy new care models. This model mirrors the investment Medicaid has made in the ACO provider network and supports the comprehensive care models being tested within the ACO program. The monthly charge for members attributed to OneCare is $3.25. We will update this estimate if we receive additional information.

6.8. Contribution to Reserve

As recommended by management, we include the following contribution to reserve factors in the rate calculation:

Contribution to Reserve	
Blue Cross Insured AHPs	1.5% of premium

A memo from Blue Cross senior management regarding the contribution to reserve factors can be found as Attachment A. We consider the above-listed contribution to reserve factors to be reasonable.

6.9. State Mandates and Assessments

Vermont Vaccine Purchasing Program Payments
The Vermont Vaccine Purchasing Program offers health care providers state-supplied vaccines at no charge by collecting payments from health plans, insurers, and other payers. This assessment is a PMPM charge applied to members residing in Vermont who are ages 0 to 64. On May 4, 2022, the Vermont Vaccine Purchasing Program released a memo that included the rates for April 1, 2022 – March 31, 2023.

New Hampshire Purchasing Program Payments
The New Hampshire Purchasing Program[7] offers health care providers state-supplied vaccines at no charge by collecting payments from health plans, insurers, and other payers. The assessment for 2022 is $6.85 for each child that is a New Hampshire resident. The current best estimate of the 2023 rate is $7.15 per assessable life per month. We will use the new rate once it is approved.

New York State Health Care Reform Act
Blue Cross pays the New York GME Covered Lives Assessment[8] for all members who are New York residents as part of the New York State Health Care Reform Act. The assessment varies based on the county of residence. We will use the new rates once they are approved.

Maine Guaranteed Access Reinsurance Association
Blue Cross pays the Maine Guaranteed Access Reinsurance Association Assessment[9]. The 2019 assessment is $4.00 per member per month for each member that is a Maine resident. We will use any new rates once they are approved.

Health Care Claims Tax
The Health Care Claims Tax of 0.999 percent applies to all claims or capitations incurred by members with Vermont zip codes. We use the percentage of current members with Vermont ZIP codes to estimate the percentage of rating period claims expected to be incurred by Vermont members. Act 73 of 2013 sunset the 0.199 percent assessment for the Health IT-Fund. Given this fee has routinely been extended close to its sunset date, we will include it in the calculation and update the charge if new information becomes available.

Blueprint
Blue Cross participates in the Vermont Blueprint for Health program. The current assessments for this program, applied to members who are attributed to a Blueprint provider as of the month the renewal is produced, are $2.77 PMPM for the Community Health Team and $3.00 PMPM for the Patient Centered Medical Homes (PCMH). PCMH are eligible for up to $0.50 for performance. We project that our total PMPM for PCMH will be $3.21. We base the projected performance payment on the average payment for groups included in the manual rate for the year ended October 2021. We will incorporate any updates made to the Blueprint Manual[10] in renewals.

Green Mountain Care Board Billback
The Green Mountain Care Board assesses Blue Cross a billback. We apply billback amounts from the administrative charges experience period described in section 6.3 to projected member months to develop the charge of $2.31 PMPM.

Other Assessments
We include other state mandates and assessments in the calculation as applicable.

[7] https://nhvaccine.org/
[8] https://www.health.ny.gov/regulations/hcra/gmecl.htm
[9] http://www.mgara.org/
[10] http://blueprintforhealth.vermont.gov/

6.10. Federal Assessments

Patient-Centered Outcomes Research Institute Fee:
This fee is part of the Affordable Care Act and applies to all plan years ended after September 30, 2012 and before October 1, 2029. We provide the estimated fees in the table below. We will update this estimate if we receive additional information.

PCORI	
Plan Year Ending Between	Fee Amount
October 2021 - September 2022	$2.79 PMPY
October 2022 - September 2023	$2.93 PMPY
October 2023 - September 2024	$3.07 PMPY

Other Assessments
We include other federal mandates and assessments in the calculation as applicable.

7. Medical Loss Ratio Projection

We use the factors and formula in this filing to project a Medical Loss Ratio (MLR) for 2023. Using the manual rate as a proxy for projected claims, we project a 2023 MLR of 90.1 percent The Blue Cross credibility-adjusted MLR for Large Group[11] was 95.3 percent in 2019 and 90.1 percent in 2020. Exhibit 4C provides the development of the projected MLR. The calculations represent estimates assuming that all pricing assumptions hold true, and assuming no change from 2020 values for various quantities (e.g. HCQ, commissions).

8. Act 193 Information

This information is included template filed in SERFF with this filing (*VT Rx Data Template - Blue Cross - 2023 AHP.xlsx).*

The data in the template is based on actual and projected experience for the groups included in the manual rate.

9. Actuarial Opinion

I, Martine Lemieux, Manager, Actuarial Services, am an employee of Blue Cross Blue Shield of Vermont and a member of the American Academy of Actuaries. I have experience in the area of insured health care programs.

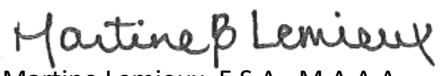
Section 10 lists applicable limitations and disclosures.

It is my opinion that the rating formula and factors presented in this filing are reasonable and have been prepared in accordance with applicable Actuarial Standards of Practice. The formula and factors will

[11] AHP results are included in the Blue Cross Large Group MLR filing.

produce premium rates that are reasonable in relation to the benefits provided and will not be excessive inadequate or unfairly discriminatory.

I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Academy's Qualification Standards to render this opinion.



Martine Lemieux, F.S.A., M.A.A.A.

July 7, 2022

10. Disclosures

Information Date: The analysis provided in the report is based on information as known on June 17, 2022.

Scope: The purpose of this filing is to establish the formula, manual rate, and accompanying factors that will be used for renewals of Blue Cross and Blue Shield of Vermont and The Vermont Health Plan large group plans. This filing is not intended to be used for other purposes.

Intended Users: This material has been prepared for the GMCB. Blue Cross understands that this memorandum and accompanying exhibits will be posted publicly.

Uncertainty or Risk: Future events may affect the results presented in the memorandum.

Reliance on Other Sources for Data and Other Information: This analysis relies upon data from the Blue Cross data warehouse. I have reviewed the data for reasonableness, but no audit was performed.

This analysis relies upon several sources of information that are cited as footnotes at their respective references. If any of the sources we have relied upon are incorrect or inaccurate, it may affect the accuracy of the results presented in the report.

This analysis relies upon several factors and formulas approved in the Blue Cross and TVHP Q3 2022 Large Group Rating Program Filing (SERFF BCVT-133154621 and BCVT-133154563). The approved mental health utilization trend was modified from the filed value as recommended by Lewis & Ellis. All other factors and formula were approved by the GMCB as filed by Blue Cross.

Subsequent Events: New information related to the COVID-19 pandemic continues to emerge on a regular basis. Subsequent events may affect the projected MLR presented herein. The degree to which future events may materially change the MLR is unknown.