BLUE CROSS BLUE SHIELD OF VERMONT
2022 VERMONT ACA MARKET - INDIVIDUAL AND SMALL GROUP RATE FILINGS
ACTUARIAL MEMORANDUM

Contents

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1. GENERAL INFORMATION

1.1. Company Identifying Information

Company Legal Name: Blue Cross and Blue Shield of Vermont
State: Vermont
HIOS Issuer ID: 13627
Market: Combined
Effective Date: January 1, 2022

1.2. Company Contact Information

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

1.3. Scope and Purpose

The purpose of this rate filing is to provide the rates and a description of the rate development for the ACA-compliant plans for the Vermont individual and small group markets that Blue Cross and Blue Shield of Vermont (BCBSVT) proposes to offer for the 2022 benefit year. This rate filing applies to plans both On-Exchange and Off-Exchange.

This filing is intended to comply with the following laws:

- Vermont State Law 8 V.S.A. § 4062
- Vermont State Law 8 V.S.A. § 4512
- Vermont State Law 33 V.S.A. § 1806
- Vermont State Law 33 V.S.A § 1811
- Vermont State Law 33 V.S.A. § 1812
- Vermont State Law 18 V.S.A. § 9375(b)(6)
- DFR Order establishing tier rate structure and multipliers (Docket No. 13-002-I)
- Vermont Agency of Human Services Health Benefits Eligibility and Enrollment Rule, Parts 1 and 2
- Green Mountain Care Board, Rule 2.000
- Federal Regulation 45 C.F.R. Part 147
- Federal Regulation 45 C.F.R. Part 153
- Federal Regulation 45 C.F.R. Part 154
- Federal Regulation 45 C.F.R. Part 155
- Federal Regulation 45 C.F.R. Part 156
- Federal Regulation 45 C.F.R. Part 158
- Federal Regulation 26 IRC § 223

1.4. Proposed Rate Change(s)

The average rate change is -0.9 percent. Changes for specific plans range from -13.2 percent to 0.3 percent. The range of changes is due to changes to the actuarial values and plan designs. Apart from the Catastrophic plan, the increases range from -2.9 percent to 0.3 percent.

1.5. Reason for Rate Change(s)

The starting point of any renewal rate analysis is an assessment of actual to expected experience results. The basis for this rate filing is calendar year 2020 experience. Due to the COVID-19 pandemic and the UVMHN cyberattack, we adjusted the experience period to a benchmark to represents an estimate of what the 2020 Vermont ACA market experience would have been in the absence of these one-time events. Even after adjusting for one-time events, the claims experience for 2020 was very favorable relative to the expectation embedded within the 2021 filing, driven by changes in population rather than changes in underlying trends. The population that enrolled with BCBSVT as of January 2020 utilized far fewer medical services than the 2019 population, partially offset by a significant increase in the utilization of retail pharmaceuticals. With the addition of an expected favorable risk adjustment transfer, the overall decrease to 2021 rates due to population changes is 3.9 percent.

As in prior years, trend is a significant driver to the change in rates (see section 3.4.7). The 2021 approved rates included assumptions for projecting 2020 to 2021. Because the 2022 filing is based on updated actuarial assumptions that reflect current data, those assumptions must be re-examined. Also, an additional year of projected trend applies from 2021 to 2022. Finally, BCBSVT adjusts the projected claims costs to reflect ongoing improvements in the fraud, waste, and abuse programs and for the absence of a leap day in 2022 (see sections 3.4.7.1 and 3.4.5). The overall anticipated increase in rates due to trend is 6.7 percent:

Trend Component	2022 Rate Impact
Restatement of 2020 to 2021	-0.6%
Additional Year of Medical Utilization	1.5%
Additional Year of Medical Unit Cost	3.1%
Additional Year of Pharmacy	3.2%
Additional Year of Dental	0.0%
Additional Year of Vision	0.0%
Fraud, Waste, and Abuse programs	-0.2%
Leap Year Adjustment	-0.3%
Total	**6.7%**

As noted in Attachments A and B, the claims underlying the federal Actuarial Value Calculator (AVC) were not trended forward to 2022. This allowed for plans to remain in their metal levels without changes to cost

shares. For both the standard plans and non-standard plans, deductibles and out-of-pocket limits were changed minimally, if at all. This means that benefit changes made by the Department of Vermont Health Access for standard plans and by BCBSVT for non-standard plans only modestly offset the impact of benefit leverage. Altogether, factors related to plan design, actuarial value, silver loading and induced utilization increased rates by 1.5 percent.

BCBSVT base administrative charges are decreasing as compared to the 2021 approved rates, lowering premiums by 0.4 percent (see section 3.8.7).

BCBSVT must comply with all regulatory requirements from both state and federal agencies. The Department of Financial Regulation (DFR) has ordered BCBSVT to be within a specific RBC range. In order to continue along the path of reaching the required range, BCBSVT must file a 1.5 percent contribution to policyholder reserves in this filing (see section 3.8.8 and Attachment C). BCBSVT is preparing to take over the billing for VHC enrolled members for plan year 2022 (see section 3.8.7). Other federal and state taxes and fees are remaining stable from 2021 to 2022. The combination of these regulatory requirements increases rates by 1.2 percent.

BCBSVT continues to find innovative ways to mitigate premium increases. Most notable this year was the launch of Vermont Blue Rx in partnership with a new pharmacy benefit manager (see section 3.4.7.1 and 3.4.6). Through this program, BCBSVT has achieved rate relief of 5.6 percent, or a projected $15.0 million.

1.6. Historical Financial Performance

BCBSVT has offered ACA products since the start of the program in 2014. Prior to offering ACA plans, BCBSVT offered Individual and Small Group products. All Vermonters that previously purchased Individual and Small Group products were required to move to an ACA product in 2014. The State allowed individuals and small groups to remain in their 2013 products through the first quarter of 2014. All financial information below includes only the ACA experience in 2014. The table below does not include risk corridor payments in order to more accurately display the performance of pricing assumptions[1].

[1] Risk corridor payments, while not reflective of plan performance or pricing accuracy, do impact solvency and overall financial results. As such, they are considered in the information presented in Attachment C.

Historical Financial Performance for BCBSVT Vermont ACA Market					
Year	Member Months	Filed Contribution to Reserve	Approved Contribution to Reserve*	Actual Contribution to Reserve	Actual operating gains/(losses) [2]
2014	638,492	1.0%	-0.1%	1.0%	$2,637,153
2015	768,293	1.0%	1.0%	-2.5%	($8,038,393)
2016	835,541	2.0%	0.8%	-3.8%	($14,311,831)
2017	820,156	2.0%	1.0%	1.0%	$4,251,320
2018	630,163	2.0%	-1.0%	-1.6%	($5,713,876)
2019	520,854	1.5%	0.0%	-0.7%	($2,120,848)
2020	453,744	1.5%	1.5%	5.2%	$15,912,962 [3]
Cumulative	4,667,243	1.6%	0.5%	-0.3%	($7,383,513)

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

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

1.7. Environmental Factors

Unmerging the Market

Vermont took an unprecedented opportunity to significantly lower health care premiums for small employers by unmerging the individual and small group market for 2022. BCBSVT championed this effort, strongly advocating for an immediate change so that Vermonters could benefit in the 2022 plan year.

Vermont's Affordable Care Act marketplace is atypical, requiring that individuals and small groups are rated together in a combined, community-rated risk pool. Historically, this has lowered health insurance premiums for individual purchasers while increasing the cost for those purchasing through an employer. Taking steps to align our structure with that of 48 other states will lower premiums, expanding access and affordability of health insurance for Vermonters.

This concept was studied in 2019, resulting in the Health Insurance Affordability and Merged Markets[4]

[2] Risk corridor receivables were ($66,780), $4,324,909 and $5,761,067 for 2014 through 2016, respectively. These amounts are not included in the actual operating gains and losses in this table.
[3] The 2020 results were significantly impacted by the COVID-19 pandemic and UVMHN cyberattack. Both events caused services originally expected to take place in 2020 to be deferred to 2021 or canceled. We have observed thus far in 2021 approximately $2.6 million of claims for services originally scheduled for 2020. These are predominantly services that were rescheduled due to the UVMHN cyberattack. We reallocate the deferred care to 2020 results in the table above. See https://www.uvmhealth.org/uvm-health-network-cyber-attack, accessed May 1, 2021
[4] https://legislature.vermont.gov/assets/Legislative-Reports/Act-63-Report-on-Health-Insurance-Affordability-and-Merged-Markets.pdf

report, which estimated that if the Vermont marketplace was divided, employees of small businesses would see a 5.8 percent reduction their health insurance premiums because they would no longer be subsidizing the risk of the individual market. With that shift in risk, individual premiums are expected to have a corresponding increase of about 7 percent that will be insulated by increased federal subsidies. The main drawback previously was the impact to individuals who did not qualify for federal premium subsidies. Now that hurdle is largely erased, and our current actuarial analysis shows the reduction for BCBSVT small group members will be even larger than estimated. In conjunction with BCBSVT cost containment efforts, the separation of the markets results in an unprecedented average reduction of 7.8 percent in small employer premiums for the 2022 plan year.

The scale of the federal benefit expansion is enormous, covering an estimated 92% of all families nationally[5] – which means individuals with income up to $94,500, couples with income up to $189,500, single-parent households with income of $182,300, and families with incomes up to $265,500[6] all now qualify for premium assistance when purchasing insurance through Vermont Health Connect. Splitting the marketplace has enabled them to qualify for additional tax credits and expand their choices for which type of health insurance coverage is best for their families while simultaneously reducing premiums for small businesses.

The analysis to prove that this will benefit the vast majority of the Vermonters who purchase health insurance through Vermont Health Connect is actuarial and complex, but the beneficial financial impact to Vermont is simple and clear.

All Payer Model

The All Payer Model contract between the State of Vermont and CMS is in year four of a five-year arrangement that includes scale target and performance requirements for an Accountable Care Organization (ACO) value-based care arrangement. ACO performance for the All Payer Model is assessed by comparing per capita medical expense growth to pre-COVID benchmarks. Under this new model, Medicare, Medicaid, and commercial payers entered into risk sharing agreements with Vermont's single ACO, OneCare Vermont "to deliver meaningful improvements in the health of a state's entire population by transforming the relationships between and amongst care delivery and public health systems throughout Vermont[7]."

BCBSVT has supported and participated in the state's all payer model health care reform effort since its inception. We are the only insurer that has enabled participation for the majority of our members in all types of coverage, including the individual and small group markets and large group insured and self-funded customers, in risk-based arrangements. We are currently working to expand fixed prospective payments with willing providers.

The All Payer Model requires that ACOs strive to reduce cost and meet three health improvement goals: improved access to primary care, reduced deaths from suicide and drug overdose, and reduced prevalence

[5] https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/
[6] These figures are approximations. The final dollar amounts will be dependent upon the premium of the second-lowest Silver plan offered on Vermont Health Connect.
[7] https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model

and morbidity of chronic disease. BCBSVT's 2021 agreements with OneCare align with the All Payer Model, including quality metrics. Beginning this year, we have embarked on a jointly developed quality work plan that affords OneCare the opportunity to work with providers to improve the quality of care received by their patients. Ongoing efforts to reduce cost are addressed through a medical expense target methodology aligned with approved premiums. This alignment between BCSBVT premiums and the medical expense target is necessary both to demonstrate OneCare's impact on health plan rates and to share savings with policyholders.

Although measurable progress toward the State's scale goal was achieved by the attribution of several thousand BCBSVT large group members to OneCare, an analysis of 2019 results indicates that OneCare's performance did not result in savings relative to the medical expense[8]. Because the performance to date of this arrangement gives no clear basis for projecting savings in the near term, this filing does not include any adjustment to projected expenditures related to the OneCare program.

Vermont State Legislature

The rates submitted reflect current law regarding coverage, benefits and cost sharing amounts in place for 2022. The Vermont Legislature is currently in session, and there are a number of bills being considered that could impact the 2022 rates described in this filing.

The most recent Legislative proposals, some of which may have conflicting goals, could have a costly and disruptive impact on the state health care system, specifically our state health care reform initiatives. If any of these bills pass and become effective for the 2022 plan year, BCBSVT expressly reserves the right to amend these submitted rates to reflect any changes required by new law.

Every additional report increases the administrative costs of regulation, reporting, taxes and fees in Vermont, thereby increasing non-health care costs for consumers. For example, the amounts from the GMCB billed to Blue Cross for regulation have increased 136 percent between 2014 and 2021. In 2014, Blue Cross paid $627 thousand to support the GMCB's activities. Today the payment has increased to $1.5 million in 2021, or 19.5 percent per year on average.

Shifting the billing for Vermont Health Connect from DVHA to the carriers is moving the cost for this service from the state to ratepayers and will become an additional component of health insurer administrative expenses.

Consolidated Appropriations Act

The Consolidated Appropriations Act of 2021 (CAA) includes numerous provisions that have the potential to create changes in the health care delivery system, although it is entirely too soon to determine what impact, if any, the CAA will have on health care costs and, in turn, health insurance premiums.

The CAA contains provisions that are intended to protect consumers from surprise bills from out of network providers when in an emergency or when receiving services at in-network facilities. Ideally, these protections will reduce the overall cost of out of network services, but until rulemaking occurs it will be difficult to determine if that goal will be achieved. However, some of the services that must be covered

[8] Measurement of savings in 2020 is inconclusive due to the impact of the COVID-19 pandemic and the UVMHN cyberattack.

under the CAA are not currently covered. Thus, even if services are less expensive, the cost of covered care may rise.

The CAA also requires providers and insurers to institute new cost estimating capabilities. The statute requires providers to provide cost estimates to patients and their insurers after scheduling an appointment. In turn, the statute requires insurers to confirm such cost estimates, as well as provide other information such as cost share, required prior approvals, if any, and, if the service is out of network, recommendations for in-network options. Although these are valuable services, there is little to no infrastructure in place for providers to provide these estimates. Likewise, insurers do not currently have processes to verify provider cost estimates. The information technology spend across the system for these services will be considerable, and those costs will likely be borne by rate payers.

In addition to pre-service cost estimates, the CAA contains numerous other provisions that will cost money to implement, such as mandatory data on insurance ID cards. It is possible these increased expenses will have an impact on future premiums.

The filed premiums do not include any adjustment for additional cost or savings pursuant to the CAA.

COVID-19

The COVID-19 pandemic has caused unprecedented disruption to the health care system. Actuarial considerations for the impacts on 2020 and projected 2022 costs are discussed in section 3.4.8. Further exploration of the BCBSVT response to COVID-19 can be found in Attachment C.

1.8. Vermont Statutory Rate Review Criteria

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

> whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.

8 V.S.A. § 4062(a)(3). The Board must also consider the Vermont Department of Financial Regulation's ("DFR") "analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves." *Id*. § 4062(a)(2)(B). The purpose of this memorandum is to provide the actuarial basis for the proposed rate. Although a number of the rate review criteria are not technically actuarial in nature, this section briefly explains how BCBSVT's actuarial calculations relate to the criteria, with the understanding that (consistent with Board practice) these issues will be more fully developed during the rate review process.

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

Unlike quality care and access to care, "protection of insurer solvency" is demonstrably *not* in tension with affordability. DFR considers insurer solvency to be the most fundamental aspect of consumer protection[9]. Insurer solvency is a necessary pre-condition for affordability, because reducing rates to levels that result in insurer insolvency would place the entire burden of the cost of care on consumers. Because members likely cannot afford the full cost of their care without insurance, this result would restrict patient access and impede providers' ability to provide high-quality care. Furthermore, reductions producing rates that are inadequate to any extent do not promote long-term affordability, as it simply shifts costs from current policyholders to future policyholders. The full funding of adequate rates is thereby critical to both insurer solvency and affordability.

The federal rate review criteria of "not excessive" and "not inadequate" are tested by actuarial analysis. Actuarial Standard of Practice No. 8[10] provides guidance to actuaries preparing regulatory filings for health insurance premium rate requests. It defines rates as "adequate" if they "provide for payment of claims, administrative expenses, taxes, [and] regulatory fees and have reasonable contingency or profit margins[11]." Similarly, rates are "excessive" if they exceed the amount necessary for these items. As documented in Section 5.2, the rates filed herein are neither excessive nor inadequate. It follows that rates that are adequate but not excessive cannot jeopardize insurer solvency or be deemed to be unjust, unfair, inequitable or misleading. Nor are the rates contrary to Vermont law.

Here, projected increases in health care costs would have fueled a premium increase of 4.5 percent in the absence of actions undertaken by BCBSVT to mitigate that increase.

Spending on specialty pharmaceuticals, through both the retail pharmacy and medical benefits, is driving 4.2 percentage points of the total rate increase, including 0.6 percent to cover the cost of a life-changing therapy for a single member. BCBSVT supports and protects our members by ensuring access to medications that significantly improve quality of life, and in many cases save lives. The cost of these drugs is an appropriate topic for public policy discussion, particularly given their impact on rates. However, given the need to provide access to this care, BCBSVT must include the very high cost of these drugs in this year's rate development in the absence mitigating federal or state legislation. The additional cost of providing these life-altering therapies is expected to lead to greater affordability and/or quality of life in the long term.

In summary, these rates strike the best balance available among affordability, access to care, and quality of care by providing coverage for necessary medical services that improve Vermonters' quality of life at a cost of insurance that is far lower than that allowed by federal and State medical loss ratio requirements (see section 3.8.9). BCBSVT is decreasing base administrative costs (see section 3.8.7) which reduced the increase to premiums by 0.3 percent, or just under a million dollars, while adding new services for policyholders. Meanwhile, new programming implemented by BCBSVT (see section 3.4.7.2) shaved over $15.0 million, or 5.6 percent, from required rates. Finally, BCBSVT stepped to the fore with strong, unqualified support of legislation that would separate the individual and small group markets in Vermont in order to capture premium savings of an estimated 5.8 percent for Vermont small businesses while drawing millions of dollars in federal funds to aid Vermont individuals and families.

[9] See, for instance, DFR solvency opinion in filing BCVT-132371410.
[10] http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop008_100.pdf

2. PROPOSED BENEFITS

2.1. Description of Benefits

BCBSVT will offer two types (Standard and Non-Standard) of plans to the Individual and Small Group markets in 2022. These plans include coverage for all Essential Health Benefits (EHBs). All plans are on the Exclusive Provider Organization (EPO) network and offer members access to a nationwide network of providers, including over 96percent of the providers in Vermont.

BCBSVT Standard Plans: BCBSVT is providing rates for the Standard plans with benefits as approved by the Green Mountain Care Board, which are outlined in Exhibit 1A – "State of Vermont Standard Plan Designs." The form filing for these products can be found under BCVT-132667078 for deductible plans and BCVT-132691982 for CDHP plans. BCBSVT is also providing rates for the catastrophic plan, also outlined in Exhibit 1A. The form filing for this plan can be found under BCVT-132691989.

BCBSVT Non-Standard Plans: BCBSVT is providing rates for two non-standard products. The first product, Vermont Select, offers HSA compatible plans with deductible at the same level as the out-of-pocket. The second product, Vermont Preferred, offers plans with zero cost share for some primary care or mental health visits and some specialist visits to manage diabetes and heart disease. Both products waive deductibles for wellness drugs. Please see Exhibit 1B – "Non-Standard Plan Designs" for details on the benefit structure. The form filing for these products can be found under BCVT-132691926 for Vermont Preferred and BCVT-132691945 for Vermont Select.

Reflective Silver Plans
Pursuant to Act 88, BCBSVT will offer certain silver plans only off-exchange for the 2022 plan year. These plans are "reflective" of the Exchange plans, with only have a $5 copayment, 5% coinsurance or $25 deductible difference from the Exchange plan.

Uniform Compliance
Benefits of all Standard, Vermont Preferred, and Vermont Select plans are in compliance with 45 CFR §147.106. Specifically, the benefits continue to be offered on BCBSVT's Exclusive Provider Organization (EPO) network and continue to cover the same service area. Some cost sharing levels were modified to maintain the same metal tier levels. Each product covers the same benefits as covered for plan year 2021.

2.2. AV Metal Values

Standard plans are designed by the State of Vermont and offered by all issuers in the individual and small group markets. Please see *Attachment A – Standard Plans AV Certification - 2022* for the certification provided by the State.

Non-Standard plans are designed by BCBSVT. The metal values included in the Unified Rate Review Template (URRT) were calculated using an alternate methodology, as allowed by 45 CFR §156.135. Multiple benefit designs offered in BCBSVT's Non-Standard plans are not supported by the AV Calculator. Please see *Attachment B –Non-Standard Plans AV Certification - 2022*, for the actuarial certification, which includes the process used to develop the AV Metal Values.

3. EXPERIENCE RATING

3.1. Experience Period Premium and Claims

Our analysis begins with the 2020 experience of Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group markets. We will refer to this population as the Vermont ACA market.

We analyzed claims incurred January 1, 2020 through December 31, 2020 and paid through March 31, 2021. We completed both the paid claims and the allowed charges using BCBSVT's monthly reserving models that underpin the financial statement reserves (best estimates before margin). These methods are subject to review by independent auditors and examination by Vermont Department of Financial Regulation (DFR). For the purpose of calculating completion factors, the reserving method categorizes claims by reporting/payment process (Local, BlueCard, Retail Pharmacy, Medicare Supplement, etc.). We calculate completion factors separately for each category. We also included an estimate of outstanding pharmacy rebates.

The paid claims and allowed charges are sourced directly from claim records in BCBSVT's data warehouse. For fee-for-service claims, we combined plan payment with member cost sharing to calculate the allowed charges. For claims under a capitation arrangement, we combined capitation paid to the provider with the member cost sharing to generate allowed charges.

The table below shows details underlying the incurred claims and allowed claims (from URRT, Section I of Worksheet 1) for the experience period.

Calculation of Experience Period Claims Per Member Per Month (PMPM)		
	Incurred Claims	**Allowed Claims**
Claims incurred January 1, 2020 through December 31, 2020 and paid through March 31, 2021	$253,286,120	$298,867,855
Estimate of IBNR for claims incurred January 1, 2020 through December 31, 2020 as of March 31, 2021	$1,949,809	$1,517,431
Estimate of IBNR pharmacy rebates incurred January 1, 2020 through December 31, 2020 as of March 31, 2021	-$4,125,203	-$4,125,203
Total completed experience period claims	$251,110,727	$296,260,083
Member months	452,386	452,386
Total claims per member per month (PMPM)	$555.08	$654.88

The experience period total allowed charges are $652.77 PMPM.

In the experience period, the earned premium was $287,515,509. BCBSVT will not be required to pay minimum loss ratio (MLR) rebates for the 2020 calendar year. Vermont does not currently have a 1332 waiver for a Reinsurance program. The estimated 2020 risk adjustment receivable, according to the information from the Interim Report, is $22,068,111.

3.2. Benefit Categories

Medical claims are initially categorized into two categories based on the type of claim form the provider submitted: UB-04/CMS 1450 (Facility Inpatient/Outpatient) or HCFA/CMS 1500 (Professional/Other). We then separate facility claims into the Inpatient and Outpatient categories in Worksheet 1, Section II of the URRT by the place of service listed on the UB-04 claim form.

Professional and Other medical claims are subdivided based on whether the provider is a medical professional or medical supplier as submitted on the HCFA 1500 claim form.

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

We populate the capitation benefit category with claims that run through our internal capitation system. The capitation category uses “Benefit Period” as a utilization description and the units represent the number of capitations in a given year.

3.3. Index Rate

The Index Rate is equal to the experience period allowed charges for EHB. As shown in section 3.1, the allowed charges per member per month in the experience totals $652.77. In 2017, BCBSVT removed an exclusion for routine circumcision (see section 3.8.3 for details). Those services are not considered EHB and must be removed from the experience to calculate the Index Rate.

Calculation of the Experience Index Rate PMPM	
Allowed Claims in section 1 of worksheet 1 of URRT	$654.88
Allowed Claims for Non-EHB	$0.06
Experience Index Rate in section 2 of worksheet 1 of URRT	$654.82

The experience index rate for 2020 is $652.70.

To calculate the Projected Period Index Rate, we first exclude pharmacy rebates, BlueCard fees, and payments to the Blueprint program. These claims are not dependent on benefits and are not subject to the projection factors described in the following sections. They are added back into the Projected Period Index Rate as described in section 3.4.6.

BCBSVT has access to the detailed claims information underlying capitated claims. We use the FFS equivalent rather than the capitation.

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

Reconciliation of Allowed Claims from section 1 of URRT to Line A1 of Exhibit 5		
	Total Dollars	**PMPM**
Allowed Claims in section 1 of worksheet 1 of URRT	$296,260,083	$654.88
Remove BlueCard Fees	($975,693)	($2.16)
Remove Pharmacy Rebates	$8,967,145	$19.82
Remove Payments to Blueprint Program	($1,714,282)	($3.79)
Replace Capitation with FFS equivalent	($241,551)	($0.53)
Line a1 of Exhibit 5	**$302,295,703**	**$668.23**

3.3.1. Pooling experience claims

Starting in 2020, BCBSVT purchased reinsurance coverage for the ACA market that covers the portion of claims above one million dollars that is not reimbursed by the high cost risk pool. To project the claims above the pooling point, we cap the claims and include the full cost of reinsurance and high cost risk pool. To cap the projected claims, we calculate the de-trended pooling level by removing the total trend (see section 3.4.7 for details) from the attachment point of one million dollars. We then exclude the claims above the resulting de-trended limit of $872,573. In 2020, BCBSVT had a member in the ACA market with over $2 million in claims, with the majority of claims paying for a drug that treats a rare disease. This type of drug is excluded from BCBSVT's reinsurance agreement. We excluded the total allowed charges from the experience period, as none of the projection factors described below apply to this specific member. The net expected allowed charges after recoveries from the High Cost Risk Pool are included in the reinsurance component (see item e_5 on Exhibit 5).

Calculation of the Impact of Capping Claims		
CY 2020 total allowed claims	A1	$302,295,703
Allowed charges for drugs not included in the BCBSVT reinsurance agreement	A2	$2,096,613
Net allowed charges	A = A1 – A2	$300,199,090
Claims above $872,573	B	$99,844
Capped Claims	C = A - B	$300,099,246
Impact of capping claims ($1+a_3$ on Exhibit 5)	D = C / A	0.9997

3.4. Projection Factors

3.4.1. Membership Projections

As of March 2021, BCBSVT had 34,663 members enrolled in the Vermont ACA market, either individually through Vermont Health Connect or directly as individuals or small group employees.

We used this information as the starting point to project the 2022 enrollment and the distribution by plan.

In the experience period, BCBSVT covered employees and dependents of a sizable group whose members are younger than the remainder of the single risk pool and were exclusively enrolled in the Platinum plan. As this group was established for a specific and temporary effort, only members currently on COBRA are enrolled with BCBSVT. We do not expect them to continue enrollment into 2022. We therefore exclude these members from all our membership projection factors.

Exhibit 2A shows the 2022 BCBSVT Individual and Small Group projected population by plan and market.

BCBSVT expects to cover 415,596 member months in the Vermont ACA market in 2022.

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

3.4.2. Changes in the Morbidity of the Population Insured

Change in market mix ($1+b_3$)
In the experience period, the individual market comprised 44.9 percent of the member months. The portion of individual members is projected to increase to 45.8 percent. Since individual members' experience period allowed charges PMPM were 18.3 percent higher than small group allowed charges, we adjust the projected index rate to reflect the projected membership weights. To calculate the adjustment, we weight each claim type PMPM for individual and small group using the projected enrollment weights. The impact of the change in market mix is 1.0016, as shown on Exhibit 2B.

Changes in pool morbidity ($1+b_9$)
This factor measures morbidity differences between the experience period population and projection period population due to choices made by small groups and individuals to voluntarily disenroll from BCBSVT ACA market coverage. The impact is measured by observing experience period claims costs for groups and members known to be no longer enrolled as of March 2021.

The base for our experience period is calendar year 2020. Using March 2021 enrollment, we group members into broad categories of active and canceled. We can further divide canceled members into two categories: voluntary cancelation and cancelation due to death. We can further break down voluntary cancelations by aging out, cancellations from normal group turnover, and individual cancellations. We capture individuals aging out in our demographic adjustment (see section 3.4.5). In 2021, we again experienced significant cancelations in the Small Group segment. To reflect this dynamic, we adjust for Small Group members leaving BCBSVT ACA market. If all members in a group are no longer enrolled in BCBSVT ACA market, we exclude them under the assumption that the entire group moved to a different

carrier or different product. If members that canceled were part of a group that is still with BCBSVT ACA market, we assume that group turnover will lead to the hiring of similarly-situated individuals; therefore, an adjustment is not needed for such members. We also exclude members from a sizable group established for a specific and temporary effort, as we do not expect them to continue enrollment into 2022.

We split the experience claims costs based on these categories in order to compare the different populations. We adjust the allowed charges from the experience period to reflect the average claims cost of members who did not voluntarily terminate or are part of a small group still enrolled with BCBSVT prior to the end of calendar year 2020.

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

As shown on Exhibit 2C, the factor ($1+b_9$ on Exhibit 5) to adjust for the change in pool morbidity is 1.0114.

3.4.3. Changes in Benefits

Impact of changes in benefits ($1+c_1$)
The impact of benefit changes ($1+c_1$ line on Exhibit 5), represents the anticipated change in the average utilization of services due to the change in average cost sharing in the projection period compared to the experience period. In previous filings, we used BCBSVT ACA market allowed relativities to calculate this factor. This approach implicitly includes the impact of selection and morbidity. Based upon ACA rating rules, it is more appropriate to use the HHS induced utilization factors by metal to limit the quantification to only the impact of varying cost shares between the experience plan distribution and the projected plan distribution. Using the experience member months for members included in the "All Other Members" category of the morbidity factor described above and the projected membership by metal, we calculate an average induced utilization factor for each and compare the two averages to generate the impact of changes in benefits. The impact of the movement among benefit plans ($1+c_1$ on Exhibit 5) is 0.9974, as shown on Exhibit 2D.

3.4.4. Changes in Demographics

Impact of changes in demographics ($1+c_3$)
To ensure that we account for all moving pieces of the reasons for the change in demographics, we changed our method for developing the change in demographic factor (factor $1+c_3$ on Exhibit 5) in the previous filing and continue to use the new methodology in this filing. We calculate factors for small groups and for individuals. We then combine the factors based on projected membership.

For both market segments, we use the age-gender factors from the SOA's report Health Care Cost – From Birth to Death[12] to calculate the age-gender factors for the experience membership and compare to those of the projected 2022 membership.

For small groups, we first observe the historical annual increases in average age-gender factors for continuing and new groups, excluding a sizable group established for a specific and temporary effort. After

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

adjusting to exclude this sizable group, we apply the most recent increase including the new groups to the experience average age-gender factor, to project from 2020 to 2021. The change in demographics in 2021 compared to prior year was lower than in previous years. We do not believe that this is a trend that will continue and therefore use the four-year average impact of the demographic *excluding* new groups to project from 2021 to 2022.

For individuals, we first split into VHC-enrolled and direct-enrolled members. We then categorized each member in the following sub-categories: continuing, retired, newborn, moved to other BCBSVT line of business, and voluntarily canceled. For continuing members, we age all members by one year starting with their March 2021 age and calculate the average duration by age. We assigned the age one duration to members age zero in 2021. We assessed historical persistency by age for members who are eligible for Medicare. Based on historical patterns, we assume that 28 percent of members age 64 in 2021 will remain enrolled through 2022, and that 61 percent of members age 65 and over in 2021 will remained enrolled through 2022 Finally, in order to complete the age distribution, we add new members age zero in 2022. Again, we examined historical patterns to develop newborn assumptions. For the VHC enrolled population, we expect newborns to comprise 0.31 percent of the total population with an average duration of 3.66 months. For direct enrolled members, we expect the newborns to comprise 0.47 percent with an average duration of 4.65 months. We apply these percentages to the in-force 2021 enrollment to estimate the newborns in 2022. We then compare the experience period average age-gender factor to the projected period average age-gender factor.

Finally, we combine the individual and small group impacts based on projected enrollment to calculate the demographic adjustment of 0.9993 ($1+c_3$ factor on Exhibit 5).

Details of the calculation are shown on Exhibit 2E.

3.4.5. Other Adjustments

Changes in Provider Network ($1+c_2$)
Since the experience period claims and the projection period claims are both on the EPO network, the factor for the change in provider networks (factor $1+c_2$ on Exhibit 5) is 1.000.

Impact of the ACO program ($1+b_4$ and $1+b_6$)
In 2020, BCBSVT and OneCare VT (OCV) had a shared-risk/shared-savings agreement covering approximately 20,000 lives within the ACA market. The agreement provides for 50/50 sharing of savings or risk up to six percent above or below the expected medical spend, which is derived from the final 2020 GMCB rate order for the ACA market. Due to the COVID-19 pandemic, the contract between OCV and BCBSVT limited the shared savings and risk to $50,000. Our current best estimate of the 2020 transfer is $50,000 from BCBSVT to OCV. We do not adjust the experience period for this transfer as it driven by claims slowdown due to the pandemic rather than ACO programming. Therefore, the factor for this program ($1+b_4$ on Exhibit 5) is 1.000.

BCBSVT expects to continue the shared risk/shared-savings agreement with OneCare into 2022. While BCBSVT anticipates the risk arrangements to go back to 50/50 sharing of savings or risk up to six percent above or below the expected medical spend, the contract negotiations with OCV are still in progress. We

therefore include no projected shared savings or risk for this program for 2022. The factor for these initiatives ($1+b_6$ on Exhibit 5) is 1.000.

Impact of Leap Year ($1+c_4$)
Calendar year 2020 was a leap year. Compared to the projection period, members had an extra day to incur services in the experience period. To account for this impact, we include a factor of 365 divided by 366, or 0.9973, in our projection of the 2022 allowed claims.

3.4.6. Non-System Claims

We add other costs to the buildup of the Projected Index Rate to account for non-system claims (Items e_1-e_8 on Exhibit 5). As previous explained in section 3.3, these non-system claims are claims that are independent from the benefits but considered claims from an MLR standpoint.

Due to the change in mix between individual and small group between the experience and projection periods, each non-system claim PMPM is weighted between the two markets using projected membership.

- Pharmacy Rebates (e_1):
  Through Vermont Blue Rx[13], BCBSVT expects to be able to greatly enhance rebates from drug manufacturers. To estimate the 2022 rebates, we start with calendar year 2020 scripts for drugs eligible for rebates (preferred brands, including specialty drugs). We then apply utilization trend for each type of drug to project to 2022 using the utilization trends from Exhibit 3J. Finally, we apply contractual rebate guarantees to the projected scripts to calculate the projected total rebates.

Calculation of projected pharmacy rebates PMPM		
	Individual	**Small Group**
Projected Rebates PMPM	$68.32	$52.24
Projected Membership	15,878	18,755
Projected overall PMPM	= ($68.32 x 15,878 + $52.24 x 18,766) / 34,633 = **$59.61**	

- Blueprint Payments (e_2):
  BCBSVT participates in the Vermont Blueprint for Health[14] program. The Vermont Blueprint for Health Manual, effective October 1, 2018, details the funding for both portions of the program: Community Health Teams (CHT) and Patient Centered Medical Homes (PCMH). The experience PMPM for Blueprint payments has been stable from year to year. We therefore do not expect the funding for either CHT or PCMH to change in 2022. and instead assume that the experience period PMPM would continue to 2022.

[13] See section 3.4.7 for a description of Vermont Blue Rx.
[14] http://blueprintforhealth.vermont.gov/

Calculation of projected Blueprint payments PMPM		
	Individual	**Small Group**
Experience Member Months	203,230	249,156
Experience Blueprint Payments	$699,883	$1,014,399
Blueprint Payments PMPM	$3.44	$4.07
Projected Membership	15,878	18,755
Projected overall PMPM	= ($3.44 x 15,878 + $4.07 x 18,766) / 34,633 = **$3.78**	

- Interplan Teleprocessing System (ITS) (e_3):
  The BlueCard® Program gives BCBSVT members healthcare coverage wherever they go across the country and around the world. The fees associated with this program are independent of the dollar amount of the claims and therefore solely dependent on utilization of BlueCard participating providers. As described below, we have selected an annual medical utilization trend, before the impact of the fraud, waste and abuse program, of 1.9 percent; therefore, these fees are assumed to increase at 1.9 percent annually.

Calculation of projected ITS fees PMPM		
	Individual	**Small Group**
Experience Member Months	203,230	249,156
Experience ITS fees	$325,637	$649,529
ITS fees PMPM	$1.60	$2.61
Trend (1.9% for 2 years)	1.03772	1.03772
Projected ITS fees PMPM	$1.66	$2.71
Projected Membership	15,878	18,755
Projected overall PMPM	= ($1.66 x 15,878 + $2.71 x 18,755) / 34,633 = **$2.23**	

- Vermont Vaccine Purchasing Program Payments (e_4):
  The Vermont Vaccine Purchasing Program[15] (VVPP) offers health care providers state-supplied vaccines at no charge by collecting payments from health plans, insurers and other payers. This assessment is a PMPM charge applied to members residing in Vermont who are under age 65. On April 26, 2021, the Vermont Vaccine Purchasing Program released a memo[16] that included the rates for SFY2022 (April 2021 through March 2022) and the anticipated rates for SFY2023[17]: *"The new monthly rate for child covered lives will be $12.02. The new monthly rate for adult covered lives will be $1.70. […] For planning*

[15] http://www.vtvaccine.org/
[16] https://www.vtvaccine.org/vtvaccine.nsf/documents/ApprovalofFY2022AssessmentRateNoticeandLetterfromCommissioner2.html/$File/2021-04-21%20Assessment%20Rate%20Notice%20SFY2022%20and%20Commissioner%20Recommendation.pdf
[17] The State Fiscal Year runs from April 1 through March 31.

purposes, the best estimate at this time for the SFY2023 assessment rate is $9.26 per child covered life per month and $0.96 per adult covered life per month."

Using the projected enrollment for children and adults, we calculate a projected period PMPM of $2.71PMPM.

Calculation of the VVPP PMPM			
Market	**Age Category**	**Weighted Rate for CY 2022[18]**	**Projected Membership**
Small Group	Child	$9.95	2,845
Small Group	Adult	$1.15	15,293
Small Group	Over 65	$0.00	617
Individual	Child	$9.95	1,208
Individual	Adult	$1.15	14,493
Individual	Over 65	$0.00	177
Total		**$2.15**	**34,633**

- Net Cost of Reinsurance (e_5):
  BCBSVT uses reinsurance to protect itself against very high claims. Starting in 2020, BCBSVT purchased reinsurance for 40 percent of claims above $1 million. When combined with the High Cost Risk Pool program, BCBSVT is fully reinsured at an attachment point of $1 million. Since we capped claims in the projected period allowed claims for EHB (line D of Exhibit 5) at $1 million, we include the full cost of reinsurance. The projected rate for this coverage in 2022 is $[redacted] PMPM, which is the 2021 cost of coverage with expected increases due to trend leveraging. As mentioned in section 3.3.1., BCBSVT has a member with ongoing high cost pharmacy claims which are not covered by BCBSVT reinsurance. We include the claims, net of High Cost Risk Pool recoveries, in this component.

- OneCare Coordination Fee (e_6):
  BCBSVT is paying OneCare VT a PMPM care coordination fee for attributed BCBSVT members to directly support ACO providers, including community providers, as they deploy new care models. This model mirrors the investment Medicaid has made in the ACO provider network and supports the comprehensive care models being tested within the ACO program. The monthly PMPM for members attributed to OneCare is $3.25. For 2022, we expect that the commercial ACO network will include the same hospitals as in the 2021 network.

[18] Using the SFY2022 rates for Q1 2022 and the SFY2023 for Q2 2022 through Q4 2022.

Calculation of projected OneCare Coordination Fee PMPM		
	Individual	**Small Group**
March 2021 Attributed Members	7,444	8,984
PMPM per Attributed Member	$3.25	$3.25
Projected Membership	15,878	18,755
PMPM per Member	= 7,444 x $3.25 / 15,878 = $1.52	= 8,984 x $3.25 / 18,755 = $1.56
Projected overall PMPM	= ($1.52 x 15,878 + $1.56 x 18,755) / 34,633 = **$1.54**	

- PBM Administration Fees (e_7):
  BCBSVT's PBM offers additional services to BCBSVT for clinical management programs. These programs include prior authorizations, step therapy, quantity reviews, copay reviews, and pharmacy vaccination programs, as well as a safety management program, which protects patients against potentially harmful drug interactions. The total PMPM in the experience period was $[redacted] PMPM for these services, and we project them to be the same in 2021.

- Accordant Health Services Fees (e_8)
  BCBSVT partners with Accordant Health Services to provide members support with managing their rare diseases. The program targets patients with complex, chronic diseases in neurology, rheumatology, hematology and pulmonology. Accordant provides early intervention and patient compliance services to support BCBSVT's care management strategies, improve patient health and strengthen physician-patient relationships. The total PMPM in the experience period was $[redacted] PMPM for these services, and we project the PMPM to be the same in 2022.

3.4.7. Trend Factors (cost/utilization)

3.4.7.1. Data and Population

The source of the data is BCBSVT's data warehouse, except where noted below. To ensure accuracy of claims information, the data has been reconciled against internal reserving, enrollment, and other financial reports. The analysis examined claims incurred between January 1, 2017 and December 31, 2020, paid through February 28, 2021. We apply completion factors, based on best estimates from financial reporting before margin for conservatism, to estimate the ultimate incurred claims for each period shown in the exhibits.

The data includes claims from the VISG market and Pathway 2 Association Health Plans. Over the past few years, we have experienced membership retroactivity, primarily associated with members enrolled through VHC. This retroactivity causes some claims to no longer be associated with active membership. The data excludes claims that are no longer associated with active enrollment.

BCBSVT experienced large membership movement out of the VISG market in 2018, 2019 and 2020. To ensure that the trend factors do not implicitly reflect changes in the BCBSVT population, we created a

matched population specific to each benefit year. This methodology ensures that the mix of age, gender, metal level, market, duration, and conditions is the same over the four years of data.

To match the population, we first summarize the enrollment data by member and by year to calculate the number of months with active enrollment for each member in each year. We then assign the age category (0, 1, 2 to 4, five-year bands until 64, 65 and over), gender, metal level, and market (individual subsidized, individual unsubsidized, and small group) associated with the last month of enrollment for that member in that year.

Using pharmacy claims, we then assign condition categories based on drug utilization. Each category is assigned a 1 or 0 value. Members can have multiple condition categories. Using medical claims, we assign pregnancy indicators, and newborn weights and condition indicators following the categories used in the HHS-HCC risk adjustment model. Finally, we assign a high claimant indicator for members with annual claims above $500,000 and. we excluded high claimants from the matching process[19].

Starting with calendar year 2020, we match backward to the 2019, 2018 and 2017 populations. Summary statistics of the full BCBSVT VISG and AHP population and the matched population are shown on Exhibit 3B.

We use the full population for the medical cost trend calculation and the matched population for all other trend estimates[20] .

3.4.7.2. Medical Trend Development

Using the historical contracted reimbursement schedules, we calculate network factors that represent the various contracts. Using these factors, we can modify the claims to reflect a common contract. From there, we can observe the historical cost increases using all claims information.

Medical trend is composed of three pieces: cost, utilization, and intensity. In our analysis, we combine utilization and intensity within the utilization metric and analyze the unit cost separately. We normalize historical experience for contract changes so that we can derive a utilization trend in the absence of unit cost changes. We develop future unit cost trends on a discrete basis, using the most recent round of contract negotiations as a starting point. The overall trend is the product of these two components.

Unit Cost

Observations of recent contracting and provider budgetary changes are the main source of unit cost trend. In prior filing, we used the most recent calendar year as the basis for the medical cost trend projection. Due to the pandemic, medical care was deferred during the spring 2020 and returned starting in the third quarter of 2020. Not every type of care could be deferred and the degree to which deferred care returned varies based on provider and service type. This change in pattern of care in 2020 impacted the proportion of the total claims incurred at different facilities and providers. We do not expect the 2020 proportions to

[19] The utilization component includes intensity, an increase in high cost claimants can disproportionately impact the year-over-over and regression calculations.

[20] Using the full population for the cost trend base ensures that the weights among facilities and other providers reflect the most accurate weights for the ACA population.

continue through 2022. We therefore use calendar year 2019 as the base for mix of site of care and projected costs three years to 2022.

During calendar year 2019, about 53 percent of total medical claims dollars occurred at Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board (GMCB). For hospitals under the jurisdiction of the GMCB, we start with the assumption that the GMCB will approve hospital budgets for the 2021 cycle that support identical commercial increases as those approved in the 2019 cycle. In previous filing, we assumed that the most recent year of approved hospital budgets was the best proxy for the upcoming year. Driven primarily by a rebasing to actual expenses, the approved budgets in the 2020 cycles were higher than historically approved budgets. On March 31, 2021, the GMCB issued the FY2022 hospital budget guidance[21] and "established a Net Patient Revenue/Fixed Prospective Payment growth guidance of up to 3.5% for FY22." [redacted] Based upon the above assumptions concerning hospital budget and fee schedule changes, the provider contracting and actuarial departments worked together to assess the impact such an increase would have on contract negotiations specific to the network used for the VISG market.

We assumed for other providers within the BCBSVT service area that overall 2021 and 2022 budget increases would be identical to those implemented during the 2020 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 specific to the network used for the VISG market.

BCBSVT entered into a contract with a lab benefit manager (LBM) in August 2019 that instigated dramatic changes in the cost of independent labs. To recalibrate to the LBM fee schedule, we recalculate the cost of labs using the October 2019 fee schedule for January 2019 through September 2019 and assume that 2022 lab claims will remain at that level.

For drugs dispensed in a facility or office, we use the average increase for each facility or provider group to calculate an estimated unit cost trend. As described below, we apply an overall allowed trend for these drugs but, per the URRT instructions, we must separate cost and utilization. This estimated unit cost trend is used for URRT purposes as actual unit cost increases by type of service are not readily available.

Finally, we derive unit cost increases for providers outside the BCBSVT service area from the Fall 2020 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

[21] https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY22%20Hospital%20Budget%20Guidance-%20Final%203%2030%202021.pdf

The chart below summarizes the results of the analysis:

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in Estimated 2020[22]	Cost Trend from 2020 to 2021	Cost Trend from 2021 to 2022	Total Annual Cost Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	54.4%	5.9%	4.1%	5.0%
Other facilities and providers	45.6%	3.6%	3.6%	3.6%
Total	100.0%	4.9%	3.9%	4.4%

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

Utilization & Intensity

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

We measure increases for fee schedules and other chargemasters by applying each schedule to a market basket of services. We define the market basket by using Current Procedural Terminology (CPT) codes & CPT modifier combinations that were present in each of the effective periods the schedules covered. Using the same experience period data used throughout the trend analysis, we compare total allowed costs for the selected combinations of CPT and CPT modifier under each schedule to estimate the percentage increase. For contracts under Diagnosis Related Group (DRG) arrangements, we compared the charge for the 1.000 DRG service for each period. Finally, for services under a discount of charge arrangement, we used the contracted chargemaster increase provided by our Provider Contracting department.

We derive contracting changes for out-of-area services from the Fall 2020 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

We normalize claims to the December 2020 contract at each unique provider by applying a factor equal to the product of the impact of each contracting change from the experience month through December 2020. We assume the derived trend for other claims is continuous.

[22] While the calculation of the cost trend uses calendar year 2019 as the base, the trends are applied to calendar year 2020. The table shows the estimated calendar year 2020 percentages.

We select the following utilization trends:

Category	Annual Selected Utilization Trend
Inpatient	1.5%
Outpatient	0.3%
Professional	1.8%
Medical Drugs	6.7%

While we select distinct trends for inpatient and outpatient claims, the weighted average trend of 0.7 percent is well aligned with the 0.6 percent facility trend in the most recent Large Group filing.

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

In the prior filing, we adjusted the experience to normalize for age, gender, and benefit mix. This is no longer necessary due to the use of a matched population, which excludes high claimants.

Since early 2014, BCBSVT has implemented many programs to combat fraud, waste and abuse (FWA). As shown in the table below, the return of FWA programs increased rapidly from 2015 to 2018. Due to BCBSVT's migration to a new operating platform, FWA programs slowed in 2019. The Vermont Department of Financial Regulations (DFR) ordered the suspension of all routine provider audits from March 18, 2020 to August 3, 2020. We did not engage in routine audits of the University of Vermont Health Network providers as they dealt with a cyberattack in the fall. These events limited our ability to return our FWA program to pre-2019 levels.

Calendar Year	Percent of claims recovered as part of FWA programs
2017	1.09%
2018	1.42%
2019	0.77%
2020	0.52%

To control for the changes in recoveries we normalize claims on a monthly basis based on each respective month's recovery rate. The impact of projected changes to the FWA programs is described in the cost containment section below.

We normalize the claims cost such that each month reflects the average number of working days per month in 2020, as defined by our reserving models.

Exhibit 3B shows the calculation and resulting factors for these adjustments for the matched population.

Inpatient Facility Claims

In prior filings, we combined inpatient and outpatient facility claims and selected an overall facility utilization trend. This was due to the shift of services from inpatient to outpatient setting. This shift is no longer a driver of the increase in outpatient claims and the two types of facility services are now experiencing diverging patterns. We therefore chose to separate the analysis for this filing.

For inpatient facility claims, we select a 1.5 percent utilization trend.

Using the array of PMPM claims costs adjusted for contract, FWA programs, and number of working days, we performed 24-month regressions, 36-month regressions and time series calculations. Certain time series methods, such as those assuming no trend, those assuming that trend is dampening or those for which there is not sufficient historical data[23] are not included, as these are inappropriate for use in trend development and/or for the data available.

Calendar year 2018 claims were uncharacteristically high. Inpatient claims are subject to more random fluctuation than outpatient or office visits. A few additional admissions can skew the year over year trend results. Due to these annual fluctuations, a longer view of trend is appropriate for inpatient claims.

Due to 2019 results being lower than 2018, many time series project highly negative trends producing projected negative claims, which are unreasonable in this context. To smooth out these results, we also calculate trends on a rolling 24-month basis as well as two-year trends.

While the exhibits show monthly data through December 2020, only months through February 2020 are used in the regressions, time series and annual trend calculations due to the impact of COVID-19 pandemic on inpatient claims. The exhibits also show regressions and time series for the periods ended December 2019 for comparison purposes only.

Summary of Statistics for Periods Ended February 2020 for Inpatient Claims		
Method	**Trend**	**RMSE[24]**
Two-year trend	1.6%	
Rolling 24 months	1.4%	
36 Months Logistic Regression	1.6%	12.83
36 Months Linear Regression	1.3%	13.24

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

[24] Root Mean Square Error (RMSE) is the standard deviation of the prediction errors. It measured the delta between the residuals and line of best fit.

We select a 1.5 percent trend for inpatient facility claims. The long-term trend results, which are the only reliable estimates due to the large fluctuation in 2018, are all very close to this figure.

Details on inpatient facility trends are shown on pages 1 to 2 of Exhibit 3C.

Outpatient Facility Claims

For outpatient facility claims, we select a 0.3 percent utilization trend.

Using the array of PMPM claims costs adjusted for contract, FWA programs and number of working days, we performed 24-month regressions, 36-month regressions and time series calculations. Certain time series methods, such as those assuming no trend, those assuming that trend is dampening, or those for which there is not sufficient historical data[25], are not included, as these are inappropriate for use in trend development and/or for the data available.

Outpatient services have been increasing steadily over the past few years at a relatively low rate.

Summary of Statistics for Periods Ended February 2020 for Outpatient Claims			
Method	**Trend**	**RMSE**	**Theil's U[26]**
Year over Year	-0.4%		
36 Months Logistic Regression	1.2%	34.38	
36 Months Linear Regression	1.1%	34.48	
Holt-Winters' Multiplicative 36 Monthly	-0.1%	11.13	0.80
Holt-Winters' Additive 36 Monthly	-0.1%	11.13	0.80

We select 0.3 percent trend for facility outpatient claims. The 24-month statistics are generally higher than the 36-month statistics due to the high fourth quarter in 2019. We therefore relied on the 36-month statistics to better smooth this outlier quarter. Our trend selection is informed by the weighted average of the year over year trend, 36-months regressions and Holt-Winters' time series. The other time series have Theil's U close or higher than one and/or projected negative claims costs, neither of which are statistically acceptable results.

When combined with inpatient trend, the overall facility trend assumption is 0.7 percent. This figure is somewhat lower than facility trend assumptions in the 2021 individual and small group filing and the most recent large group filing.

Details on outpatient facility trends are shown on pages 3 to 4 of Exhibit 3C.

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

[26] Thiel's U is a relative accuracy measure to compare actual results to forecasting results. Theil's U statistics under 1 mean that the technique is better than guessing.

Professional and Ancillary

We select a 1.8 percent utilization trend for professional and ancillary claims.

Professional claims utilization experienced one-time events that skewed the overall year over year results. First, BCBSVT introduced a lab benefit manager in August 2019, which helped reduce the number of services through the application of rigorous clinical protocols and cost of lab services with a drastically reduced fee schedule. Second, in the fall of 2019, we observed a shift in site of care for vaccines from provider offices to pharmacies. While the cost of the administration continues to flow through the medical benefit, the cost of the vaccines has shifted to the retail pharmacy benefit. Facility professional services are expected to follow the facility inpatient and outpatient trends. Finally, mental health and service abuse (MHSA) services have seen larger than average increases for the past two years.

To account for these events, we analyzed the number of services by type of service as identified using place of service and CPT or HCPCS codes on the claims.

After excluding claims for independent labs and vaccinations and carving out mental health and substance abuse (MHSA) and facility services, the number of services per thousand members per month are increasing at a declining rate each year. By contrast, MHSA services have increased by over 10 percent each of the last two years.

For non-MHSA and non-facility services, the logistical regressions over 24 and 36 months for the period ended February 2020 result in annual trends of 1.5 percent and 2.0 percent, respectively, while the year over year trend for the period ended February 2020 was 0.2 percent and the two-year trend ended February 2020 is 1.5 percent. Professional services have manifested a two-year cycle, which may be driven by preventive care patterns. Therefore, using a longer-term view is most appropriate. Based on these results, the best estimate for non-MHSA and non-facility services trend is 1.5 percent; but influenced by the most recent year-over-year result, we select a modestly lower utilization trend assumption of 1.0 percent.

Based on the historical patterns and the work in Vermont to expand access to mental health services, especially during and after the pandemic, a continuation of the observed 10.5 percent increase in MHSA services best project the utilization of these services. This is aligned with the year ended February 2020 increase and the 24- and 36-months regressions.

For facility services, we apply the selected utilization trend for inpatient and outpatient claims, weighted by the uncapped adjusted experience period allowed claims for EHB PMPM (from Exhibit 3J). This calculation yields 0.7 percent.

Over the past few years, services with lower cost per service, such as office visits and urgent care, have seen higher than average increases in number of services. Using the year ended February 2020 cost per service normalized for cost increases as described above, along with the number of services by type (excluding independent labs, therapeutic services, and vaccines), we calculate an annual cost per service (see page 4 of Exhibit 3D)

We expect the historical patterns of increased services at lower cost to continue through the projection period, yielding a cost per service trend of negative 0.5 percent. This aligns with the historical patterns. We expect that the changes to the coding rules around the evaluation and management codes will impact the mix of services, with more intensive codes being used. Due to the anticipated increase in intensity, we do not expect that the mix trend will continue to decelerate but will instead remain at the most recent rate of decrease.

Combining the selected number of services and mix trend, we get the following total professional utilization trend:

Calculation of Overall Professional Utilization Trend			
Category	**Annual Increase in Services**	**Annual Change due to Mix**	**Total Annual Professional Utilization Trend**
All, Except excluded categories	1.0%	-0.5%	0.5%
MHSA	10.5%	NA	13.0%
Facility	0.7%		0.7%
Total			**1.8%**

We observed very consistent levels of increase in number of services (with the exceptions of the services excluded above) and very consistent decreases in the average cost per service, driven by a change in mix. There is no reason to believe that these consistent patterns will change through the projection period. We therefore calculate, based on the selected trends above an aggregate professional trend of 1.8 percent, which will be applied to all outpatient services, including those excluded from the trend calculation.

Exhibit 3D shows the number of services and cost per service by for MHSA, facility services, and all other services (except independent labs and vaccines) combined.

Pharmaceuticals

We select a 6.7 percent utilization trend for pharmaceuticals processed through the medical benefit.

The recent acceleration in cost for pharmaceuticals processed through the medical benefit warrants a separate analysis for these claims. The accelerating cost for these drugs may unduly affect utilization trend, so it is appropriate to develop a discrete trend for these claims. These types of claims have seen drastic increases in the year-over-year trend.

Ocrevus, a blockbuster drug for treatment of multiple sclerosis, was the main driver of a high increase in 2018. Other drugs also experienced very high increases and we expect some of these drugs to continue trending at very high rates.

To isolate trend from the one-time events of new drugs becoming available, we separate the drugs by the first year a claim for them took place. We then calculate year over year trends, rolling two-year trends, and

regressions on the allowed PMPM cost for drugs with claims since at least 2017. While these types of claims were less impacted by the deferral of care due to the COVID-19 pandemic, they still experienced lower than expected claims in the period from March 2020 to May 2020 and higher than expected claims from June 2020 through December 2020. This is likely due to members delaying the start of their treatment. That said, the two-year trends ended February 2020 and December 2020 are very similar, at 6.5 percent and 5.7 percent respectively.

Summary of Statistics for Periods Ended February 2020 for Pharmaceutical Claims	
Methodology	**Trend**
Two-Year Ended Feb 2020	6.5%
Two-Year Ended Dec 2020	5.7%
36mths Regression Ended Dec 2020	7.5%
24mths Rolling Regression Ended Dec 2020	4.4%
36mths Regression Ended Feb 2020	6.5%
24mths Rolling Regression Ended Feb 2020	3.8%

The methodologies that use a smaller amount of historical data yield results that are outliers relative to the more consistent results produced by methodologies that consider longer-term observations. We attribute the variance to short-term fluctuations and use the average of the long-term results as a trend ore indicative of long-term patterns. We therefore select a 6.0 percent overall trend.

Using the average projected cost increase for outpatient services from 2021 to 2022 (5.3 percent; see Exhibit 3A), we calculate a projected annual utilization increase of 0.6 percent for existing treatments. The impact of new drugs for the past three years was 16.7, 6.5, and 4.9 percent, respectively. We discard the 2017 to 2018 result as an outlier and expect the future impact of new drugs to increase trend by six percent. We therefore select a 6.7 percent utilization trend for pharmaceuticals.

Exhibit 3E shows the PMPM and regressions for the pharmaceuticals with claims from at least 2017, the calculation of the impact of the pipeline and the overall calculation of the pharmaceutical trend.

Overall Medical Utilization Trend

Using the 2020 allowed charges PMPM, adjusted for the index rate projection factors described earlier in this section, we calculate a 1.9 percent overall medical utilization trend:

Calculation of the overall medical utilization trend		
Category	**Uncapped Allowed Charge PMPM, adjusted for projection factors**	**Selected Utilization Trend**
Inpatient	$110.85	1.5%
Outpatient	$210.61	0.3%
Pharmaceuticals	$76.73	6.7%
Professional	$142.90	1.8%
Total	**$541.08**	**1.9%**

Cost Containment Strategy

Due to COVID-19 and UVMHN's cyber-attack, we stopped some FWA programs a portion of 2020.We expect that the 2022 FWA activities will return to the 2018 levels of recoveries.

Calculation of the FWA adjustment to Utilization Trend	
Calendar Year	**Percent of claims recovered as part of FWA programs**
2018	1.42%
2020	0.52%
Factor to adjust back to 2018 level	= (1.0142/1.0051) - 1 = 0.9910

3.4.7.3. Pharmacy Trend Development

With the emergence of new and expensive specialty drugs, as well as the increasing shift to generics as more brand drugs come off patent, we analyze the components of trend (cost and utilization) separately for brands, generics, and specialty drugs. Specialty drugs are very high cost drugs with low utilization. Because of their relative infrequency, it is more appropriate to look at the overall PMPM trends for these drugs rather than separate cost and utilization components. We then calculate the overall pharmacy trend by combining the separate projections.

Non-Specialty Drug Utilization

As described above, we use a matched population as the basis for our trend analysis and adjusted for working days. Using the array of monthly PMPM claims after adjustments, we performed 24-month and 36-month regressions as well as time series, with appropriate underlying assumptions for trend and seasonality.

Exhibit 3F provides the monthly and the 12-month rolling data, along with the corresponding year-over-year and exponential regression trends and time series, for non-specialty drug utilization. We use the number of days supply, rather than the number of scripts, to normalize for changes in the days supply per script (e.g. increased use of 90-day fills). Because there are several popular brand drugs that have become generic during the experience period, or will become generic during the projection period, we combine the data for generic and brand drugs for the purpose of analyzing utilization patterns. Vaccines and devices days have been moving from the medical benefit to the pharmacy benefits. These two categories are excluded from the non-specialty trend calculations as they would skew the results.

Due to the relaxation of clinical edits in response to COVID-19, many members refilled their prescription early in March 2020. This changed the pattern of monthly days supply per member. To adjust for this one-time event, we smooth monthly days supply per member for the periods from March 2020 to May 2020 and June 2020 to August 2020 by using the monthly spread from the same months in 2019.

The 24-month regression and time series results are higher than both the most recent year over year results and the 36-month regressions and time series. We observed a high fourth quarter in 2020, which is skewing the 24-month statistics. The longer views also suggest that the most recent year–over-year trend may be artificially low. We select 3.0 percent, the average of the 36-month statistics and the most recent year over year results, as the non-specialty drugs utilization trend.

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

- Generics: Drugs that have been generic since at least January 2018
- New Generics: Generic drugs that have been in the market for less than 36 months (January 2018 to December 2020)
- Brands going Generic: brands that are expected to become available in generic form in the projection period, based on a list from our pharmacy benefit manager
- Vaccines
- Over the Counter (OTC)
- Compounds
- Devices, such as continuous glucose monitoring and insulin pens
- All other Brands

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

<u>Generic Cost Trend</u>

In the previous filing, we used the generic drugs that have been in the market for at least 3 years to determine the generic cost trend. We modified the definition of *new generic* to be at the drug name level and not NDC level, which reduced the number of new generics. This change in definition and the use of all generics instead of only the generics that have been in the market for at least three years reduced the differences between the regressions and year over year results.

Exhibit 3H, page 1, shows monthly Average Wholesale Price (AWP) cost per days supply and the 24-month regression. We select 3.0 percent for the generic cost trend, which is the slightly below the average of the 24-month regression and the year over year result. The rolling annual trends have been between 2.5 and

3.8 percent for the last thirteen 12-month periods. We consider 3.0 percent to be a reasonable long-term outlook for generic cost trend.

Brands that are going generic will become subject to generic discounts. We do not expect that the AWP for these drugs will significantly change from the experience period due to the lack of generic competition for the main drugs in this category. We adjust the price to reflect the different experienced effective discounts between brands and generics. We also adjust the price of the new generics to reflect the difference in effective discounts as compared to the generics that have been in the market for at least three years.

Brand Cost Trend

To ensure that the brand cost trend is not skewed by brands going generic, vaccines, over the counter, devices, and compounds, we performed a 24-month regression on monthly AWP cost per days supply on the all other brand category only. The monthly AWP cost per day supply for brand drugs is impacted by the mix of new and older brands. Brands that have been in the market for one to two years have been, on average, less expensive than older brands. To account for this change in mix, we perform a 24-month regression on monthly AWP cost per day supply for brand drugs that have been in the experience for at least four years.

Exhibit 3H, page 2, shows monthly cost per days supply and the 24-month regression. We select 10.0 percent for the brand cost trend, which is slightly lower than the average of the 24-month regressions and the most recent year over year result. This selection is consistent with recent filings, and we consider it to be a reasonable outlook of future trend.

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

Vaccine costs have been increasing rapidly over the previous three years, with 2020 experiencing slightly lower than historical increases due to fewer travel--related vaccines and more flu vaccines. We expect vaccine costs to trend at levels experienced in 2018 and 2019 and include a 20 percent cost trend for vaccines.

We also do not expect over-the-counter drugs to follow the overall brand cost trend. The price of OTC drugs decreased drastically in 2018 and 2019 but leveled off in 2020. Based on historical data, we select a 0 percent cost trend for OTC drugs.

The cost of pharmaceutical devices has been increasing rapidly over the previous years due to the introduction of new and more expensive options. To calculate both the cost increases and impact of mix through 2022, we observe the increases by drug and their respective market share With the rollout of Vermont Blue Rx, some brands will no longer be covered and members will be directed to the preferred options. We adjusted the projected mix to reflect this change. We select an overall cost trend for devices of 25 percent.

Specialty Drugs

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

We did not adjust the experience to reflect aging or benefits because we used the matched population. We did not adjust for working days, as nearly all retail specialty medications are provided through mail service and the vast majority of prescriptions are refills. Using the array of weighted PMPM claims costs after adjustments, we performed 24-month and 36-month regressions.

Exhibit 3G contains the results of the regressions. We select 17.6 percent as the contracted adjusted trend[27], which is consistent with previous filings, as a reasonable and appropriate trend for specialty drugs.

Changes in Pharmacy Contracts.
On November 9, 2020, BCBSVT announced Vermont Blue Rx, an innovative prescription drug benefit service that will improve the consumer experience, drive better health outcomes, and reduce costs for members, providers, and employers.

As part of this program, BCBSVT has selected a new pharmacy benefit manager (PBM). Effective July 1, 2021, Vermont Blue Rx will leverage custom programs, tools, and digital technology designed to better manage overall drug spending and increase member engagement in pharmacy and health care through a more integrated health and wellness service platform. This collaboration will advance BCBSVT's commitment to providing members with convenient and affordable access to prescription medications through a comprehensive retail and home delivery pharmacy network with no disruption to ongoing treatment.

[redacted] To calculate a contract improvement factor, we applied the contracted discounts and dispensing fees for each type of drug (Generic, Brand and Specialty) to calendar year 2020 claims for contract provisions applicable to both the experience period and the projected period. We apply the contract improvement factor to the projected pharmacy claims for each type of drug, calculated by taking the ratio of the projected pharmacy claims under each contract (see Exhibit 3I for details). [redacted]

Overall Pharmacy Trend
Exhibit 3I summarizes the trends and calculates our total allowed pharmacy trend as 8.4 percent. Note that changes in pharmacy contracts are included in the cost trend component on Exhibit 3J.

3.4.7.4. Vision and Dental Trend Development

Dental Trend
The pediatric dental benefit is available to all members age 21 and under. Using the matched population described above, we observed a step down in 2019 and again in 2020. Dental services were greatly impacted by the COVID-19 pandemic, with some dentist offices closing during the spring of 2020. We expect projection period dental services to return to 2019 levels. We therefore apply no trend for dental services, after adjusting calendar year 2020 for the impact of the pandemic (see section 3.4.8 for details on this adjustment).

[27] [redacted]

Historical PMPM for Dental Claims – Using matched population	
Calendar Year	**PMPM**
2017	$1.98
2018	$1.90
2019	$1.74
2020	$1.36

Vision Trend

The pediatric vision claims experience shows 2018 to be an outlier with much higher PCMPM than the other three years in the analysis. While the slowdown in the spring of 2020 due to the COVID-19 pandemic impacted vision services, the deferred care returned in the second half of the year. The calendar year PCMPM is aligned with the prior year.

Historical CPMPM for Vision Claims – Using matched population		
Calendar Year	**PCMPM**	**Trend**
2017	$0.63	
2018	$0.71	11.8%
2019	$0.58	-18.9%
2020	$0.57	-1.2%

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

3.4.7.5. Overall Total Trend

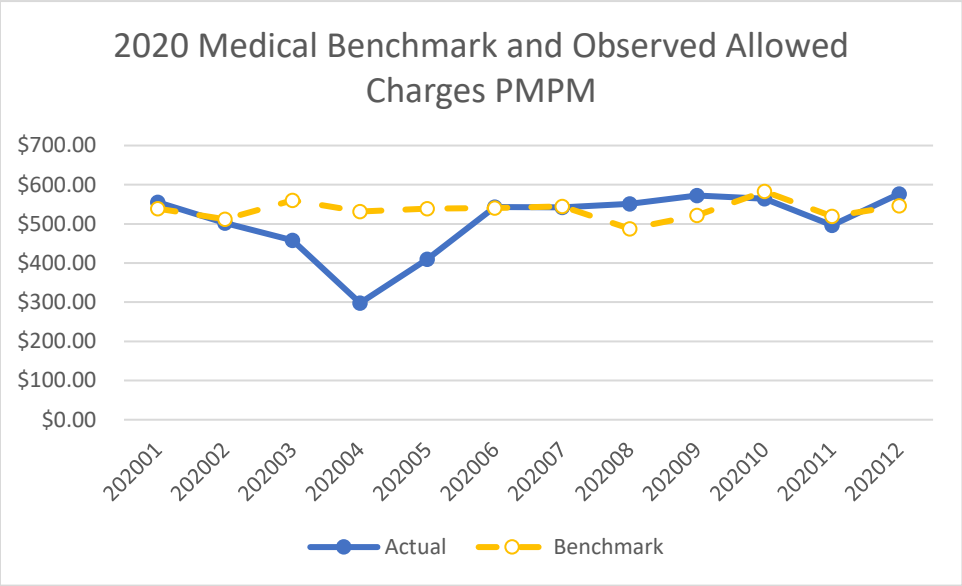
To calculate the overall trend, we apply the trend factors described above to the adjusted experience period allowed claims for EHB (Exhibit 5, line C), but exclude the adjustment for claims above $1 million. Exhibit 3J shows the calculation of the resulting factors $1+d_1$ and $1+d_2$ in Exhibit 5.

	Row on Exhibit 5	Factor
Cost Trend Factor	$1+d_1$	1.071
Utilization Trend Factor	$1+d_2$	1.070

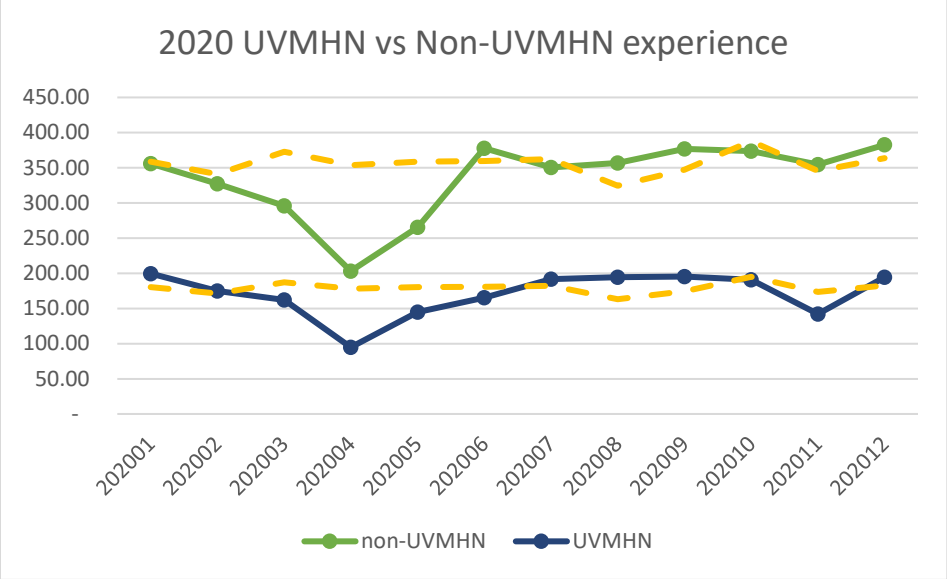
3.4.8. Adjustment to Experience for one-time events

2020 Benchmark and Experience Adjustment

To quantify the impact to our 2020 experience period for one-time events we develop a seasonal monthly allowed charge benchmark. This benchmark represents an estimate of what our 2020 Vermont ACA market experience would have been in the absence of one-time events. We start with the 2019 allowed medical claims experience of members in the ACA market and AHP members that had ACA market enrollment in 2020. From this base we apply monthly medical cost and utilization trends using the trend factors described in memo section 3.4.7.2. We make monthly seasonal adjustments to reflect historical patterns and apply working days adjustments to each month. The following graph illustrates the 2020 benchmark and actual 2020 medical allowed charges.



The actual experience shows a large dip during March, April and May due to the shelter in place measures that existed at that time. There is another dip in November that is a result of the cyberattack on the University of Vermont Health Network (UVMHN) information technology systems. Some services at UVMHN that were originally scheduled in November were rescheduled to subsequent months. The following graph shows the benchmark and actual experience for services rendered at a UVMHN provider as compared to non-UVMHN providers.



November 2020 was 18 percent below benchmark at UVMHN providers in contrast to non-UVMHN utilization that was 3 percent above benchmark.

The experience adjustment was calculated as the weighted average benchmark PMPM relative to the total observed experience PMPM. The resulting factor is 1.0608, of which 1.0547 is the COVID-19 impact and 1.0058 is the cyberattack impact. This factor is applied to medical claims on line $1+c_5$ of Exhibit 5.

Dental claims also experienced a large slowdown in the spring of 2020. As described in section 3.4.7.4, we expect projections dental claims to return to 2019 levels. We therefore estimate the impact of the slowdown on dental claims by comparing the 2019 PMPM to the 2020 PMPM, resulting in a factor of 1.2756. This factor is applied to dental claims on line $1+c_5$ of Exhibit 5.

2022 Projected Impacts

BCBSVT modeled the impact of ongoing costs of the COVID-19 pandemic through 2022. These costs include vaccination costs, continued treatment and testing, and additional changes in demand. Most notably, the professional MHSA claims are expected to increase by about 20 percent from 2020 to 2022. This is much higher than the selected professional MHSA trend of 10.5 percent[28]. It is likely that the ongoing pandemic will increase 2022 claims costs beyond the levels projected within this filing. However, because of the margin guidance provided in Attachment C (as discussed in section 3.8.7.2), the addition of a COVID-related factor of any magnitude would be offset by a reduction in CTR of equal and opposite magnitude, resulting in no change to the premiums presented herein. We therefore include a COVID-19 impact of zero within the 2022 premium rates.

3.5. Credibility of Experience

BCBSVT's experience period had 452,386 member months and is therefore fully credible.

[28] See section 3.4.7.1 for details.

3.6. Credibility manual rate development

Since BCBSVT's experience is fully credible, no manual rate is needed in the development of rates for the experience period claims.

3.6.1. Source and Appropriateness of Experience Data Used: Not Applicable

3.6.2. Adjustments Made to the Data: Not Applicable

3.6.3. Inclusion of Capitation Payments: Not Applicable

3.7. Market Adjusted Index Rate

The Market Adjusted Index Rate (line H of Exhibit 5) is $686.65. We calculate this quantity by adjusting the Projected Index Rate (line F of Exhibit 5, $757.19) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustment Transfer PMPM:

On March 31, 2021, CMS published an Interim Summary Report on Risk Adjustment for the 2020 benefit year[29]. The BCBSVT data included in the report represents claims incurred in 2020 and paid through December 31, 2020. We made the assumption that MVP's 2020 interim submission includes the same incurred and paid data as BCBSVT, consistent with previous years' interim submissions. The final 2020 report will include the impact of supplemental diagnosis files and claims runout. We estimate the impact of claims runout and supplemental diagnoses for BCBSVT and MVP by considering historical relationships of the plan liability risk score (PLRS) in the 2017, 2018 and 2019 Final Summary Reports relative to the 2017, 2018 and 2019 Interim Summary Reports.

The 2022 risk adjustment calculation starts with the estimated final 2020 risk adjustment and projects to 2022 based on projected membership changes, market-wide premium increases, PLRS adjustments due to model changes, and other factors impacting the transfer.

Market-Wide Premium Increases

We calculate the 2022 market-wide premium PMPM by applying the expected 2022 rate increase by carrier to the estimated 2021 premium PMPM by carrier and averaging the carrier specific PMPMs by projected 2022 market share. The 2021 market-wide premium represents the weighted average of BCBSVT's billed premium as of March 31, 2021 and MVP's imputed premium PMPM from their 2021 URRT exhibit based on projected 2022 membership. The BCBSVT 2021 PMPM is adjusted by the average 2022 rate change for non-Catastrophic plans and the MVP 2021 PMPM is adjusted by their average filed increase over the last three years. The adjustments are 0.9915 and 1.0650 for BCBSVT and MVP, respectively. The market-wide premium PMPM is adjusted for the ratio of billable member months to total member months as well as the 86 percent premium adjustment factor and thus our projected per billable member per month premium amount is $578.88. See Exhibit 4, Table 1 for the statewide premium calculation.

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

Model Adjustments

We adjust the PLRS for both BCBSVT and MVP for the impact of the proposed 2022 HHS risk adjustment model coefficient changes.

In order to estimate the impact of the model changes we calculated risk scores for every BCBSVT Exchange member in the 2020 experience period using our DIY software. In addition, we mapped each BCBSVT member's experience risk score to a 2022 risk score based on the proposed HHS risk adjustment model coefficients. From this data we isolated the impact on BCBSVT's risk score due to changes in the risk adjustment model. We observed that members in bronze plans saw higher increases on average compared to members in richer plans and observed that child risk scores increased at a higher rate compared to adults across all metal levels. BCBSVT's average 2022 risk score would be higher than its 2020 average risk score by a factor [redacted] using the 2020 experience as the basis. To estimate the impact of the risk adjustment model change to MVP we created a model that randomly subsets the member-specific BCBSVT risk score data such that the resulting subset has MVP-like metal distributions as well as an MVP-like percentage of adults. MVP has a larger percentage of its membership on bronze plans but also has more adults as a percent of total membership as shown in the tables below.

CY2020 Membership Distribution by Metal				
Issuer	**Platinum**	**Gold**	**Silver**	**Bronze**
MVP	9.8%	35.2%	31.5%	23.5%
BCBS	19.2%	29.0%	34.8%	17.0%

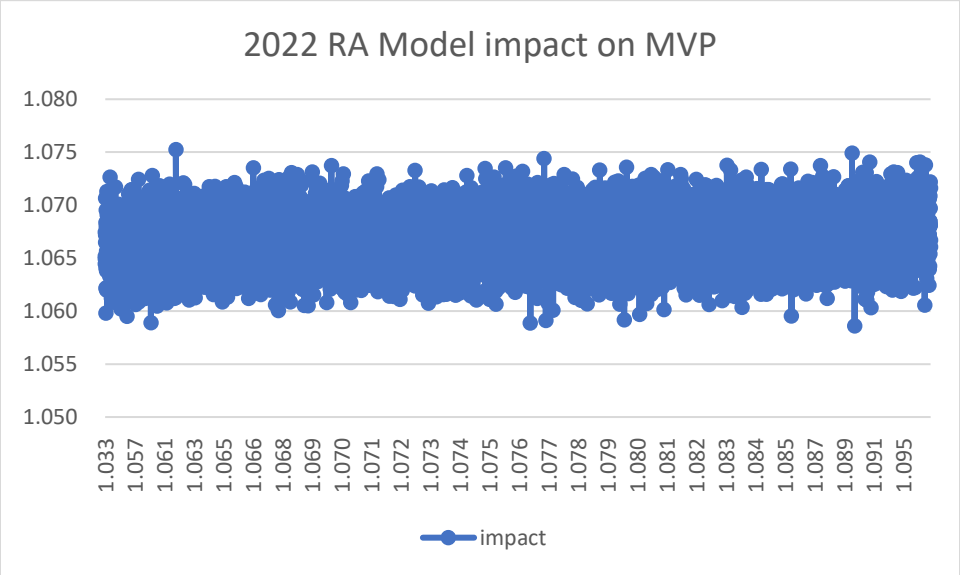
Calculation of Adult to Member Ratio		
Issuer	**MVP**	**BCBSVT**
Contract Type	**As of February 2020[30]**	**Average 2020**
Single	16,104	14,926
Couple	4,187	4,085
Adult + Child(ren)	914	947
Family	2,659	3,050
Contracts	**23,864**	**23,008**
Members	**36,971**	**37,344**
Adults	**30,710**	**30,143**
Adults/Members	**83.1%**	**80.7%**

The model created 10,000 simulations with the MVP characteristics described above. The graph below shows the relationship of modeled 2020 average risk scores (x-axis) relative to the impact of the 2022 model changes for each simulation. The average of these simulations was [redacted]. We concluded that result

[30] https://ratereview.vermont.gov/sites/dfr/files/PDF/MVPH-132371260%20as%20of%20Sept%209%202020.pdf

was sufficiently close to the BCBSVT observation that the overall impact of model changes can be assumed to be 1.00.

The final 2022 risk adjustment model coefficients were released after this analysis was performed. We assume that the final factors will also have no material impact to the relative risk scores between BCBSVT and MVP.



Population Adjustments

We adjust the PLRS for both BCBSVT and MVP for the impact of members migrating from BCBSVT's small group market to MVP's, the impact of individual members leaving the market, and the impact of new members to BCBSVT.

Comparing membership in force as of March 2021 to experience membership, we categorize members into "renew", "cancel" or "new" buckets. We adjust BCBSVT's projected 2022 risk score by removing members that canceled for reasons other than retirement, death, birth or transition to another BCBSVT line of business. [redacted].

The impact of new members to BCBSVT is estimated by first imputing a 2022 demographic risk score from in force enrollment data using observed age, gender and plan selection. The remaining risk score components—diagnosis, interaction, duration, prescription drug and cost-share reduction (silver only)—are estimated by applying the average of these non-demographic risk scores of the renewing population by metal to the new members. [redacted].

We observed that the statewide individual market decreased by 2,138 members, of which 542 were from MVP, mostly within their CSR plans. We assume that the average risk scores for the CSR sub-population have the same relativity between BCBSVT and MVP as that of the total individual market, or 1.245. [redacted]

[redacted].

MVP's small group enrollment grew by 1,035 members. We assume that the growth came from 2020 BCBSVT small groups. We identified which of the canceled BCBSVT small groups transferred to MVP by reaching out to the largest customers within this subset to ask how they are currently insured. We assume that canceled groups that had fewer than 10 members also transferred to MVP due to the absence of alternatives in the market. The combination of feedback we received from specific customers plus the assumption of the smaller sized groups yields approximately the same total (1,015) as the observed MVP small group growth. [redacted]

[redacted]

The final population adjustment accounts for the impact of the projected 2022 plan mix for both BCBSVT and MVP. The following tables show the plan mix for each carrier between the experience and projection periods. From 2020 to 2021, MVP saw a decrease in silver plans and an increase in platinum, gold and bronze. BCBSVT projects increases in silver and bronze plans and decreases in platinum and gold plans. We use observed 2021 plan mix as the estimate for the projected 2022 plan mix.

MVP Membership Distribution by Metal				
Year	**Platinum**	**Gold**	**Silver**	**Bronze**
2020	9.8%	35.2%	31.5%	23.5%
2022[31]	11.2%	35.3%	29.6%	23.8%

BCBSVT Membership Distribution by Metal				
Year	**Platinum**	**Gold**	**Silver**	**Bronze**
2020	19.2%	29.0%	34.8%	17.0%
2022	17.5%	28.2%	35.7%	18.6%

Utilizing the data set that contains risk scores for every BCBSVT member, we added additional detail that assigns a 2022 risk score for each metal level and not just the metal they had in the experience period. This allows us to determine the impact of changing metal levels while holding the risk characteristics of the population constant. An adjustment is made to the summarized data to reflect a higher percentage of adults when calculating the MVP impact. The impact is calculated by taking the weighted average of each respective metal distribution compared to the risk score by metal using the average population. For the MVP metal distributions, we use the adjusted average population as described above. [redacted]

See Exhibit 4, table 2 for a summary of all population and model adjustments.

[31] Report provided by DHVA to carriers on February 18, 2021

Other Factors

The catastrophic plan adjustments were made to the 2020 Interim Summary Report for the impact of 2020 runout and supplemental diagnosis files and the impact of the 2022 model coefficient changes. . Like the merged market, we considered the relationships of the catastrophic plan liability risk score (PLRS) in the 2017, 2018 and 2019 Final Summary Report relative to the 2017, 2018 and 2019 Interim Summary Report. The relative impact of runout and supplemental diagnosis was greater for BCBSVT in 2018 and 2019 but greater for MVP in 2017. Given this historical fluctuation we assume that the 2020 impact would not benefit either carrier and therefore apply the same factor adjustment for each carrier.

The 2022 risk adjustment model coefficients are increasing substantially compared to the 2020 model, primarily within the demographic factors. We calculate the BCBSVT impact by comparing the observed 2020 risk scores by member to the mapped 2022 risk score by member [redacted] Since there is only one plan in the catastrophic market, we assume that MVP's risk score will be impacted similarly. BCBSVT had approximately 98 percent of the catastrophic market in 2020 and we project a similar market share in 2022. Since BCBSVT has a similar majority in both the experience and projection periods, we did not make any population adjustments to the 2020 experience.

Other factors impacting the risk adjustment transfer include the actuarial value (AV), induced demand factor (IDF) and allowed rating factor (ARF). The AV and IDF factors change from the estimated final 2020 calculation as a result of the metallic distribution changing in 2022. The total transfer amount to BCBSVT increases by approximately $1.2 million after updating AV and IDF factors. We assume the ARF is unchanged from 2020. These results are shown in Exhibit 4, Table 3.

The 2020 Interim Summary Report has a total transfer amount $22,155,163. Due to claims runout and the expected impact of the supplemental diagnosis file, we estimate the final 2020 transfer will be $20,713,080 for the merged and catastrophic markets combined. Adjusting the final 2020 transfer for model, population and plan changes, we estimate the final 2022 transfer will be $22,162,855 prior to the charges for the High Cost Risk Pool program.

The 2022 transfer amount PMPM is partially offset by the projected charges and payments for the High Cost Risk Pool (HCRP) program. The plan year 2019 High-Cost Risk Pool charge for the merged markets, which are included in the nationwide individual market, was 0.24 percent of premium[32]. Due to trend leverage for a constant attachment point, the charge will increase over time as a percentage of total premium. To estimate the 2022 charge, we trend the charge using an 18.6 percent trend for three years for claims above $1 million[33]. We then divide by an estimated average nationwide premium increase of 7 percent annually for three years. This calculation yields an estimate of the 2022 charge of 0.327 percent of premium, or $2.12 PMPM. Because the methodology described in Section 3.3.1 nets projected reinsurance payments from projected claims, we effectively assume HCRP payments of zero, apart from expected payments for the high claimant we excluded from that calculation.

[32] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf

[33] This leveraged trend is based on factors in the Milliman Reinsurance Guidelines.

Since the Market Adjusted Index Rate is on an allowed claims basis, we adjust the net projected risk adjustment payment by the average paid-to-allowed ratio (from Exhibit 6C).
The overall market-wide adjustment (line g_1 of Exhibit 5) for the risk adjustment program is -$70.54 PMPM as shown on Exhibit 4.

3.7.2. Exchange User Fees

BCBSVT does not expect Vermont Health Connect to charge a user fee for 2022.

3.8. Plan Adjusted Index Rates

3.8.1. Plan Adjustment – Actuarial Value and Cost Sharing adjustment

This plan adjustment, as shown on Exhibit 6A, is informed by two factors:

- Benefit Richness Adjustment
- Paid-to-Allowed Ratio

The paid-to-allowed ratio comes from the federal actuarial value calculator (AVC) and is adjusted for benefit items that are not supported by the calculator as well the impact of aggregate and stacked deductibles. The adjustments to the federal AVC come from BCBSVT's internal re-adjudication model. The experience used to calculate the adjustments to the-paid-to allowed ratio is our calendar year 2018 data trended to calendar year 2022 using the trend factors described in section 3.4.7. The model re-adjudicates claims by starting with the allowed charges and applying appropriate cost sharing for each service. The model generates the projected average paid claims for each benefit based on what the AVC can support as well as what the model cannot support. The relationship between these outputs from the BCBSVT based model is applied to the federal AVC paid-to-allowed ratio. The BCBSVT re-adjudication model is calibrated to 2018 experience and reproduces the experience paid-to-allowed ratio to within 0.1 percent.

The benefit richness adjustment reflects the expected changes in utilization due to different levels of cost sharing. This adjustment is based on the 2020 adjusted federal AVC. The 2022 federal AVC was not used as the basis because the updates made to the AVC in 2021 and carried forward to 2022 produced counterintuitive results across metal levels. The AVC, while not developed as a pricing tool, is used here to set the relativities between the plans because it represents the best approximation of a total market distribution free from selection bias. The adjustment described in section 3.8.6 ensures that the total premium collected is appropriately based on BCBSVT's re-adjudication model and experience, and not the federal AV calculator.

3.8.1.1. Benefit Richness Adjustment

The Benefit Richness Adjustment is the counterpart of the Change in Benefit projection factor ($1+c_1$ line on Exhibit 5) described in Section 3.4.3. This factor represents the different projected utilization for each plan based solely on benefit design. We apply the HHS Induced Utilization formula ($IU=AV^2-AV+1.24$) to each plan's paid-to-allowed ratio described in the section above.

These factors are normalized using the projected membership to ensure that the total adjustment is 1.000. The plan-level adjustment for benefit richness is calculated by applying the benefit richness adjustment by

base benefit and applying a factor of 1.000 for non-system claims and market-wide adjustments. See Exhibit 6B for details.

3.8.1.2. Paid-to-Allowed Ratio

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

3.8.2. Silver Loading:

The silver loading plan level adjustment represents the impact of the defunding of the federal cost share reduction (CSR) program. Each base silver plan measures the impact of the 73%, 87%, 94% and 100% CSR plans by running each plan design through the BCBSVT re-adjudication model and observing the projected paid-to-allowed ratio differences. These plan specific differences are multiplied through by projected CSR membership. Projected CSR membership is assumed to be equal to the observed March 31, 2021 CSR membership. The total impact of the silver loading is $4.6 million. Please see details in Exhibit 6C.

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

Not applicable.

3.8.4. Adjustment for benefits in addition to the EHBs:

We trend our 2020 experience period non-EHB claims using the medical trends described in section 3.4.7, which produces an average allowed charge of $0.07 per member per month. Applying the same paid-to-allowed ratio to this benefit as to the EHB benefit, we calculate plan level factor adjustments that range from 1.0001 to 1.0004, as shown on Exhibit 6A.

3.8.5. Impact of specific eligibility categories for the catastrophic plan

This plan adjustment includes two components of the impact of the specific eligibility categories for the catastrophic plan. Both adjustments are based on the eligible population. Due to the additional subsidies available, we project that 100 percent of the population eligible for this product in 2022 will be under age 30.

To adjust for the eligible population, we first calculate the adjustment for the impact on the pricing actuarial value of the expected lower allowed charges of the group eligible to enroll in the catastrophic plan. We calculate that the overall expected allowed charges are 0.5308 of the total allowed charges. We then adjust the paid–to-allowed ratio based on the average total allowed charges. This factor is 0.9199.

These factors are applied to the EHB portion of the Projected Period Index Rate. Because this adjustment has no impact on the Non-System claims and Market Wide Adjustment, we calculate the expected claims cost and back into the plan level adjustment for the impact of eligibility.

The total adjustment for the specific eligibility categories for the catastrophic plan is 0.3729. See Exhibit 6D for details.

3.8.6. Impact of Selection

Subscribers will make financial decisions that are right for them. Typically, this manifests itself in healthier subscribers selecting low-cost plans while less healthy subscribers select richer benefits. While we do not reflect selection in the plan-level adjustments, as per the instructions, it can be demonstrated that total premium will be understated without adjusting the index rate to spread the impact of selection across all plans (see Exhibit 6E). This is due to the plan share of allowed costs being greater for richer plan designs, which demonstrably experience anti-selection in excess of benefit richness adjustments. The left section of Exhibit 6E shows the build-up of paid claims from allowed charges using actual plan-level adjustments described in Section 3.8 of this memorandum. The right section of the same exhibit demonstrates the impact on total paid claims of using benefit richness adjustments that instead reflect actual 2020 Vermont ACA market experience. The ratio of weighted average projected paid claims calculated via each of these two approaches produces a factor that must be included in the index rate so that application of the various plan-level adjustments results in the correct total paid claims across all plans. In order to account for the changing weights between the individual and small group markets, we calculate a market-specific selection factor and weight the factors using projected enrollment to calculate the overall factor. The total impact of selection is 1.1060, as shown in Exhibit 6E.

3.8.7. Adjustment for distribution of the administrative costs

3.8.7.1. Administrative Expense Load:

BCBSVT did not initially calculate the administrative expense load as a percent of premium adjustment. This adjustment is the sum of the following fees divided by the average premium PMPM from Exhibit 6A:

<u>BCBSVT Base Administrative Charges</u>

We use calendar year 2020 data from both individual and small group members to develop the base administrative expenses PMPM. The starting PMPM for the base administrative charges is $44.68 PMPM. The Vermont ACA market population is comprised of individuals who can choose to enroll through the Vermont Health Connect (VHC) website or directly with BCBSVT, and small groups that enroll directly with BCBSVT.

The table below shows the reconciliation from GAAP accounting data to base administrative charges, including the removal of federal fees, GMCB billback, and fees paid to vendors for the administration of Health Savings Accounts and Health Reimbursement Accounts linked to our insurance products. Each of these items that have been removed are added to premiums elsewhere. We also remove any expenses incurred due to one-time, non-recurring events, such as the expenses related to enabling full-time remote work and the startup costs of new programs and new vendor relationships, as these costs are not expected

to continue to occur in the projection period. Finally, we adjusted the allocation of overhead among lines of business to reflect a consistent percentage of premium or premium equivalent, which is a more appropriate (i.e. lower, in the case of this filing) basis for pricing purposes.

Reconciliation of Experience Base Administrative Expense to Reported GAAP Expenses		
	Total Dollars	**PMPM**
Reported Expenses	$35,962,084	$79.49
Federal and State fees	($8,456,810)	($18.69)
Fees for outside vendors	($177,448)	($0.39)
Exclusions	($1,132,995)	($2.50)
Reallocations	($6,937,858)	($15.34)
Base Administrative Charges	**$19,256,973**	**$42.57**

Due to the projected change in market mix, we reweighted the experience administrative costs for individual and small group to reflect the projected membership.

Reweighted Experience Base Administrative Expenses PMPM			
	Individual	**Small Group**	**Total**
Base Administrative Expense PMPM	$50.09	$36.43	= ($50.09 x 15,878 + $36.43 x 18,755) / 34,633 = $42.69
Projected Membership	15,878	18,755	34,633

The reweighted base administrative charges are projected to 2022 using a 2.2 percent annual trend. This projection factor is intended to make reasonable but modest provision for increases in overall operating costs PMPM. We assume that personnel costs (wages and benefits) will increase by 3 percent annually, the typical budgeted wage increase, over the projection period. We assumed that other operating costs remain flat. Based on calendar year 2020 information, we calculated that 73.6 percent of our administrative costs are for salaries and benefits. We therefore increase our projected administrative expenses by the weighted average of 2.2 percent per annum. We assume no trend for 2021, and apply trend from 2021 to 2022, which broadly aligns with the decision to forgo cost of living wage increases in 2021.

Development of Administrative Charges Trend		
		Percent of Total
Employee costs:	A	55.4%
Purchased services	B	24.7%
Other operating costs	C	19.9%
Total Administrative Expenses	D = A + B + C	100.0%
BCBSVT Personnel Cost	E = A /(A + C)	73.6%
Projected Personnel Cost Increase	F	3.0%
Projected Administrative Cost Increase	G = (E x (1+F) + (1-E)) -1	2.2%

We calculate PMPM admin charges with experience period enrollment and projected enterprise-wide 2022 enrollment. When projecting the 2022 enrollment, we include the observed membership losses in 2021, projected organic growth in 2022, and expected growth due to the additional subsidies from the American Rescue Plan and its expected impact on membership. Using the lower 2022 enrollment increases the PMPM by 5.4 percent. A recent cost accounting exercise indicates that variable costs represent approximately 30 percent of total administrative expenses. BCBSVT is committed to providing insurance coverage for our members at the most affordable rates possible; as a result, even though it is impractical to react to enrollment shifts by immediately right-sizing staff, we nonetheless remove from our projection the entirety of variable costs associated with the reduced enrollment. We therefore apply a net increase of 3.8 percent to the base PMPM charges to account for the reduction in membership. The table below shows the calculation.

Development of Enterprise Membership Adjustment			
	Enterprise Admin Expenses	**Members**	**Admin PMPM**
Experience Period	$73,222,924	173,910	$35.09
Projected 2022 Enrollment		165,000 [34]	$36.98
Elimination of 100% of variable costs for reduced enrollment			$36.41
Adjustment for Enterprise Membership		$36.41 / $34.41 = 1.038	

[34] The projected membership is higher than in the most recent Large Group filing due to expected growth from additional tax credits from the American Rescue Plan. While BCBSVT expects this membership growth, the impact of these additional members is only reflected in administrative charges as we do not have information about the health status of the currently uninsured population. BCBSVT expects that while the morbidity of currently uninsured members might be lower than currently insured members, the anti-selection of members choosing to newly enroll is likely to offset the improved morbidity. The most reasonable assumption is that newly enrolled members will not have a material impact on pool morbidity.

To calculate the projected base administrative charges, we increase the reweighted base experience PMPM by 2.2 percent for one year of trend and by 3.8 percent for the impact of membership.

Projected Administrative Charges Calculation		
Experience Base Administrative Charges PMPM	A	$42.69
Trend Projection	B	1.0221
Impact of Membership changes	C	1.0378
Projected Base Administrative Charges (Exhibit 7A)	D = A x B x C	$45.29

The projected base administrative charges PMPM of $45.29 is 7.0 percent of premium.

VHC Billing

Carriers will take over premium billing for VHC enrolled members for plan year 2022. Expenses in plan year 2022 related to VHC billing are estimated at $1.75 PMPM. These are added to BCBSVT projected base administrative expenses.

Debit and Credit Card Fees

Starting in plan year 2021, BCBSVT offers members the opportunity to pay their premiums via debit and credit cards. Prior to 2021, BCBSVT only offered direct debit and check payments. Banks charge fees as a percent of the transaction for debit and credit card payments. To estimate the average fee, we relied on most recent month of payment and fee data. Currently, only individual and small groups directly enrolled with BCBSVT have access to the online platform. With the transition of VHC billing to the carriers, all individuals and small groups will now have access to the online platform and debit and credit card payment option. While the uptake of this new payment option has been lower than expected in the 2021 filing, over time an increasing number of members each month elect to pay their premium using a debit or credit card. We also received information from VHC about the use of credit and debit card members for BCBSVT members enrolled through VHC. In 2020, approximately 13.2 percent of households enrolled through VHC paid their premium by credit or debit card.

The table below shows the expected percentage of membership paying by credit and debit card in 2022 and the expected fee, based on recent data.

Projected Credit and Debit Cards Fees as a Percent of Premium					
	Projected Membership	**Expected percentage of debit/credit card payment**	**Member Responsibility Premium PMPM**	**Total Premium PMPM**	**Credit Card Fee PMPM**
	(A)	(B)	(C)	(D)	(E) = 3.0% x (C)
VHC Enrolled	10,863	20.0%	$306.79	$680.79	$1.84
Individual Direct Enrolled	5,015	20.0%	$603.54	$603.54	$3.62
Small Groups	18,755	7.5%	$651.62	$651.62	$1.47
Total Projected Members	**34,633**	**13.2%**	**$536.50**	**$653.80**	**$1.90**

The average fee of 3.0 percent applied to the member responsibility PMPM and multiplied by the projection of 13.2 percent paying by debit or credit card yields a premium load of 0.29 percent ($1.90 / $653.80 = 0.002900).

Charges for Outside Vendors

- CBA Dental and VSP Vision

Dental and vision benefits are administered by third parties. The administrative fees are charged for eligible members only. We assume that these fees will not increase from those in the experience period, and therefore add a charge equal to the experience period PMPM.

- HRA/HSA Integration Services

All Vermont ACA market members are eligible for HRA and/or HSA integration services. For plans with an HSA-compatible benefit design, we offer a service to integrate with the mechanics of depositing monies into and paying claims out of Health Savings Accounts (HSAs). All plans are also eligible for this service in connection with Health Reimbursement Accounts (HRAs). To calculate these fees, we use the experience of members that are already enrolled in this program and compare it to all members enrolled in the Vermont ACA market in the first quarter of 2021.

The total of all administrative charges outlined in this section is 7.61 percent of premium. The details of the administrative charges are on Exhibit 7A.

Reconciliation to the Supplemental Health Care Exhibit

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

In the SHCE, administrative expenses are included in lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4. Line 1.5 also includes an allocation of federal income taxes that are not part of administrative expenses. Those must be excluded to reconcile to statutory basis administrative expenses. Statutory and GAAP accounting treat

some expenses differently, mainly related to network fees and pension costs. The following chart demonstrates a reconciliation of the SCHE to GAAP base period administrative charges:

Reconciliation of SCHE and GAAP accounting		
		Individual and Small Group
SCHE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	$38,991,550
Less taxes in SCHE 1.5 that are not admin	B	$1,652,162
Total administrative charges - STAT basis	C = A – B	$37,339,388
Differences in STAT and GAAP treatment	D	($1,377,304)
Total administrative charges - GAAP basis	**E = C + D**	**$35,962,084**

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

Contribution to Policyholder Reserves

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

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

Other Risk Margin

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

Calculation of the Unpaid 30-day Grace Period as a Percent of Premium			
	Unpaid 30-day Grace Period Premium	**Total Billed Premium**	**Percent of Billed Premium**
2017	$415,186	$408,055,901	0.1%
2018	$276,549	$342,711,239	0.1%
2019	$232,289	$298,258,610	0.1%
2020	$269,037	$287,515,509	0.1%
Total	**$1,193,062**	**$1,336,521,186**	**0.1%**

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

3.8.7.3. Taxes and Fees:

The proposed rates include on average 1.53 percent in taxes and fees. These taxes and fees are imposed by both the state and federal government.

Green Mountain Care Board Billbacks
BCBSVT is assessed a billback from the Green Mountain Care Board. In 2020, $1,026,263 was allocated to the ACA market**.** To calculate the increase to this fee, we used the increase in BCBSVT invoice from FY2020 to FY2021 and applied to the portion allocated to the ACA market in 2020. The BCBSVT total invoice increased by 7.2 percent. We therefore calculate the projected 2022 billback allocated to BCBSVT ACA products as $1,100.629, or $2.65 PMPM.

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

Patient-Centered Outcomes Research Institute Fee
This fee is part of the Affordable Care Act and applies to all plan years through October 1, 2029. We estimate that the fee will be $0.24 PMPM for the plan year ending December 2022.

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

Risk Adjustment User Fees

Per the 2022 final Notice of Benefits and Payment Parameters (86 Fed. Reg. 24140), the risk adjustment user fee is $0.25 per member per month.

Details of the taxes and fees by product are on Exhibit 7C.

3.8.8. Calibration

Age, tobacco, and geographic factors are not allowed in Vermont. Therefore, no calibration is required.

3.8.9. Projected Loss Ratio

The MLR calculation at the combined market level has a minimum requirement of 80 percent. We project that the overall Loss Ratio, using the federally prescribed MLR methodology for the combined market, will be 90.0 percent. See Exhibit 8 for details.

3.9. Consumer Adjusted Premium Rate Development

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

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

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

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

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

3.10. Small Group Plan Premium Rates

All Small Groups must renew on January 1, 2022 according to the combined market rules. BCBSVT will not file small group rates for Q2-Q4 2022.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

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

	Terminated Plans		New Plans	
Market	**2020 Name**	**2020 QHPID**	**2022 Name**	**2022 QHPID**
Small Group	Blue Rewards Gold	13627VT0360001	Vermont Preferred Gold	13627VT0360005
Small Group	Blue Rewards Silver	13627VT0360002	Vermont Preferred Silver	13627VT0360006
Small Group	Blue Rewards Silver - Reflective	13627VT0360004	Vermont Preferred Silver - Reflective	13627VT0360008
Small Group	Blue Rewards Bronze	13627VT0360003	Vermont Preferred Bronze	13627VT0360007
Individual	Blue Rewards Gold	13627VT0380001	Vermont Preferred Gold	13627VT0380005
Individual	Blue Rewards Silver	13627VT0380002	Vermont Preferred Silver	13627VT0380006
Individual	Blue Rewards Silver - Reflective	13627VT0380004	Vermont Preferred Silver - Reflective	13627VT0380008
Individual	Blue Rewards Bronze	13627VT0380003	Vermont Preferred Bronze	13627VT0380007

4.2. Plan Type

The plan type is EPO.

4.3. Act 193 Information

The table below shows the percentage of the 2022 proposed PMPM premium for generic, brand, and specialty drugs. The percent of premium rate is calculated by applying the brand, generic and specialty weights from Exhibit 3G to the total pharmacy projected allowed PMPM from Exhibit 5, adjusted for non-trend factors in the Projected Index Rate and adjusted for the plan level adjustment. Pharmacy rebates are weighted based on projected brand and specialty paid claims. We assume that the plan level adjustments apply to each category equally.

Drugs Processed Under the Pharmacy Benefit	
Type	**Percent of premium**
Generic	3.5%
Brand	4.9%
Specialty	9.4%

The table below shows the change in allowed charge PMPM from calendar year 2019 to calendar year 2020 and the annualized projected increase to 2022, including the impact of contract changes.

Drugs Processed Under the Pharmacy Benefit		
Type	**CY 2019 to CY 2020**	**CY 2020 to CY 2022, Annualized**
Generic	3.8%	5.3%
Brand	9.3%	1.8%
Specialty	36.2%	17.6%

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

Premium Increases	
Component	**Increase**
Rx Claims	-3.5%
Medical Claims	-1.7%
Non-Claims Components	12.0%

Information about BCBSVTs National Performance Formulary is located on our website https://www.bcbsvt.com/VermontBlueRX BCBSVT's benefits do not have a specialty tier. All brand drugs, specialty or otherwise, are included in the preferred brand or non-preferred brand tiers.

Drugs administered in an outpatient setting and covered by the medical benefit represent 14.1 percent of the projected 2022 premium PMPM.

OptumRx will act as the pharmacy benefit manager (PBM) for BCBSVT's Vermont Blue Rx pharmacy program beginning in July 2021. OptumRx will manage claims processed through the pharmacy benefit but not claims processed through the medical benefit for use in a facility.

5. RELIANCE AND ACTUARIAL CERTIFICATION

5.1. Reliance

For the metallic AV values of the standard plans we relied upon the certification provided by Julie A. Peper, FSA, MAAA, Principal and Senior Consulting Actuary and Brittney Phillips, ASA, MAAA, Senior Consulting Actuary with Wakely Consulting. (Attachment A)

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the plans that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to offer to the Vermont individual and small group markets in 2022. These calculations are not intended to be used for any other purpose. This memorandum documents the methodology used to calculate the AV Metal Value for each Qualified Health plan and Reflective plan offered by BCBSVT in 2022, the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, that the

Index Rate is developed in accordance with federal regulations, and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

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

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

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

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

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

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

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers.

_____

Paul A. Schultz, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont
May 7, 2021

5.3. Disclosures

Information Date: The analysis provided in the report is based on information as known on May 7, 2021.

Scope: The purpose of this filing is to establish the premium rates for products offered by Blue Cross and Blue Shield of Vermont in the ACA market for the 2022 plan year. This filing is not intended to be used for other purposes.

Intended Users: This material has been prepared for the GMCB. BCBSVT 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 BCBSVT 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.

Subsequent Events: New information related to the COVID-19 pandemic continues to emerge on a regular basis. Subsequent events may affect the adequacy of the rates presented herein. The degree to which future events may materially change the adequacy of the rates is unknown. Notably, the filing does not include an assumption for additional claims expense due to ongoing COVID-19 vaccination on an annual basis. It remains uncertain whether the vaccines will require annual administration.

As of May 7, 2021, Vermont remains in a state of emergency regarding the COVID-19 pandemic. Given BCBSVT's previously communicated position of paying for pandemic-related costs through policyholder reserves, we would not include vaccine costs in the rate development even if emerging evidence demonstrates that an annual booster will be required.