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Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Blue Cross and Blue Shield of Vermont
Vermont Health Connect 2022 Individual and Small Group Rate Filings
SERFF# BCVT-132829271 (Individual) and BCVT-132829562 (Small Group)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2022 Individual and Small Group Filings for Blue Cross and Blue Shield of Vermont (BCBSVT or Company) and to assist the Green Mountain Care Board (GMCB or Board) in assessing whether to approve, modify, or disapprove the Company's requested rate changes.

## FILING DESCRIPTION

1. BCBSVT is a non-profit hospital and medical service corporation that provides health insurance coverage to Vermonters. This filing proposes premiums for BCBSVT's Qualified Health Plans (QHPs) that will be offered on Vermont Health Connect (VHC), beginning January 1, 2022.

2. Due to the unmerging of the individual and small group markets[1], two filings were submitted; one addresses BCBSVT's individual members and the other addresses BCBSVT's small groups. As of February 2021, there were approximately 34,633 members[2] enrolled in plans affected by these filings with 15,878 members enrolled in individual plans and 18,755 members enrolled in small group plans. Enrollment has decreased in recent years, as demonstrated in the following table:

**MEMBERSHIP BY COVERAGE YEAR**

| Coverage Year | Members | Percent Change |
|---|---|---|
| **2016** | 70,423 | 5.0% |
| **2017** | 70,035 | -0.6% |
| **2018** | 53,664 | -23.4% |
| **2019** | 43,939 | -18.1% |
| **2020** | 39,195 | -10.8% |
| **2021** | 34,633 | -11.6% |

[1] Act 25, Section 34 requires carriers to "offer separate health benefit plans to individuals and families in the individual market and to small employers in the small group market" during 2022.

[2] L&E uses the term "members" to refer to the number of covered lives. That is, a single policy covering two family members is comprised of two members.

3. As required by the Affordable Care Act, insurers selling plans on VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters with certain income levels, known as "Silver Loaded." These members pay a reduced premium that is limited to a specified percentage of their income. These plans include premium funding to offset the loss of federal CSR payments.

   In addition to the Silver plans offered on VHC, beginning in 2019, carriers began offering "Silver Reflective" plans outside of VHC. The Silver Reflective plans do not include CSR premium funding since federal CSR payments do not apply. While the VHC Silver Loaded plan premiums are substantially higher than the Silver Reflective premiums, most members in these plans will not pay higher premiums because of the federal premium subsidies.

4. Unlike in prior years, the 2022 Small Group and Individual markets will be separate for rating purposes. Because ACA small group employers tend to have lower claims than individual purchasers of insurance, the unmerging results in the small group rates falling relative to individual premiums.

5. The proposed rate impact of this filing is an average rate increase of 7.9% for individual plans and an average rate decrease of -7.8% for small group plans. The table below illustrates the proposed and approved premium rate changes for last year's 2021 QHP filing.

**2021 APPROVED RATE CHANGES (INDIVIDUAL & SMALL GROUP)**

| Plan Type | Average 2020 Premium PMPM | Average 2021 Premium PMPM[3] | Percent Change | PMPM Change | Percent of Membership |
|---|---|---|---|---|---|
| **Catastrophic** | $264.95 | $257.97 | -2.6% | -$6.98 | 1.4% |
| **Bronze** | $500.56 | $511.53 | +2.2% | $10.97 | 17.3% |
| **Silver Loaded** | $693.58 | $717.20 | +3.4% | $23.62 | 18.0% |
| **Silver Reflective** | $571.40 | $586.98 | +2.7% | $15.58 | 20.0% |
| **Gold** | $640.57 | $680.72 | +6.3% | $40.16 | 26.5% |
| **Platinum** | $790.02 | $824.99 | +4.4% | $34.97 | 16.7% |
| ***Overall*** | ***$634.91*** | ***$661.31*** | ***+4.2%*** | ***$26.40*** | ***100.0%*** |

[3] These values do not match the values in the next table for 2021 premiums because these reflect averages based on 2020 plan selections, whereas the next table reflects actual 2021 plan selections.

The 2022 QHP filing average rate increases are broken down by metal level in the tables below.

**2022 PROPOSED RATE CHANGES – INDIVIDUAL**

| Plan Type | Average 2021 Premium PMPM[4] | Average 2022 Premium PMPM | Percent Change | PMPM Change | Percent of Membership |
|---|---|---|---|---|---|
| **Catastrophic** | $259.79 | $250.48 | -2.5% | -$6.55 | 2.0% |
| **Bronze** | $523.14 | $557.93 | 6.6% | $34.79 | 22.2% |
| **Silver Loaded** | $716.39 | $768.60 | 7.3% | $52.21 | 30.1% |
| **Silver Reflective** | $566.55 | $610.11 | 7.7% | $43.56 | 11.9% |
| **Gold** | $699.21 | $761.38 | 8.9% | $62.17 | 22.4% |
| **Platinum** | $838.76 | $920.83 | 9.8% | $82.08 | 11.4% |
| ***Overall*** | ***$656.39*** | ***$708.14*** | ***7.9%*** | ***$51.75*** | ***100.0%*** |

**2022 PROPOSED RATE CHANGES – SMALL GROUP**

| Plan Type | Average 2021 Premium PMPM[4] | Average 2022 Premium PMPM | Percent Change | PMPM Change | Percent of Membership |
|---|---|---|---|---|---|
| **Bronze** | $498.97 | $453.53 | -9.1% | -$45.44 | 15.3% |
| **Silver** | $587.59 | $538.16 | -8.4% | -$49.42 | 29.7% |
| **Gold** | $670.20 | $619.96 | -7.5% | -$50.25 | 32.7% |
| **Platinum** | $816.99 | $760.00 | -7.0% | -$56.99 | 22.3% |
| ***Overall*** | ***$652.11*** | ***$601.34*** | ***-7.8%*** | ***-$50.77*** | ***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 proposed rate increase 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 RECEIVED DATA

BCBSVT provided the methodology used to develop the proposed 2022 individual and small group premiums. The Company provided exhibits which demonstrated the quantitative

[4] The overall PMPM will differ from the 2021 merged market table due to the different membership weights in each year and in the merged market versus the individual market vs the small group market.

development for each component of the premium request, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees. Most exhibits were provided on separate individual and small group bases, in addition to a hypothetical combined version illustrating the market in a scenario where the two cohorts are not being unmerged. The following is a description for several key exhibits:

Exhibit 3 illustrates the development of the proposed pharmacy and medical trend factors.

For medical services trend, the annualized allowed cost trend per year from 2020 to 2022 is 5.9%. The portion applicable to unit cost changes is projected to be 4.4% annually based on recent contracting and provider budgetary changes. The portion applicable to utilization and intensity changes is projected to be 1.4% annually.

For pharmacy cost trends, the combined utilization for non-specialty drugs was projected and then split into categories to separately model unit cost by category. Due to the relative infrequency and high cost nature of specialty drugs, this pharmacy category was analyzed on a PMPM basis rather than separately by utilization and unit costs. The projected allowed cost trend for pharmaceuticals is 10.9%.

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

Exhibit 6 demonstrates how the Market Adjusted Index Rate, which is the same for all plans, is adjusted to reflect each plan's particular benefits. Exhibit 7 further adjusts each plan for non-benefit costs and contribution to reserves (CTR).

Exhibit 8 demonstrates the development of expected loss ratios. BCBSVT projects the following 2022 loss ratios, which exceed the 80% minimum requirement.

| Cohort | Traditional Loss Ratio | ACA MLR |
|---|---|---|
| **Individual** | 87.7% | 88.6% |
| **Small Group** | 90.4% | 91.3% |

Exhibit 9A shows the impact of the single conversion factor which is needed to convert preliminary rates into final rates based on predetermined Vermont tier factors. Exhibit 9B shows the final proposed 2022 premiums, proposed rate increase by plan, and calculation of the average proposed rate increases.

BCBSVT provided additional exhibits and information as requested during the rate review process.

## L&E ANALYSIS

The average proposed 2022 rate increases of 7.9% for individual and -7.8% for small group are attributable to several rating components. To create a consistent comparison for both companies filing VHC products, L&E categorized the proposed premium changes reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company. Since there was a major change in the 2022 risk pools, the following table summarizes the combined rating components between the individual and small group markets. Item #14 addresses the unmerging of the markets, which was evaluated as the last rating component.

The combination of the other rating components will help simplify the comparison to the 2021 filing. Note that these combined components were estimated by L&E and likely do not appear in the individual filings directly, as assumptions may have varied between the two markets. For more information on the market assumptions and the combined estimates, see Appendix A.

**COMPONENTS OF 2022 PROPOSED RATE CHANGE**

| | Percentage Change[6] | |
|---|---|---|
| **Rating Component[5]** | **Individual** | **Small Group** |
| **1. 2020 Actual/Projected Claims Experience** | -8.3% | |
| **2. Difference in Trend from 2020 to 2021** | -0.4% | |
| **3. Trend from 2021 to 2022** | +7.2% | |
| **4. Changes to Population Morbidity Adjustment** | +0.8% | |
| **5. Demographic Shift** | -0.8% | |
| **6. Plan Design Changes** | +0.2% | |
| **7. Changes to Other Factors** | -0.2% | |
| **8. Changes to Risk Adjustment** | -0.6% | |
| **9. Changes in Actuarial Value** | +1.0% | |
| **10. Changes in Administrative Costs** | +0.0% | |
| **11. Changes in Taxes & Fees** | +0.1% | |
| **12. Changes in Contribution to Reserves** | +1.0% | |
| **13. Changes in Single Contract Conversion Factor** | +0.1% | |
| **14. Impact of Unmerging Markets** | +8.3% | -7.4% |
| **Total Proposed Rate Change** | **+7.9%** | **-7.8%** |

1. **2020 ACTUAL/PROJECTED CLAIMS EXPERIENCE:** Actual 2020 claims experience for the individual and small group markets was approximately 8.3% lower than the 2020 costs expected at the time of the 2021 filing. One major driver of this outcome is decreased utilization related to the COVID-19 pandemic. While actual 2020 experience has varied across the nation by carrier,

[5] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

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

declines have typically ranged between 4% and 16%[7]. Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate. This rating component varies significantly between markets due to differences in morbidity between the two populations[8].

While the base period experience contains some COVID-19 treatment costs, BCBSVT has long held that a pandemic is one reason to hold surplus, and they intend to fund care related to the ongoing pandemic through policyholder surplus rather than premium increases. So, projected claims do not include funding of COVID-19 vaccinations or treatment.

As discussed in item 7 below, BCBSVT has assumed that this portion of the favorable experience will revert to pre-pandemic levels in 2022.

2. **DIFFERENCE IN TREND FROM 2020 TO 2021:** In the 2021 filed rates, the assumed 2020 to 2021 trend was approximately 8.1%. BCBSVT now projects a 2020 to 2021 allowed trend rate of approximately 7.7%. Therefore, the 2021 assumed trend has reduced, resulting in a premium reduction of approximately 0.4%.

   The trend development is discussed further in the next section.

3. **TREND FROM 2021 TO 2022:** The Company projected an average total allowed trend of 7.2% per year, after adjustments for changes to Rx rebates and other untrended values.

**2021 TO 2022 ALLOWED TRENDS**

| Cost Category | Total Allowed Trend |
|---|---|
| **Medical** | 6.4% |
| **Pharmacy** | 11.1% |
| ***Total*** | ***7.2%*** |

**MEDICAL TREND:** The allowed trend reflects changes in the both the cost of medical services and changes in utilization of medical services by members. The Company projected an annual allowed medical trend of 6.4%, which is comprised of 4.4% for unit cost changes and 1.8% for utilization and intensity changes.

*MEDICAL UNIT COST TREND*

To project medical unit costs forward from 2020 to 2021, actual negotiated provider payment changes were used.

[7] Source: Kaiser Family Foundation article, "Health Insurer Financial Performance in 2020"; https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-in-2020/

[8] Anti-Selection refers to situations where actions taken by policyholders is based on their own known information that could cause a financial disadvantage to the health plan, such as purchasing plan with the intent of utilizing services.

For the BCBSVT service area, the Company analyzed recent changes to provider contracts as the starting point for the 2021 to 2022 unit cost trend estimates. Approximately 53% of medical costs are related to facilities impacted by the Board's Hospital Budget Review process.

**GMCB HOSPITAL BUDGET REVIEW**

The overall annualized unit cost medical trend of 4.4% includes:

1) a trend of 5.0% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and,

2) a trend of 3.6% for other medical facilities and providers that are not subject to the Hospital Budget Review.

BCBSVT took the following approach in setting the 2021 to 2022 unit cost trend assumptions:

- For hospitals under the jurisdiction of GMCB, commercial increases approved for the 2022 fiscal year cycle will mirror those approved for 2020. This acknowledges that the 2021 hospital budget submissions were atypical due to COVID-19 and rebasing to actual expenses.

- For non-GMCB providers within the broader BCBSVT service area, 2021 and 2022 rate increases are based on 2020 historical rate increases with adjustments made for information learned during any negotiations made prior to the date of filing.

- Unit cost trend also reflects a lab re-contracting effort that went into effect 10/1/2019 and is expected to keep lab costs flat through the end of the 2022.

- For providers outside the BCBSVT service area, the Company used the Fall 2019 Blue Trend Survey conducted by the Blue Cross Blue Shield Association.

L&E believes utilizing 2020 hospital budget figures for the assumed unit cost trends is reasonable and appropriate. Once 2022 hospital budget requests are submitted, L&E recommends that this new information be considered.

*MEDICAL UTILIZATION TREND*

BCBSVT made assumptions regarding future changes to the utilization of medical services based on analyzing historical data by benefit category. BCBSVT categorized medical claims into Facility (Inpatient/Outpatient), Professional, and Outpatient Drug categories. Claims data was also adjusted to account for differences between the individual and small group markets, outlier claimants, the age/gender of enrolled members, and changes over time in provider contracted reimbursement rates.

The Company performed typical regression and time-series methods to evaluate the utilization and intensity trend over the last several years. Based on this analysis, the Company assumed the following utilization trends:

**ASSUMED MEDICAL UTILIZATION TRENDS**

| Cost Category | 2-Year Average |
|---|---|
| **Inpatient** | 1.5% |
| **Outpatient** | 0.3% |
| **Professional** | 1.8% |
| ***Total Medical Excluding Medical Rx*** | ***1.0%*** |

To analyze utilization trends, BCBSVT considered historical cost by service category and normalized for unit cost changes as well as changes in Fraud, Waste, and Abuse ("FWA") programs. Every year, BCBSVT implements various programs to monitor and correct FWA. These programs experienced some short-term disruptions due to the migration to a new system in 2019. Then, in 2020, some fraud monitoring programs were suspended due to COVID and UVMHN's cyber-attack. As a result, 2020 recoveries were lower than historical levels.

BCBSVT adjusted the historical trend to remove the impact of these fluctuations and assumed that 2022 FWA recoveries will return to 2018 levels. L&E notes that this methodology is reasonable and is consistent with the Board's order regarding the 2021 rates.

New in this filing, BCBSVT utilized a "matched population" method to control for historical changes in population characteristics. By selecting individuals from different time periods who mirror each other regarding important demographic and diagnostic characteristics (and removing data from unmatched members), BCBSVT attempts to mitigate the impact of population changes on observed utilization trends. After adjustment, the observed trends better reflect the underlying utilization changes to be funded by premium changes.

For example, the average age of BCBSVT members rose from 41.6 to 42.5 between 2017 and 2020. This age increase would generally be expected to produce an increase in claims; however, that increase would also be offset by receiving additional risk adjustment transfers payments. In the matched population method, a constant age of 42.8 is assumed for all time periods. By carefully selecting a matched population, BCBSVT has taken significant steps towards ensuring that there is consistency in the measurement of historical trend.

The introduction of the matched population method is a substantial enhancement to BCBSVT's trend modeling and produces trend estimates that appear to better represent the covered population. More detail is provided in Exhibit 3B of the filing.

Unfortunately, disruption from the COVID-19 pandemic makes it difficult to use 2020 data for long-term trend analysis. Therefore, BCBSVT and L&E relied primarily on 2017 to 2019 data to analyze long-term trends. This data is updated from the prior filing due to the application of the population matching algorithm.

BCBSVT provided historical data, adjusted to reflect a matched population, for inpatient, outpatient, and professional claims. L&E reviewed the historical trends reflected in the data and

believe BCBSVT's trend assumptions by category are reasonable. The resulting average annual utilization trend of 1.0% for non-Rx medical costs reasonably reflects recent trends in BCBSVT's claims experience.

*Medical Rx Trend*

An increasing portion of BCBSVT's costs relate to prescription drugs that are administered in outpatient medical settings and paid through the medical benefit, such as chemotherapy. The costs for these drugs have been increasing at a very fast pace in recent years. Additionally, while the number of claims is relatively low, the cost of each claim is very high. For this reason, isolating historical unit cost and utilization trends is generally difficult for these types of claims.

BCBSVT looked at historical utilization trend by isolating just the impact of the number of type of drugs dispensed on allowed costs. Additionally, past and future FDA approval of new drugs was considered to isolate the underlying trend pattern. This analysis is shown in Exhibit 3E of the filing.

The cost trend is assumed to be 5.3%, and the utilization trend is assumed to be 6.7%. This is equivalent to an allowed trend of about 12.4% per year. This is slightly higher than the approximately 10% annual increase observed between 2018 and 2020. However, costs increased by 12.2% in 2018 over 2017, and the slightly higher assumed trend is related to new drugs not included in the base period. The assumed 12.4% trend is reasonable and appropriate.

| Year | Annual Medical Rx Trend |
|---|---|
| **2017 to 2018** | 12.2% |
| **2018 to 2019** | 4.3% |
| **2019 to 2020** | 15.8% |
| **2020 to 2022 (Assumed)** | 12.4% |

*TOTAL ALLOWED MEDICAL TREND*

The table below summarizes the trend assumptions for medical costs, and the overall medical allowed trend from 2020 to 2022.

| Cost Category | Annual Unit Cost | Annual Utilization | Annual Allowed Trend |
|---|---|---|---|
| **Inpatient** | 3.8% | 1.5% | 5.4% |
| **Outpatient** | 5.4% | 0.3% | 5.7% |
| **Professional** | 2.9% | 1.8% | 4.8% |
| **Medical Rx** | 5.3% | 6.7% | 12.4% |
| ***Total Medical*** | | | ***6.4%*** |

Based on the information available, L&E considers the 6.4% total allowed medical trend to be reasonable and appropriate.

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost assumption underlying the 2022 premium rate calculations.

### PHARMACY TREND

The Company is proposing an allowed pharmacy trend of 11.1% per year, net of changes to pharmacy rebates. This differs from the trend in the URRT, which is approximately 13.8% annual trend for Rx. The difference in these two figures is due primarily to differing approaches in accounting for pharmacy rebates. Because pharmacy rebate contractual changes are confidential carrier information, pharmacy trends will be discussed net of pharmacy rebates, as this is most relevant to the projected rates.

The Company's approach accounted for pharmacy changes by:

- Adjusting historical experience for changes in benefits and an aging population.
- Analyzing cost and utilization trends for Brands, Generics, and Specialty drugs separately.
- Including the transition of some drugs to generic status which included a unit cost reduction for those drugs.
- Analyzing trends for a matched population consistent with the medical trend analysis.

**ASSUMED ANNUALIZED ALLOWED RX TRENDS – 2020 TO 2022**

| Tier | Unit Cost | Utilization | Total Trend | Portion of Rx Spend |
|---|---|---|---|---|
| **Generic** | 3.0% | 3.0% | 6.1% | 13% |
| **Brand** | 10.0% | 3.0% | 13.3% | 31% |
| **Vaccines** | 20.0% | 3.0% | 23.6% | 1% |
| **OTC** | 0.0% | 3.0% | 3.0% | 0% |
| **Devices** | 25.0% | 3.0% | 28.8% | 1% |
| **Compounds** | 0.0% | 3.0% | 3.0% | 0% |
| **Specialty**[9] | | | 17.6% | 54% |
| ***Total***[10] | | | ***11.1%*** | ***100%*** |

The development of the pharmacy trend assumptions was provided in Exhibits 3F through 3I in the initial filing. Exhibit 3F addresses utilization trend for non-specialty drugs. Since members often have a choice of utilizing a brand or a generic version of the same compound, the utilization trend is measured in the aggregate across all non-specialty drugs.

The historical Rx trend analysis begins with a review of historical non-specialty utilization. This analysis combines brand and generic drugs, as members often have a choice of whether

[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.

[10] Total trend reflects the unit cost and utilization trends, in addition to contractual changes and the impact of brands becoming generic.

to purchase the brand or generic versions of a given non-specialty drug. Unlike the medical trend analysis, 2020 pharmacy claims did not demonstrate COVID-19 disruptions.

The 2020 increase in the number of claims was approximately 2.4%, while the 2019 increase was 1.8%. However, various time-series methods suggested the underlying utilization trend may be in the 3% to 4% range. BCBSVT assumed 3% per year, as a compromise between the conflicting figures presented by these different methods. L&E believes the chosen non-specialty utilization trend of 3.0% is reasonable.

Similarly, unit costs for generic drugs increased an average of 2.6% over the last two years, but the regression analysis suggests an underlying trend rate of 3.2% to 3.4%. BCBSVT selected a generic unit cost trend of 3.0% per year, which appears to be reasonable.

Brand unit costs have increased substantially in recent years. The average over the last two years was approximately 10.3% per year. The results for the brand drug analysis are less clear than for generics but suggests generally similar values. BCBSVT's selection of 10% per year is reasonable for the brand unit cost trend.

Specialty drugs make up the overwhelming majority of remaining pharmacy costs. Specialty costs have increased at a very high rate in recent years:

| Year | Annual Allowed Specialty Trend |
|---|---|
| **2020 vs 2019** | 20.5% |
| **2019 vs 2018** | 14.0% |
| **2018 vs 2017** | 31.7% |
| **Three-year Average** | 21.9% |

BCBSVT selected a net annual allowed cost trend of 17.6% per year for the specialty tier, which is slightly lower than the recent three-year average. L&E believes this is a reasonable assumption based on current trends.

Combining medical and prescription drug trends, the overall annual trend assumed in the filing is:

| 2020 to 2022 | Annual Allowed Trend |
|---|---|
| **Medical** | 6.4% |
| **Rx** | 11.1% |
| **Combined** | 7.2% |

The overall assumed trends are reasonable in relation to likely future unit cost changes and historical experience.

4. **CHANGES TO POPULATION MORBIDITY ADJUSTMENT:** In the 2021 filing, the Company estimated that the projected 2021 population morbidity would be 0.3% higher than the 2019 experience period morbidity.

   In the 2022 filings, the overall individual and small group morbidity is projected to be approximately 1.1% higher than the 2020 experience period. The rates are therefore increasing by the difference between the factor in this filing and the factor in the previous filing, or 0.8%.

   The assumed morbidity changes are below:

**POPULATION MORBIDITY ADJUSTMENTS**

| Source of Change | 2021 Filing | 2022 Filing |
|---|---|---|
| **AHP Impact**[11] | -0.2% | N/A |
| **Pool Morbidity** | +0.5% | +1.1% |
| ***Total Morbidity Change*** | ***+0.3%*** | ***+1.1%*** |

**CHANGES IN POOL MORBIDITY:** +1.1%
The claims that underlie the rate filing are from 2020. Since this rate filing was submitted after the 2021 Open Enrollment Period, BCBSVT knows which 2020 members remained in the block and which members no longer had coverage.

To assess pool morbidity, the Company separated the 2020 experience into those members who remained in 2021 and those who left in 2021. This includes both individual members who voluntarily cancelled coverage as well as members of groups which are no longer with BCBSVT.

BCBSVT calculated that the members who left BCBSVT in 2021 were lower cost in 2020 than the members that maintained coverage. This enrollment change increases projected claims by 1.1%. This claims change is mitigated by the fact that the leaving members take their low risk scores with them. That is, BCBSVT can expect higher risk adjustment receivables resulting from the enrollment change. This impact is discussed in more detail in the Risk Adjustment section of this report.

**AMERICAN RESCUE PLAN ACT:** -0.4%
During the course of this review, BCBSVT acknowledged that the American Rescue Plan Act (ARPA) would cause an adjustment that would more accurately reflect the 2022 population. Federal legislation from March 2021 includes a provision extending eligibility for ACA health insurance subsidies to households whose incomes are above 400% of the federal poverty level (FPL). This provision applies through 2022.

[11] Pathway 2 AHP's were not permitted to renew for coverage year 2020. As a result, last year's filing had to incorporate the likelihood that these members, on average healthier than the ACA market, would purchase ACA coverage and produce a slightly healthier pool of covered individuals. That transition from the AHP market is already reflected in the 2020 base period of this filing, so no adjustment is necessary.

BCBSVT expects that the legislation will produce a higher membership since these additional members would not have chosen to purchase coverage without the subsidies. These members are, therefore, expected to be healthier than the current average enrollee in the individual market.

In response to L&E questions, BCBSVT acknowledged this dynamic and calculated an estimated individual market rate of approximately -0.9% (the subsidies are only available in the individual market, so the newly formed small group market will be unaffected.)

L&E assessed the impact of ARPA on a market wide basis. L&E estimated that the new subsidies will affect approximately 6,000 currently uninsured individuals who will have the option of purchasing a plan from either carrier.

L&E notes that the uninsured population closest to 400% FPL will see a 40% reduction in premium, while the premium reduction becomes smaller as income increases. Based on this change in premium, L&E believes that approximately 800 new members will enroll.

It is expected that this uninsured population has not purchased coverage to date either due to good health or due to the high cost of premiums. L&E assumes that this new population will be 10% healthier than the currently covered population.

If these individuals are equally distributed between the carriers in the market, the rate impact is a 0.2% decrease to the individual rates. To the extent that these new enrollees preferentially enroll with one carrier over the other, the risk adjustment calculation should account and adjust for the difference.

Therefore, L&E recommends a 0.2% decrease to the individual rates due to ARPA. This represents a merged market impact of 0.1%.

L&E finds the population morbidity assumptions, including the recommended ARPA adjustment, to be reasonable and appropriate.

5. **DEMOGRAPHIC SHIFT:** This factor represents the expected change due to the aging of the population, newborns entering the covered population, and other demographic shifts between 2020 and 2022.

Last year's filing assumed that aging of the population would lead to a 0.7% increase in costs. However, updated data suggests that the population will be slightly younger in 2022 than in 2020, resulting in a 0.1% decrease in cost. Replacing a +0.7% with a +0.1% has the combined effect of reducing rates by 0.8% from the previous approved level. This rate change provision varies significantly between markets due to the different risk levels observed by each of the carriers in the two markets.

The demographic adjustment is calculated in Exhibit 2E based on data from the Society of Actuaries. L&E considers the demographic shift factor to be reasonable and appropriate. As with morbidity adjustments, the changes in demographics are partially offset by changes in risk adjustment. This dynamic will be discussed further in the Risk Adjustment section of this report.

6. **PLAN DESIGN CHANGES:** The plan design changes factor addresses any rate changes that are needed because members purchase products with different plan designs versus the prior year. Because BCBSVT observed a change in purchased plan designs in 2021, BCBSVT expects a change in average cost sharing and average utilization from the experience period to the projection period.

   Since members are expected to choose plans with higher cost sharing in 2022 compared to 2020, there is an anticipated 0.2% decrease in utilization. The projected enrollment shift by plan and benefit level is based on emerging 2021 experience, and therefore reflects more up-to-date information than the 2020 base period plan selections.

   In the 2021 filing, BCBSVT projected that there would be a shift to leaner plans, resulting in a 0.4% decrease. Since the 2022 filing replaces a 0.4% decrease with a 0.2% decrease, the net effect relative to current premiums is a 0.2% premium increase.

   L&E believes that the plan design adjustment and its calculation are reasonable and appropriate.

7. **CHANGES TO OTHER FACTORS:** BCBSVT expects other changes to account for a 1.0% decrease relative to the prior filing. This rate change provision varies significantly between markets due to the differing claims patterns between individual and small group. This reduction is the result of the following factors:

   **NON-SYSTEM CLAIMS:** -5.2%
   This includes changes to pharmacy rebates, Blueprint payments, Interplan Teleprocessing System (ITS) fees[12], vaccine payments (excluding COVID vaccines), and the net cost of reinsurance. The primary driver of this change is the reduction to pharmacy costs due to a growth in pharmacy rebates.

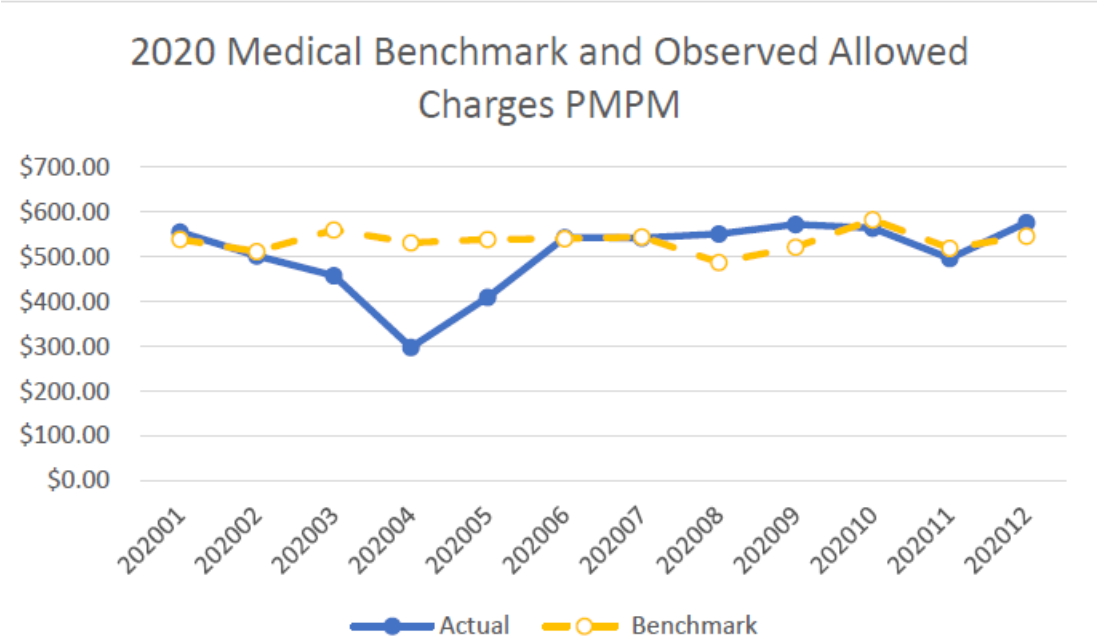
   **IMPACT OF LEAP YEAR:** -0.3%
   Because 2020 was a leap year, it had one more day than 2022; however, there were still 12 monthly premiums. As such, claims calculated from 2020 imply premiums which are too high by approximately one in 365 for a non-leap year.

   **RETURN OF PRE-COVID UTILIZATION LEVELS**: +4.7%
   The base period claims, which have been noted to be approximately 8.3% lower than expected claims, took place during the COVID-19 pandemic and associated restrictions. Much of this

[12] BCBSVT provides members with healthcare coverage when they travel nationally or internationally.

favorable experience is due to foregone and deferred care during 2020 as Vermonters limited their potential exposure to the virus.

To estimate the impact of COVID-19 on the base period experience, BCBSVT developed a benchmark of what costs would have looked like during 2020 in the absence of the pandemic. A summary of this benchmark is shown below.




As expected, claims were substantially lower than normal between March and June 2020. Costs were slightly elevated in August and September as patients and providers were able to make up some of the deferred care. BCBSVT applied an adjustment of +4.7% to the 2020 experience to account for the difference between actual experience and the benchmark costs. L&E believes this methodology is reasonable and appropriate to estimate 2022 costs.

L&E does not recommend any changes to the "other" factors described above and finds the assumptions to be reasonable and appropriate.

8. **CHANGES TO RISK ADJUSTMENT:** As noted previously, BCBSVT paid less in claims during 2020 than anticipated; additionally, they received more in risk transfers than in 2019. Anticipated changes to risk adjustment account for an anticipated 0.6% decrease in premiums.

   BCBSVT projected the 2022 risk adjustment transfer payment based on the most recent data available at the time of the rate filing. The data available was: 1) CMS's interim risk adjustment report[13] published in March 2021, and 2) BCBSVT's internal risk adjustment data. Based on

[13] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2020.pdf

this combined information, BCBSVT estimated that final 2020 risk adjustment receivable would be $20,708,982.

Actual risk adjustment transfers were published[14] by CMS on June 30, 2021. Based on the report, BCBSVT will receive $21,771,777 in risk adjustment payments.

Prior to the publication of the recent report from CMS, L&E requested that both VHC carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports to compile them confidentially and to provide both carriers with an updated risk adjustment estimate. This calculation indicated the following risk transfer payments.

**ESTIMATED 2020 RISK ADJUSTMENT TRANSFERS (RECEIVABLE)**

| Population | BCBSVT Estimate | L&E Estimate |
|---|---|---|
| **Merged Market[15]** | $20,708,982 | $21,711,763 |
| **Individual** | $9,108,655 | $12,437,969 |
| **Small Group** | $11,136,213 | $8,750,057 |
| **Catastrophic** | $4,098 | $7,559 |

The approximate $1 million increase in receivables over BCBSVT's expectations produces an additional 0.3% decrease in premiums. This update has unequal effects on the individual and small group markets, as further discussed in section 14 below.

Given the precise nature of the merged market calculation as compared to the recently published transfer, L&E recommends revising the risk adjustment calculation such that each carrier begins with the same 2020 value.

BCBSVT also considered the impact on risk adjustment resulting from population changes between 2020 and 2022. The Company's population adjustments appear consistent with the way projected claims were developed. That is, the Company accounted for members and groups known to have left BCBSVT based on their 2021 enrollment status, and for demographic changes. L&E believes this calculation to be reasonable and appropriate.

BCBSVT originally projected a 2022 risk adjustment receivable of $65.68 PMPM for individual and $42.02 PMPM for small group. L&E recommends that the final risk adjustment estimate should be increased to $82.99 PMPM for individual and decreased to $33.42 PMPM for small group to account for the data that was not available at the time of filing. This would result in an approximate 0.3% overall decrease to 2022 premiums relative to the current filing, comprised of an increase to small group and a larger decrease to individual.

[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2020.pdf

[15] Note that due to the intricacies of the calculation, the total transfer from the unmerged individual and small group markets is not equal to the transfer in the merged market.

9. **CHANGES IN ACTUARIAL VALUE:** The Change in Actuarial Value (AV) assumption reflects Pricing AV changes, such as changes in Metal AVs, induced utilization, cost sharing changes, and changes in projected enrollment among plans. The increase in the AV assumption is 1.0% relative to the 2021 filing.

   After the filing was submitted, the Internal Revenue Service (IRS) released final guidance regarding high-deductible health plans and the plan design for the Standard Bronze CDHP plan was modified accordingly. In the update, the out-of-pocket maximum for the Standard Bronze HDHP plan was lowered from $7,100 to $7,050. BCBSVT recalculated the actuarial value for this plan, which increased the single premium by $0.82 per month in the small group market and $0.97 per month in the individual market. The premiums for the other plans went down slightly due to normalization of selection and induced utilization factors. L&E considers this to be an immaterial impact to overall rates. L&E consider this change to be reasonable and L&E recommends it be applied in the final filing.

   The AV assumptions by plan consider the anticipated average effect of correlation between allowed cost and Actuarial Value. L&E notes this effect has intensified since 2021, as documented in Exhibit 6E. This assumption appears to be the primary driver for the expected factor change. L&E believes the paid-to-allowed ratios and pricing AVs appear reasonable and appropriate.

10. **CHANGES IN ADMINISTRATIVE COSTS:** The 2020 administrative costs are projected to be the same as 2021 on a percentage of revenue basis. That is, both administrative costs and premium are changing at the same rate.

    The 2022 projected administrative cost is based on the following costs:

    - *Base Administrative Charges:* A base administrative cost of $45.29 PMPM is included equally in all plans' rates to cover BCBSVT's operating costs. This amount reflects actual 2020 administrative costs of $42.57 adjusted for three factors, as outlined in the following table.

| Line Item | Impact PMPM | Updated Admin Cost PMPM |
|---|---|---|
| **Actual 2020 Admin Cost** | - | $42.57 |
| **Shift towards Individual Market** | $0.12 | $42.69 |
| **Personnel Increases for 2022** | $0.94 | $43.63 |
| **Impact of Decreasing Enrollment** | $1.66 | $45.29 |

      - *Shift towards Individual Market*: The first adjustment is a 0.3% increase due to the anticipated shift towards individual membership for 2022. The individual market has a slightly higher administrative cost than the small group market.
      - *Personnel Increases for 2022*: The second adjustment is a 2.2% increase to reflect a single year of personnel cost increases. Given approximately 74% of BCBSVT's operating costs are for wages and benefits, a 3% increase between 2021 and 2022

corresponds to a 2.2% increase. This is consistent with the decision to forgo cost of living wage increases in 2021.

- *Impact of Decreasing* Enrollment: The third adjustment is to reflect the impact of BCBSVT's continually decreasing enrollment across all lines of business. BCBSVT projects that the increased burden on remaining members should equate to approximately a 5.4% PMPM cost increase, since it is impractical to immediately reduce staffing to match enrollment changes. However, in order to produce more affordable premiums, BCBSVT calculated administrative costs as if variable costs had been immediately reduced in proportion to enrollment changes. Therefore, rather than increasing administrative costs by 5.4%, administrative costs were increased by 3.8%.

- *Administrative Charges for Outside Vendors:* Dental and vision benefits are administered by third parties. In addition, an external vendor provides HSA and HRA integration services. The fees charged for these programs vary by plan but are equivalent to a $0.37 PMPM.

- *VHC Billing*: In 2022, BCBSVT will be responsible for billing members enrolled through VHC. Expenses related to this new responsibility are estimated to be $1.75 PMPM.

- *Credit Card Fees:* Prior to 2021, BCBSVT members could only pay their premiums by check or direct debit. Beginning in 2021, off-Exchange members could pay with debit and credit cards. Beginning in 2022, VHC members will also be able to pay with cards. Based on assumed 2022 take-up rates as well as current non-VHC payment patterns, BCBSVT projects that credit card fees will amount to $1.90 PMPM average cost.

In addition to reviewing each of BCBSVT's specific proposed modifications, 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 2020 National Association of Insurance Commissioners (NAIC) Annual Statements.

BCBSVT's administrative costs on a percentage of premium basis ranked 57$^{th}$ out of 62 plans assessed. That is, on a percentage of premium basis, BCBSVT had lower expenses than approximately 90% of the Blues plans who sold individual and small group products.

BCBSVT's administrative costs on a PMPM basis ranked 52$^{nd}$ out of 62 plans assessed. That is, BCBSVT had lower PMPM expenses than approximately 82% of Blues plans.

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

11. **CHANGES IN TAXES & FEES:** The 2022 taxes and fees provision are projected to be 0.1% higher than 2021 as a percentage of premium revenue. The increase is due to slight increases to the HCA assessment, the GMCB billback, and the Risk Adjustment User Fee. The projected taxes and fees appear reasonable and appropriate.

12. **CHANGES IN CONTRIBUTION TO RESERVES:** The Company has proposed an aggregate contribution to reserve of 1.6% which consists of: 1) a base CTR of 1.5%, which is consistent with the requested CTR in the prior filing, and 2) an additional 0.1% to account for uncollected premiums and bad debt. The bad debt margin is consistent with the 0.1% approved amount in 2021.

The table below shows the actual historical CTR and the expected CTR based on the Company's forecasting model, which incorporates final premiums and modifications ordered by the Board. L&E believes that the results demonstrate that BCBSVT has successfully projected future results based on the information available at the time final rates are approved the Board.

**ACTUAL-TO-EXPECTED CTR**

| Year | Company Expected | Company Actual |
|---|---|---|
| **2014** | -0.1% | 1.0% |
| **2015** | 1.0% | -2.5% |
| **2016** | 0.8% | -3.8% |
| **2017** | 1.0% | 1.0% |
| **2018** | -1.0% | -1.6% |
| **2019** | 0.0% | -0.7% |
| **2020** | 1.5% | 5.2% |
| ***Average*** | ***0.5%*** | ***-0.3%*** |

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 2021, there were 802 QHP Filings (individual and small group combined) filed across the country. Across the 802 filings, the average submitted CTR was 2.7% and the median submitted CTR was 3.0%. Based on 2021 filings, an assumed base CTR of 1.5% would rank 588$^{th}$ out of the 802 filings. That is, over 70% of the filings had assumed CTRs higher than 1.5%. In 2019, over 80% of the filings had assumed CTRs higher than 1.5%. In 2019, over 82% of the filings had assumed CTRs higher than 1.5%.

In addition to reviewing the CTR assumption relative to other QHP insurers, L&E reviewed BCBSVT's capital and surplus position based on several metrics compared to 65 Blues plans based on information provided in the 2020 NAIC Annual Statements.

The first metric was the Company's Risk Based Capital (RBC)[16] percentage relative to other BCBS plans. BCBSVT's actual 2020 RBC percentage is ranked 57$^{th}$ out of 65 insurers with available data.

Of these 65 plans, the average RBC percentage was approximately 948% and the median RBC percentage was approximately 789%. This implies that BCBSVT's target RBC range of 590% 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.

745% falls in the bottom half of actual RBCs for nationwide BCBS plans. That is, over half of the Blues plans had actual RBCs higher than the BCBSVT's targeted maximum.

The second capital and surplus metric assessed was how much surplus was held on a PMPM basis. At the end of 2020, BCBSVT held $46.98 PMPM of surplus. This value ranked 53rd of 63 Blues plans with available data. BCBSVT's surplus PMPM was less than half of the median value of $132.87 PMPM.

The third capital and surplus metric assessed was how much surplus was held as a percentage of premium. At the end of 2020, BCBSVT held 21.6% of annual premium as capital and surplus. This value ranked 51st of 65 Blues plans. BCBSVT's surplus as percentage of premium was significantly lower than the median value of 39.9%.

The fourth capital and surplus metric assessed how much surplus the Company held relative to the number of months of claims could be paid out to members. At the end of 2020, BCBSVT held 3.2 months of claims as surplus. This value ranked 51st out of 65 Blues plans. BCBSVT's 3.2 months of claims was significantly lower than the median value of 5.4 months.

L&E recommends that the Board take this into consideration when evaluating BCBVT's CTR provision. Additionally, L&E recommends that any solvency analysis performed by the Department of Financial Regulation around these issues be strongly considered.

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%.

Last year, the Board ordered that the CTR be reduced by 1.0% from the filed level. Because BCBSVT is requesting that it be returned to 1.5%, the impact to rates is a 1.0% premium increase.

L&E believes the CTR assumption is reasonable and appropriate. Additionally, L&E recommends that any solvency analysis performed by the Department of Financial Regulation (DFR) be considered.

13. **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 increasing by 0.1% from the prior filing. This corresponds roughly to a slight increase in the number of covered children per policy and is based on emerging 2021 membership data. This is considered reasonable and appropriate.

14. **IMPACT OF UNMERGING MARKETS**: Since the creation of VHC in 2014, premiums have been equal for individual members and members enrolling through small group employers. In general, this

[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.

has caused slightly higher premiums in the small group market in exchange for lowering premiums in the individual market.

The American Rescue Plan Act is extending federal subsidies for individual coverage to substantially more households in 2022. To take advantage of this change, the State of Vermont elected to unmerge the two markets for 2022. This means small group premiums will decrease, and the individual premium increases will be mostly covered by increases to federal premium subsidies. Therefore, overall premiums paid by Vermont families will reduce.

The impact of unmerging the market, as filed by BCBSVT, is an 8.3% increase in individual market premiums and a -7.4% decrease in small group premiums. This is an approximate 17% differential between the two markets. These changes are primarily the result of the following contributing elements:

- Claims experience for small group members are substantially lower than for individual members. Based on 2020 claims experience, this accounts for approximately a 20% difference between the two cohorts and is the primary reason for the unmerging impact.
- While the two cohorts use the same trend assumptions for inpatient, prescription drugs, etc., the distribution of these different types of claims differs between individual and small group. Therefore, the overall weighted average trend differs slightly between the two populations.
- The individual market has a higher-morbidity population than the small group market. As such, BCBSVT receives risk transfer payments to cover their higher costs. Because of the unmerging, those payments will no longer need to be shared with the comparatively healthy small group enrollees, resulting in a slight mitigation of the claims differential.
- Individual and Small Group members have different benefit packages, due both to consumer choice and the availability of Cost Sharing Reductions in the individual market. Therefore, the inter-plan subsidies and the impact of induced utilization differ between the two populations.
- The Single Conversion Factor is a Vermont-mandated system whereby single individuals pay higher premiums in exchange for lower premiums for families. The individual market covers fewer children than the small group market. As a result, unmerging the two markets results in the individual market rates decreasing relative to the small group premiums.

L&E's recommended changes do not impact the individual and small group markets equally. Therefore, L&E's recommendations modify the impact of the unmerging market. These changes are as follows:

| | Individual Factor | Small Group Factor |
|---|---|---|
| **Initially Filed** | +8.3% | -7.4% |
| **Bronze CDHP Change** | +0.0% | 0.0% |
| **Risk Adjustment Change** | -2.4% | +1.6% |
| **ARPA Change** | -0.1% | +0.1% |
| ***Net Impact*** | ***+5.8%*** | ***-5.7%*** |

It is unclear at this time whether the market will remain unmerged in 2023. If it does not, these changes will likely revert, resulting in a higher rate change for small group than individual in 2023.

Due to the potentially negative effect unmerging the markets could have on Vermont households via the increased individual rates, L&E considered the likely relationship between the filed premiums, which do not account for federal subsidies, and the actual premium likely to be paid be households after subsidies.

The amount of subsidy available to individual households is based on their income and the marketplace premium for the second lowest Silver plan. Because all individual Silver plans are projected to have substantially increased premiums, the Advance Premium Tax Credits (APTCs) for those plans will increase as well. The APTC is calculated as a fixed per month value which members can use to help pay for any Exchange plan. If the plan purchased is another Silver plan, subsidized households do not pay a material increase in premium, regardless of the filed premium increase.

Subsidized households purchasing Bronze coverage pay lower net premiums in response to rate increases because their subsidy increase substantially outweighs the bronze premium increase. Gold and Platinum purchasers typically experience higher relative rate increases, as the fixed subsidy is based on Silver premiums. Therefore, the change in the subsidy does not fully counteract increases in the higher Gold and Platinum premiums.

Additionally, BCBSVT has historically had slightly higher premiums than their competitor. The second lowest Silver plan is offered by the competitor, whose premiums are projected to increase more this year than BCBSVT's premiums. As a result, subsidies available to BCBSVT members will increase much faster than 2022 premium increases.

For households that do not receive Premium Tax Credits, the actual amount paid by BCBSVT members in the individual market will increase by approximately 7.9% on average. However, the premium for the second lowest Silver plan is projected to increase by slightly more than $100 PMPM. Each $1 increase in the premium for the second lowest Silver increases APTC by $1 as well, for the approximately 75% of the population who receive subsidies[18]. That means net premiums will actually decrease on average by an estimated 10.5% for members who receive APTC.

Across all BCBSVT individual members, L&E projects that the net paid premiums would decrease by 3.4% on average based on the rates initially filed by both carriers.

[18] L&E performed this analysis using data on APTC in 2020, prior to the American Rescue Plan Act. So, actual APTC in 2022 will likely be even larger, producing an even stronger effect mitigating the rate increase.

## RECOMMENDATIONS

After modification, 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:

- **CONSIDER UPDATED HOSPITAL BUDGET INFORMATION:** 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 2022 premium rate calculations. The impact of such a change cannot be estimated at this time.

- **REFLECT UPDATED RISK ADJUSTMENT TRANSFERS:** L&E recommends that the projected risk adjustment receivable be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. This will decrease rates by approximately 0.3%.

- **UPDATE TO BRONZE CDHP COST SHARING:** L&E recommends that the rates be updated to reflect IRS-required changes to the Standard Bronze HDHP. This change is immaterial to the overall rates.

- **REFLECT IMPACT OF AMERICAN RESCUE PLAN ACT ON CLAIMS:** L&E recommends that the premiums in the individual market be reduced by 0.2% to account for the impact of new enrollees related to the American Rescue Plan Act.

After the modifications, the anticipated rate changes will change from +7.9% to +5.0% for the individual market and from -7.8% to -6.4% for the small group market.[19]

[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.

## 2022 RECOMMENDED RATE CHANGES

A breakdown of L&E's recommendation by rating component is provided below with L&E's recommended changes highlighted:

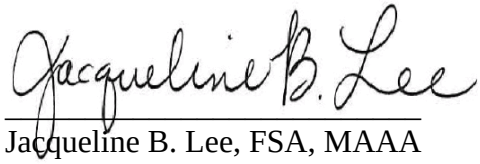
| Rating Component[20] | Percentage Change[21] | |
|---|---|---|
| | Individual | Small Group |
| 1. 2020 Actual/Projected Claims Experience | -8.3% | |
| 2. Difference in trend from 2020 to 2021 | -0.4% | |
| 3. Trend from 2021 to 2022 | +7.2% | |
| 4. Changes to Population Morbidity Adjustment | +0.7% | |
| 5. Demographic Shift | -0.8% | |
| 6. Plan Design Changes | +0.2% | |
| 7. Changes to Other Factors | -0.2% | |
| 8. Changes to Risk Adjustment | -0.9% | |
| 9. Changes in Actuarial Value | +1.0% | |
| 10. Changes in Administrative Costs | +0.0% | |
| 11. Changes in Taxes & Fees | +0.1% | |
| 12. Changes in Contribution to Reserves | +1.0% | |
| 13. Changes in Single Contract Conversion Factor | +0.1% | |
| 14. Impact of Unmerging Markets | +5.8% | -5.7% |
| **Total Proposed Rate Change** | **+5.0%** | **-6.4%** |

[20] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

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

Sincerely,

Kevin Ruggeberg, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.



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Vice President & Principal
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Senior Vice President & Principal
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## APPENDIX A

Because L&E's rating component breakdown ordered the unmerging of the markets last, all other rating components listed one merged impact even though the assumptions filed by market may have varied. The tables below show key filed assumptions between the individual and small group markets and the resulting, weighted average, merged assumption.

### BREAKDOWN OF MERGED RATING ASSUMPTIONS

| Rating Assumption | Individual | Small Group | Merged[22] |
|---|---|---|---|
| **2020-2021 Trend** | +8.0% | +7.6% | +7.8% |
| **2021-2022 Trend** | +7.4% | +7.0% | +7.2% |
| **Morbidity Adjustment** | +1.4% | +0.9% | 1.1% |
| **Demographic Shift** | -0.6% | +0.4% | -0.1% |
| **Plan Design Changes** | -0.2% | -0.2% | -0.2% |
| **Other Adjustment** | -2.0% | -0.1% | -1.0% |
| **Single Conversion Factor** | 1.08 | 1.15 | 1.12 |
| **General Administrative Costs** | 7.5% | 6.9% | 7.2% |

### BREAKDOWN OF MERGED RATING COMPONENT CHANGES

| Rating Component | Individual | Small Group | Merged[22] |
|---|---|---|---|
| **1. 2020 Actual/Projected Claims Experience** | +0.6% | -15.8% | -8.3% |
| **2. Difference in Trend from 2020 to 2021** | -0.2% | -0.5% | -0.4% |
| **3. Trend from 2021 to 2022** | +7.4% | +7.0% | +7.2% |
| **4. Changes to Population Morbidity Adjustment** | +1.1% | +0.6% | +0.8% |
| **5. Demographic Shift** | -1.3% | -0.3% | -0.8% |
| **6. Plan Design Changes** | +0.2% | +0.2% | +0.2% |
| **7. Changes to Other Factors** | -1.2% | +0.7% | -0.2% |
| **8. Changes to Risk Adjustment** | +0.0% | +0.0% | -0.6% |
| **9. Changes in Actuarial Value** | +0.0% | +0.0% | +1.0% |
| **10. Changes in Administrative Costs** | -2.6% | +1.1% | +0.0% |
| **11. Changes in Taxes & Fees** | +0.0% | +0.0% | +0.1% |
| **12. Changes in Contribution to Reserves** | +5.8% | -3.0% | +1.0% |
| **13. Changes in Single Contract Conversion Factor** | +0.3% | -0.3% | +0.1% |
| **14. Impact of Unmerging Markets** | -- | -- | 8.3% / -7.4% |
| **Total Proposed Rate Change** | **+7.9%** | **-7.8%** | **+7.9% / -7.8%** |

[22] Weighted based on the distribution of expected total 2021 premium. This results in a 54% weight for the small group market and 46% weight for individual market.

## BREAKDOWN OF MERGED RATING COMPONENT CHANGES – L&E RECOMMENDATIONS

| Rating Component | Individual | Small Group | Merged |
|---|---|---|---|
| 1. 2020 Actual/Projected Claims Experience | +0.6% | -15.8% | -8.3% |
| 2. Difference in Trend from 2020 to 2021 | -0.2% | -0.5% | -0.4% |
| 3. Trend from 2021 to 2022 | +7.4% | +7.0% | +7.2% |
| 4. Changes to Population Morbidity Adjustment | +0.9% | +0.6% | +0.7% |
| 5. Demographic Shift | -1.3% | -0.3% | -0.8% |
| 6. Plan Design Changes | +0.2% | +0.2% | +0.2% |
| 7. Changes to Other Factors | -1.2% | +0.7% | -0.2% |
| 8. Changes to Risk Adjustment | -4.9% | +2.7% | -0.9% |
| 9. Changes in Actuarial Value | +5.8% | -3.0% | +1.0% |
| 10. Changes in Administrative Costs | -2.6% | +1.1% | +0.0% |
| 11. Changes in Taxes & Fees | +0.0% | +0.0% | +0.1% |
| 12. Changes in Contribution to Reserves | +5.8% | -3.0% | +1.0% |
| 13. Changes in Single Contract Conversion Factor | +0.3% | -0.3% | +0.1% |
| 14. Impact of Unmerging Markets | -- | -- | +5.8% / -5.7% |
| **Total Proposed Rate Change** | **+5.0%** | **-6.4%** | **+5.0% / -6.4%** |

## ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[23], 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[24], 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 ACTUARIES

The responsible actuaries are:

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

### IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 6, 2021. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 4, 2021.

### 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.

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- 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 BCBSVT 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.

[23] 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.

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

- Notwithstanding the ongoing COVID-19 pandemic, 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.

### 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 actuaries 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.