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Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Blue Cross and Blue Shield of Vermont
Vermont Health Connect 2023 Individual Rate Filing
SERFF# BCVT-133243519

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2023 Individual Filing for Blue Cross and Blue Shield of Vermont (BCBSVT or Company) and to assist the Green Mountain Care Board (GMCB or Board) in assessing whether to approve, modify, or disapprove the Company's requested rate changes.

FILING DESCRIPTION

1. BCBSVT is a non-profit hospital and medical service corporation that provides health insurance coverage to Vermonters. This filing proposes premiums for BCBSVT's Qualified Health Plans (QHPs) that will be offered on Vermont Health Connect (VHC), beginning January 1, 2023.

2. As of March 2022, there were approximately 16,566 members[1] enrolled in individual plans. Enrollment from the last several years is demonstrated in the following table:

INDIVIDUAL MEMBERSHIP BY COVERAGE YEAR

Coverage Year	Members	Percent Change
2017	28,710	
2018	23,361	-18.6%
2019	19,431	-16.8%
2020	17,627	-9.3%
2021	15,878	-9.9%
2022	16,556	+4.3%

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

3. For the 2022 rating year, the Small Group and Individual markets were separated for rating purposes. In accordance with Act 137, Section 9, the markets will continue to be separate for rating year 2023. This report will focus on the proposed unmerged premium rates for the Individual market.

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

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

5. The proposed rate impact of this filing is an average rate increase of 12.3%. The tables below illustrate the approved premium rate changes for last year's 2022 QHP filing and the proposed premium rate increase for the 2023 QHP filing.

2022 APPROVED INDIVIDUAL RATE CHANGES

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$259.79	$234.15	-9.9%	-$25.64	1.2%
Bronze	$523.23	$537.75	+2.8%	$14.52	20.7%
Silver Loaded	$713.93	$743.91	+4.2%	$29.98	40.1%
Silver Reflective	$570.15	$594.48	+4.3%	$24.34	8.1%
Gold	$696.08	$737.33	+5.9%	$41.25	21.0%
Platinum	$844.39	$905.38	+7.2%	$60.99	8.9%
Overall	***$665.03***	***$695.79***	***+4.6%***	***$30.76***	***100.0%***

2023 PROPOSED INDIVIDUAL RATE CHANGES

Plan Type	Average 2022 Premium PMPM	Average 2023 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$234.15	$261.64	11.7%	$27.49	1.2%
Bronze	$537.75	$609.78	13.4%	$72.03	20.7%
Silver Loaded	$743.91	$827.15	11.2%	$83.24	40.1%
Silver Reflective	$594.48	$656.32	10.4%	$61.84	8.1%
Gold	$737.33	$837.44	13.6%	$100.11	21.0%
Platinum	$905.38	$1027.26	13.5%	$121.87	8.9%
Overall	***$695.79***	***$781.26***	***12.3%***	***$85.47***	***100.0%***

STANDARD OF REVIEW

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

SUMMARY OF RECEIVED DATA

BCBSVT provided the methodology used to develop the proposed 2023 individual and small group premiums. The Company provided exhibits which demonstrated the quantitative development for each component of the premium request, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees. Most exhibits were provided on separate individual and small group bases, in addition to a hypothetical combined version illustrating the market in a scenario where the two cohorts are being remerged.

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

For medical services trend, the annualized allowed trend per year from 2021 to 2023 is 9.0%. The portion applicable to unit cost changes is projected to be 6.9% annually based on projected contracting and provider budgetary changes. The portion applicable to utilization changes is projected to be 2.0% annually.[2]

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

[2] The trend assumptions are the same for individual and small group markets. However, due to slight differences in distribution between facilities/services, the average for each market is slightly different. In this report, we will discuss average trend for the two markets because this is the basis on which these assumptions were set.

than separately by utilization and unit costs. The projected allowed trend for pharmaceuticals is 13.2% annually[3].

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

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

Exhibit 8 demonstrates the development of expected loss ratios. BCBSVT projects the following 2023 loss ratios, which exceed the 80% minimum requirement.

PROJECTED 2023 LOSS RATIOS

Cohort	Traditional Loss Ratio	ACA MLR
Individual	89.4%	90.2%
Small Group	91.3%	92.3%

Exhibit 9A shows the impact of the single conversion factor which is needed to convert preliminary rates into final rates based on predetermined Vermont tier factors. Exhibit 9B shows the final proposed 2023 premiums, proposed rate increase by plan, and calculation of the average proposed rate increases.

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

[3] The trend assumptions are the same for individual and small group markets. However, due to slight differences in distribution between drug tiers, the average for each market is slightly different. In this report, we will discuss average trend for the two markets because this is the basis on which these assumptions were set.

L&E ANALYSIS

The average proposed 2023 individual market rate increase of 12.3% is attributable to several rating components. To create a consistent comparison for both companies filing VHC products, L&E categorized the proposed premium changes reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

COMPONENTS OF 2023 PROPOSED RATE CHANGE

Rating Component[4]	Percentage Change[5]
1. 2021 Actual/Projected Claims Experience	+1.8%
2. Difference in Trend from 2021 to 2022	+1.4%
3. Trend from 2022 to 2023	+10.8%
4. Changes to Population Morbidity Adjustment	-1.5%
5. Demographic Shift	-0.6%
6. Plan Design Changes	-0.2%
7. Changes to Other Factors	+0.8%
8. Changes to Risk Adjustment	+1.9%
9. Changes in Actuarial Value	-0.2%
10. Changes in Administrative Costs	-1.0%
11. Changes in Taxes & Fees	-0.1%
12. Changes in Contribution to Reserves	-0.3%
13. Changes in Single Contract Conversion Factor	-0.7%
Total Proposed Rate Change	**+12.3%**

1. **2021 ACTUAL/PROJECTED CLAIMS EXPERIENCE:** Actual 2021 claims experience for the individual market was approximately 1.8% higher than the one-year-trended 2020 costs expected in the 2022 filing.[6] Since this change is based on actual claims experience, this rate component appears to be reasonable and appropriate.

2. **DIFFERENCE IN TREND FROM 2021 TO 2022:** In the 2022 filed rates, the assumed 2021 to 2022 trend was approximately 7.7%. BCBSVT now projects a 2021 to 2022 allowed trend rate of approximately 9.2%. Therefore, the 2022 assumed trend has significantly increased, resulting in a premium increase of approximately 1.4%. The trend development is discussed further in the next section.
3. **TREND FROM 2022 TO 2023:** The Company projects an average total allowed trend of

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

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

[6] L&E has historically used the URRT's base period and Year 1 Trend factors to calculate this value. However, because the COVID impact in the 2022 rates was primarily a first-year effect, we have moved that into this first line item as well.

approximately 9.9% per year, after adjustments for changes to Rx rebates.

2021 TO 2023 ALLOWED TRENDS

Cost Category	Total Allowed Trend
Medical	9.0%
Pharmacy	13.2%
Total	***9.9%***

GMCB HOSPITAL BUDGET REVIEW

The overall annualized unit cost medical trend of 6.9% includes:

1) a trend of 8.0% for facilities and providers that are impacted by the GMCB's Hospital Budget Review, and

2) a trend of 5.6% for other medical facilities and providers that are not subject to the Hospital Budget Review.

MEDICAL TREND: The allowed trend reflects changes in the both the cost of medical services and changes in utilization of medical services by members. The Company projected an annual allowed medical trend of 9.0%, which is comprised of 6.9% for unit cost changes and 2.0% for utilization and intensity changes.

Medical Unit Cost Trend

To project medical unit costs forward from 2021 to 2022, actual negotiated provider payment changes were used.

For the BCBSVT service area, the Company analyzed recent changes to provider contracts as the starting point for the 2022 to 2023 unit cost trend estimates. Approximately 53% of medical costs are related to facilities impacted by the Board's Hospital Budget Review process.

BCBSVT took the following approach in setting the 2022 to 2023 unit cost trend assumptions:

- For hospitals under the jurisdiction of GMCB, commercial increases approved for the 2023 budget cycle are assumed to be equal to the increases approved in the previous cycle, adjusted upwards for unapproved midyear increase requests.

- For non-GMCB providers within the broader BCBSVT service area, 2022 and 2023 rate increases are based on 2021 historical reimbursement increases except for cases where early negotiations have indicated otherwise.

- For providers outside the BCBSVT service area, the Company used the Fall 2021 Blue Trend Survey conducted by the Blue Cross Blue Shield Association.

During L&E's review of the filed trends, BCBSVT found a mistake in their calculations related to one of their cost trends. Correcting this mistake would result in premiums that are approximately 0.1% lower. L&E agrees with BCBSVT that this mistake should be corrected.

Once 2023 hospital budget requests are submitted, L&E recommends that this new information be considered.

Medical Utilization Trend

BCBSVT made assumptions regarding future changes to the utilization of medical services based on analyzing historical data by benefit category. BCBSVT categorized medical claims into Facility (Inpatient/Outpatient), Professional, and Outpatient Drug categories.

BCBSVT adjusted the historical trend to remove the impact of these fluctuations and assumed that 2023 FWA recoveries will remain at 2021 levels. L&E notes that this methodology is reasonable.

Starting in the 2022 filing, BCBSVT utilized a “matched population” method to control for historical changes in population characteristics. By selecting individuals from different time periods who mirror each other regarding important demographic and diagnostic characteristics (and removing data from unmatched members), BCBSVT attempts to mitigate the impact of population changes on observed utilization trends. After adjustment, the observed trends better reflect the underlying utilization changes to be funded by premium changes.

For example, the average age of BCBSVT members rose from 42.1 to 42.6 between 2018 and 2021. This age increase would generally be expected to produce an increase in claims; however, that increase would also be offset by receiving additional risk adjustment transfers payments. In the matched population method, a constant age of 42.9 is assumed for all time periods. Similarly, the population used to analyze trend data have a constant split between male and female, individual and small group, and choice of metal tier. By carefully selecting a matched population, BCBSVT has taken significant steps towards ensuring that there is consistency in the measurement of historical trend.

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

BCBSVT provided historical data, adjusted to reflect the matched population, for various service categories. All trend data is for individual and small group combined. This data was provided in Exhibits 3C through 3E of the filing.

Using this data, the Company performed regression and time-series methods as part of their analysis to support their utilization trends. They ultimately assumed the following:

ASSUMED MEDICAL UTILIZATION TRENDS

Cost Category	2-Year Average
Facility	1.5%
Mental Health Professional	8.5%
Facility Professional	1.5%
Other Professional	1.0%
Medical Rx	3.6%
Total Medical	***2.0%***

We have concerns with some of these components, and additionally have concerns with these assumptions in aggregate (i.e., the 2.0%).

Facility Trend
For services provided at a facility, BCBSVT assumed a 1.5% per year utilization trend. The initial filing pointed to various 36-month statistics, calculated from unadjusted historical data. BCBSVT has stated that these statistics "strongly suggest an expectation of forward-looking trends very near 1.5% percent." The 36-month period in question is calendar years 2019 through 2021. Performing regressions and time-series analyses on this time period is likely to capture the impact of COVID lockdowns, which were most severe in the first half of 2020, and report it as the impact of trend.

As L&E indicated to BCBSVT, removing the data from 2020 and performing the same analyses yields trend estimates typically in the range of 0.0% to 0.5%. This speaks to the fundamental challenge of estimating long-term trends in utilization based on data from the era of COVID-19. Regardless, it does not appear that the initial filing contained appropriate support for this assumption.

Subsequently, BCBSVT provided a revised argument for the use of a 1.5% utilization trend. The data supporting this argument are recreated below.

ACTUAL AND PROJECTED FACILITY UTILIZATION

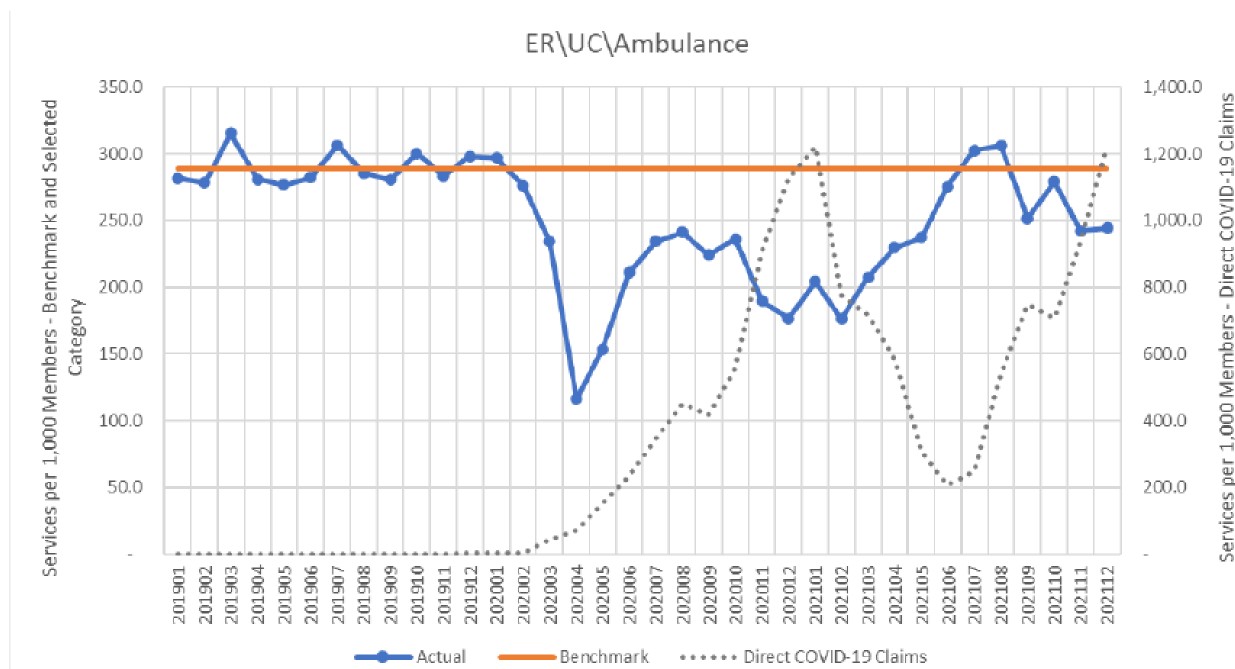
Year	Normalized Facility PMPM	Annual Utilization Increase
Actual 2018	303.98	
Actual 2019	295.29	-2.9%
Actual 2020	255.42	-13.5%
Actual 2021[7]	**297.28**	+16.4%
Projected 2022	*301.74*	*+1.5%*
Projected 2023	*306.26*	*+1.5%*

BCBSVT has argued that the change from 2019 to 2021 shows a positive increase in utilization. However, it is important to note that the figure presented as 297.28 in this table was, in actuality,

[7] This figure reflects adjustments to actual data for BCBSVT's belief that Emergency Room services were artificially low during 2021.

approximately 293. That is, actual 2021 data was lower than both 2018 utilization and 2019 utilization. We believe that the adjustment applied to the 2021 data is reasonable, based on the following information.

BCBSVT's support for using a higher-than-observed Facility Utilization PMPM ultimately lies in the following exhibit. From this experience, BCBSVT has argued that 2021 claims for emergency rooms, ambulances, and urgent care centers were suppressed for all of 2021 except the summer, when COVID cases were lowest. For this reason, they are using a modified utilization figure of about 297 rather than the observed figure of 293 in the table referenced above.



Medical utilization in 2021 must be studied cautiously due to the competing influence of two uncertain factors: returning care and suppressed care. A significant portion of medical treatment in 2020 was delayed due to COVID-19 lockdowns and social distancing. Some of those treatments deferred during 2020 were subsequently rescheduled during 2021. These "returning" claims resulted in an increase to claims in 2021. However, due to the continued presence of COVID-19 during 2021, some treatments that normally would have occurred in 2021 were themselves foregone or delayed, resulting in a decrease to 2021 claims. The combination of returning care and this "suppressed" care creates a situation where it is impossible to determine with certainty whether 2021 claims were lower, higher, or equivalent to what they would have been in the absence of COVID-19.

Because emergent care by definition cannot be deferred, it is reasonable to assume that it would be unique in this regard and exhibit only the suppression rather than the return of deferred care. BCBSVT reasonably assumed that the observed reduction in emergency utilization is the result of this suppression.

For all non-emergency medical service categories in aggregate, 2021 utilization was highly in line with 2019 utilization. On this basis, BCBSVT has assumed that the returning deferred care from 2020 almost perfectly offset the suppression of care during 2021 for all other service categories.

We believe this assumption is also a reasonable one. We agree with BCBSVT's assessment that non-emergency utilization returned to pre-pandemic levels during 2021 in aggregate. However, this would appear to be consistent with an environment in which there is little or no trend in utilization. We therefore note a significant tension between this reasoning and the assumption of positive utilization trend in all service categories.

Facility utilization increased in 2021, clearly due to the suppression of care during 2020. Outside of this increase, the most recent observed increase to BCBSVT's facility utilization was in 2018 relative to 2017 claims. Additionally, neither the two-year nor three-year observed trends ending in 2021 support the 1.5% utilization trend assumed in the proposed rates.

We also note that the filed and approved facility trend in the 2021 filing (the most recent to use entirely pre-COVID data) was 1.1%. If, as is reasonable, BCBSVT were to take the position that post-COVID data simply is not reliable as a basis for projected trends, it would, therefore, seem implausible to assume a higher trend rate than what they assumed prior to COVID. We do not believe BCBSVT has provided any information after the 2021 filing that would suggest that the long-term trend rate is higher than 1.1%.

In fact, we believe the actual 2021 data perhaps suggests trend might be lower. BCBSVT has calculated that a regression on 2019 and 2021 claims (excluding 2020), even using their adjustment to 2021 to approximate removing the impact of COVID, results in a facility trend estimate of 0.9%.

Ultimately, we recognize the uncertainty inherent in the development of trend assumptions in the wake of the COVID-19 pandemic. Undeniably, the range of possible outcomes is significant. However, we disagree with BCBSVT's assessment that a 1.5% facility trend is an appropriate best estimate based on the available data. We recommend that this assumption be reduced to 1.0%.

Mental Health Professional Trend

Unlike with facility claims, there is an unambiguous trend in historical data for mental health professional services. The four most recent years of data are shown below:

ACTUAL MENTAL HEALTH UTILIZATION

Year	Normalized Mental Health Professional Utilization[8]	One-Year Trend
2018	142	
2019	158	+11.2%
2020	174	+9.8%
2021	187	+7.7%

It would not be appropriate to assume no trend or a negative trend in this case. BCBSVT chose a utilization trend assumption of 8.5% per year. While we note that the trend has itself been decreasing over time, these three data points are insufficient to make confident statements on that point. As BCBSVT notes in their actuarial memorandum, both the demand for, and provision of, treatment for mental health conditions have been increasing, both because of COVID-19 and independently of it.

We believe that BCBSVT's use of an 8.5% mental health utilization trend is reasonable.

Facility Professional Trend

BCBSVT applies a trend factor to professional services occurring in a facility setting separate from other professional costs. The trend in these services follows a very similar pattern to facility claims, with claims from 2018, 2019, and 2021 exhibiting little to no trend. As noted previously, BCBSVT saw the return of utilization to 2019 levels as an indication that COVID had little net effect on 2021 professional utilization.

[8] These values approximately represent dollars of treatment PMPM. However, they have been normalized for unit cost changes, population changes, and other variables such that they will not tie to the actual dollar figures.

ACTUAL FACILITY PROFESSIONAL UTILIZATION

Year	Normalized Facility Professional Utilization	One-Year Trend
2018	152	
2019	149	-2.4%
2020	123	-17.0%
2021	149	+20.8%

BCBSVT assumed that utilization for these services would mirror the trend in facility services, i.e., 1.5%. We agree that these two categories should likely have the same trend assumption, given their conceptual association and the very similar patterns observed in the data for these categories.

However, this data again does not support the value of 1.5% itself. Consistent with our recommendation regarding facility utilization, we recommend that the assumed utilization trend for professional facility services be reduced to 1.0%.

Other Professional Trend

By excluding both mental health practitioners and professionals working in a facility setting, BCBSVT constructs a category for "Other Professional" utilization. BCBSVT is assuming a 1.0% per year increase to this utilization category. BCBSVT indicates that there is "insufficient evidence to suggest that the best estimate differs from our prior assumption" and continues to use the 1.0% trend assumption used in last year's filing.

BCBSVT references three statistical results in support of this assumption. One is that the year-over-year trend in utilization from 2019 to 2021 is effectively zero. This result does not seem to be in support of a 1.0% assumption.

The other two regressions both rely on monthly claims data over this same period[9]. As noted in our discussion of the facility trends, this methodology unavoidably attributes the impact of COVID to a temporal trend, as the most drastic effects of COVID occur during the first half of the regression period. Thus, we disagree with BCBSVT's assertion that these two methods are three of the "most relevant statistical results."

Additionally, BCBSVT is only partially continuing with their prior assumption. We note the following from the 2022 Individual and Small Group Actuarial Memorandum:

We expect the historical patterns of increased services at lower cost to continue through the projection period, yielding a cost per service trend of

[9] While BCBSVT refers to one as a "24-month regression", it is a regression on 24 instances of the 12-month rolling average, and therefore essentially reflects the same three years of data as the other two methods. An actual 24-month regression yields a trend assumption of +19.6% per year, highlighting the susceptibility of such methods to distortions from COVID-19 impacts.

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.

This reduction has been removed. BCBSVT states now that "This pattern does not appear to have continued," despite acknowledging that this is difficult to assess using only 2021 data, due to the impacts of deferred and returning care.

Regarding "other" professional utilization, BCBSVT asserts that it should continue using the 1.0% utilization trend assumption despite the 2021 data, but then seemingly relies on that data to indicate that it should change last year's assumed mix trend number. We have concerns about BCBSVT increasing their professional utilization trend assumption at a time when observed utilization actually shows a decrease to trend.

We also note that BCBSVT's trend methodologies differ between professional service categories. A simple way to evaluate whether these methods are reasonable in aggregate is to compare their aggregate results to historical results in aggregate. We find that the following is true regarding total professional utilization in this population:

ACTUAL PROFESSIONAL UTILIZATION

Year	Normalized Professional Utilization, Total[10]	Two-Year Change	Three-Year Change
2018	1,092		
2019	1,104		
2020	970	-5.7%	
2021	1,134	+1.3%	+1.3%

We note that BCBSVT's proposed total professional utilization trend of +2.3% per year is substantially higher than recent data suggests. We recommend that the utilization trend for non-MHSA, non-facility professional services be reduced to 0.5%.

Medical Rx Trend

BCBSVT has assumed a 3.6% utilization increase per year for pharmaceuticals processed through the medical benefit (hereon referred to as "Medical Rx".) These claims represent a small but growing portion of medical costs, currently about 14% of allowed cost. As they note in the actuarial memorandum, there has been a recent acceleration in cost for these drugs that warrants a separate consideration of them from other medical costs. The one-time nature of the introduction of new

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[10] As measured by the number of services performed per thousand members per year.

drugs and new biosimilars for existing formulations means that trends cannot simply be assumed to follow a smooth curve into the future.

BCBSVT's method for handling these costs, while too involved to describe in detail here, is described and illustrated in the actuarial memorandum and in Exhibit 3E. This methodology considers the overall usage of Medical Rx as well as the proportion of injections that will be cheaper "biosimilars". The methodology appears reasonable, and we do not recommend any changes.

Total Allowed Medical Trend

The table below summarizes the trend assumptions for medical costs, and the overall medical allowed trend from 2021 to 2023.

FILED ALLOWED MEDICAL TRENDS

Cost Category	Annual Unit Cost	Annual Utilization	Annual Allowed Trend
Inpatient	8.0%	1.5%	9.6%
Outpatient	7.3%	1.5%	8.9%
Mental Health Professional	5.1%	8.5%	14.0%
Facility Professional	5.1%	1.5%	6.7%
Other Professional	5.1%	1.0%	6.2%
Medical Rx	7.3%	3.6%	11.2%
Total Medical	***6.9%***	***2.0%***	***9.0%***

As discussed previously, we have concerns about these assumptions in aggregate. The aggregate utilization trend appears to be higher than what is a reasonable range based on the information provided. L&E recommends that the Board make the following changes to utilization assumptions:

RECOMMENDED ALLOWED MEDICAL TRENDS

Cost Category	Annual Unit Cost	Annual Utilization	Annual Allowed Trend
Inpatient (Facility)	8.0%	1.0%	9.1%
Outpatient (Facility)	7.3%	1.0%	8.4%
Mental Health Professional	5.1%	8.5%	14.0%
Facility Professional	5.1%	1.0%	6.2%
Other Professional	5.1%	0.5%	5.6%
Medical Rx	7.3%	3.6%	11.2%
Total Medical	***6.9%***	***1.6%***	***8.6%***

As noted previously, during the course of L&E's review, BCBSVT found an error in their calculation of unit cost trends that results in approximately a 0.1% decrease to total medical unit cost trend. L&E recommends this change be made, reducing allowed trend further to about

8.5%, but notes that best estimate unit cost trends will be unlikely to match those assumed currently once better information regarding hospital budgets is made available.

As noted previously, if updated information regarding unit cost trends is known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost assumption underlying the 2023 premium rate calculations.

Pharmacy Trend

The Company is proposing an allowed pharmacy trend of 13.2% per year, net of changes to pharmacy rebates.

The Company's approach accounted for pharmacy changes by:

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

ASSUMED ANNUALIZED ALLOWED RX TRENDS – 2021 TO 2023

Tier	Unit Cost	Utilization	Total Trend	Portion of Rx Spend
Generics[11]	+3.0%	+2.0%	-0.4%	15%
Brand	+9.3%	+2.0%	+11.4%	25%
Vaccines	+10.0%	+2.0%	+12.2%	1%
OTC	-	+2.0%	+2.0%	0%
Devices	+10.0%	+2.0%	+12.2%	1%
Compounds	-	+2.0%	+2.0%	0%
Specialty[12]	+9.7%	+9.1%	+19.7%	57%
Total[13]	***+6.8%***	***+6.1%***	***+13.2%***	***100%***

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

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[11] Generic drugs include both those which have been available as generics in the base period, and those that will become generic during 2022 or 2023. There is an additional adjustment made to capture this dynamic, which is why the total Unit Cost trend is not the weighted average of the Unit Cost trend by tier.

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

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

The historical Rx trend analysis begins with a review of historical non-specialty utilization. This analysis combines brand and generic drugs, as members often have a choice of whether to purchase the brand or generic versions of a given non-specialty drug. Unlike the medical trend analysis, pharmacy claims did not demonstrate COVID-19 disruptions.

The most recent three years of utilization trend data for non-specialty drugs show increases of 1.4%, 3.2%, and 1.3%. This fairly stable level of increase supports BCBSVT's assumption that it is a continuing trend that will continue into the future, and L&E agrees that an assumption of 2.0% for the next two years is reasonable.

Unit costs for generic drugs increased an average of 2.4% over the last three years. BCBSVT selected a generic unit cost trend of 3.0% per year. Based on historical data alone, this assumption might appear high. However, in light of substantially higher inflation, L&E believes the assumed 3.0% is reasonable.

Brand unit costs have increased substantially in recent years. The increases in average cost per script were 7.1%, 7.0%, and 10.1% in 2019, 2020, and 2021 respectively. BCBSVT selected a trend estimate of 10.0%. While this is materially higher than the three-year average or the two-year average, we note that the inflation environment has changed, and it is reasonable to expect that cost inflation in 2022 and 2023 will be elevated from the levels observed in recent years, when inflation was substantially lower. We believe the brand cost trend is reasonable.

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

ACTUAL ANNUALIZED ALLOWED SPECIALTY RX TRENDS – 2018 TO 2021

Year	Annual Allowed Specialty Trend
2021/2020	13.5%
2020/2019	26.5%
2019/2018	4.3%
Three-year Average	14.4%

BCBSVT selected a net annual allowed trend of 19.7% per year for the specialty tier. L&E believes this is a reasonable assumption based on recent trends and particularly the volatility observed.

L&E also reviewed prescription drug trends in aggregate. While the actual 2020 and 2021 prescription costs were both slightly below their respective filing projections, there does not appear to be a pattern of over- or under-projecting trend for prescription drugs, and BCBSVT appears to be reasonably incorporating incoming information in the development of this assumption.

ACTUAL AND PROJECTED RX TRENDS – 2018 TO 2023

Year	Filed Annual Trend Projection	Actual Annual Trend Result
2018 to 2020	12.0%	11.1%
2019 to 2021	13.4%	10.3%
2020 to 2022	11.1%	N/A
2021 to 2023	13.4%	N/A

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

TOTAL PROJECTED ALLOWED TREND

2021 to 2023	Annual Allowed Trend
Medical	9.0%
Rx	13.2%
Combined	9.9%

As noted previously, L&E recommended that the overall medical allowed trend be reduced to 8.5%.

4. **CHANGES TO POPULATION MORBIDITY ADJUSTMENT:** In the 2022 filing, the Company estimated that the projected 2022 population morbidity would be 1.2% higher than the 2020 experience period morbidity.

   In the 2023 filings, the population morbidity is projected to be approximately 0.3% lower than the 2021 experience period. The rates are therefore decreasing by the difference between the factor in this filing and the factor in the previous filing, or -1.5%.

   The claims that underlie this rate filing are from 2021. Since this rate filing was submitted after the 2022 Open Enrollment Period, BCBSVT knows which 2021 members remained in the block and which members no longer had coverage. To assess changes to pool morbidity, the Company separated the 2021 experience into those members who remained in 2022 and those who left in 2022. The impact of the members who left is expected to decrease the average claims level by 0.3%.

   L&E finds the population morbidity assumption to be reasonable and appropriate. As noted during L&E's review, BCBSVT accidentally reported the ARPA adjustment in the wrong place in the Unified Rate Review Template (URRT). We recommend this adjustment be moved from "Other" to "Morbidity", but such a change has no pricing impact. This will be discussed further in the "Other" section below.

5. **DEMOGRAPHIC SHIFT:** This factor represents the expected change due to the aging of the population, newborns entering the covered population, and other demographic shifts between 2021 and 2023.

   Last year's filing assumed that change in the age of the population would lead to a 0.6% decrease in costs. However, updated data suggests that the population will be substantially younger in 2023 than in 2021, resulting in a 1.2% decrease in cost. Replacing a 0.6% decrease with a 1.2% decrease has the net effect of reducing rates by 0.6% from the previous approved level.

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

6. **PLAN DESIGN CHANGES:** The plan design changes factor addresses any rate changes that are needed because members purchase products with different plan designs versus the prior year. Because BCBSVT observed a change in purchased plan designs in 2022, BCBSVT expects a change in average cost sharing and average utilization from the experience period to the projection period.

   Since members are expected to choose plans with higher cost sharing in 2023 compared to 2021, there is an anticipated 0.4% decrease in utilization. The projected enrollment shift by plan and benefit level is based on emerging 2022 experience, and therefore reflects more up-to-date information than the 2021 base period plan selections.

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

   This decrease is driven largely by the assumption that Silver enrollment will swell when Medicaid resumes eligibility terminations. During the public health emergency, enrollees in Medicaid were permitted to remain enrolled regardless of income changes. As referenced by BCBSVT, the Kaiser Family Foundation estimated that 17% of current Medicaid enrollees would lose Medicaid coverage. BCBSVT then assumes that all adults who lose Medicaid coverage will elect either employer coverage or individual coverage.

   This appears that it might be a slightly aggressive assumption. As BCBSVT noted on May 27, 2022, members transitioning from Medicaid will likely be eligible for substantial subsidies. However, a Kaiser Family Foundation analysis of income and coverage data found that about 7 million uninsured non-elderly Americans are eligible for Medicaid[14], typically with no premium. They also noted that many consumers most likely to benefit from subsidies and other assistance

[14] https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/

"lack basic information about the ACA and available coverage options", and this contributes to their remaining uninsured despite available, affordable coverage. We think it is reasonable to assume that some percentage of these individuals will become uninsured, either due to the premium requirements or other barriers to accessing care.

L&E is not recommending changes to this factor at this time.

7. **CHANGES TO OTHER FACTORS:** BCBSVT expects other changes to incurred claims to account for a 0.8% increase relative to the prior filing. This reduction is the result of replacing last year's 6.5% decrease[15] with the following factors:

NON-SYSTEM CLAIMS: -5.8%
This includes changes to pharmacy rebates, Blueprint payments, Interplan Teleprocessing System (ITS) fees[16], vaccine payments (excluding COVID vaccines), and the net cost of reinsurance. The primary driver of this change is the reduction to pharmacy costs due to a growth in pharmacy rebates.

CHANGES DUE TO ARPA: -0.1%
The American Rescue Plan Act of 2021 provides for substantially higher subsidies for many purchasers in the individual market. BCBSVT assumed that the increase in enrollment from September 2021 to January 2022 was the result of new members entering the market in response to these subsidies. BCBSVT additionally assumed that these members would be healthier than the usual individual market member, due to their decision to remain uninsured prior to the availability of the enhanced subsidies.

The increase in enrollment from September 2021 to January 2022 appears to be much smaller than in a typical year. Because open enrollment is available only at the end of the year, January enrollment is usually the highest, with enrollment dropping off over the course of the year. BCBSVT pointed out that this seasonal variation in enrollment was the lowest in recent years during 2021, with September enrollment at 97.2% of January enrollment. While this may be true, even that reduced level of seasonality more than explains the 1.3% increase in enrollment between September 2021 and January 2022.

In response to this concern, BCBSVT indicated that they believe the 0.1% reduction is reasonable in light of DVHA reporting and shifts in BCBSVT enrollment between direct and Exchange enrollment. So, while we have concerns with the calculation of this factor, the explanation provided by BCBSVT is reasonable and we think the resulting factor is reasonable.

However, we would like to note that this factor assumes that ARPA enhanced subsidies will continue to be funded for 2023. Under current law, these subsidies will expire at the end of 2022. While it is possible that Congress will extend these subsidies, it is far from certain. If the subsidies do expire, many existing members will see their premiums rise significantly, which

[15] As previously noted, we have treated the 2022 COVID adjustment as a component of base period experience rather than as an "other" factor for the purpose of this report.

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

could cause a reduction in the number of insured individuals and an increase to the average morbidity level of the insured.

So, while we agree with BCBSVT that the 0.1% reduction to claims is reasonable if the subsidies are extended, an increase to rates would be appropriate based on current law. Last year, BCBSVT estimated the favorable impact of the subsidy enhancement to be a 0.7% reduction to individual premiums. As an estimate, we assume that the termination of the enhanced ARPA subsidies would necessitate a 0.7% increase to the rates.

As noted elsewhere, this factor was wrongly placed in the "other" category of the URRT, rather than the "morbidity" section. We recommend it be moved, with no pricing impact.

IMPACT OF PROJECTED PANDEMIC COSTS: +0.7%
The projected claims for 2023 reflect an allowance for testing for and direct treatment of COVID-19. This is based on the average of such costs between May 2021 and July 2021, when these costs were at their lowest during the year. Note another factor removes COVID-19 costs from the base data, so there is no double-counting. We believe this assumption that direct COVID-19 costs during 2023 will look like the low periods during 2021 is reasonable.

INCREASE TO BASE PERIOD CLAIMS FOR COVID SUPPRESSION: +0.3%
As discussed in the section regarding facility utilization trends, BCBSVT has adjusted the 2021 claims data for emergency services. The adjustment increases claims from the actual 2021 level to correct for the artificial reduction to emergency services when COVID-19 cases were high. Similarly, BCBSVT is adjusting 2021 claims for the abnormally low levels of influenza observed that year. Both of these adjustments reflect reasonable, well-supported adjustments to the data that result from temporary effects of COVID-19. We believe applying this 0.3% increase to 2021 claims is reasonable for the purpose of projecting 2023 claims levels, when COVID cases will likely be much less common.

OTHER MISCELLANEOUS CLAIMS IMPACTS: -0.6%
Various other minor adjustments are made to reflect catastrophic claimants, whose experience is volatile and therefore smoothed out between years; direct COVID claims, which are removed from the base period experience; non-Essential Health Benefit claims; and changes in provider networks. L&E reviewed these changes, and they appear reasonable.

8. **CHANGES TO RISK ADJUSTMENT:** Under the Affordable Care Act, premiums are transferred between carriers in this market based on the age, sex, and health status of the enrolled members. BCBSVT consistently receives funds through this system, known as "Risk Adjustment", in this market. This additional funding serves to reduce the necessary premium. BCBSVT's updates to their projection of risk adjustment resulted in a filed rate increase of +1.9%.

   BCBSVT projected the 2023 risk adjustment transfer payment based on the most recent data available at the time of the rate filing. The data available was: 1) CMS's interim risk adjustment

report[17] published March 22, 2022, and 2) BCBSVT's internal risk adjustment data. Slightly complicating projections, 2021 risk transfers were still based on a merged individual and small group market. So, BCBSVT had to estimate the impact of the unmerging to estimate what the CMS data implied about the individual market alone. Based on this combined information, BCBSVT estimated that the final 2021 risk adjustment receivable would be $12,890,855 for the individual market. Despite a slight increase to enrollment and increasing premiums, this transfer is nearly unchanged from the 2020 transfer. So, shrinking relative to the total claims costs, this updated risk information leads to an increase in necessary premiums.

Using this estimate, BCBSVT projected CY2023 risk transfers. This projection considers changes to the number and demographics of the enrolled population, changes to the marketwide average premium, and changes the statistical model used by CMS to calculate transfer payments. This last factor has a significant impact. According to CMS, the changes being made to the model are likely to reduce the magnitude of transfers from carriers with healthy members to carriers with sicker members. Relying on CMS' estimate of this impact, BCBSVT adjusted their projection of CY2023 risk adjustment transfers. This contributed to a further rate increase.

Actual risk adjustment transfers were published[18] by CMS on June 30, 2021. Based on the report and analysis performed by L&E using confidential information from both carriers, BCBSVT will receive $13,209,383 in risk adjustment payments for the individual market.

We recommend that the Board require that BCBSVT use this updated transfer estimate in calculating the final premiums. The approximately $0.3 million increase in receivables over BCBSVT's original expectations produces a 0.1% decrease in premiums.

9. **CHANGES IN ACTUARIAL VALUE:** The Change in Actuarial Value (AV) assumption reflects Pricing AV changes, such as changes in Metal AVs, induced utilization, cost sharing changes, and changes in projected enrollment among plans. The decrease in the AV assumption is 0.2% relative to the 2021 filing.

   As previously discussed, BCBSVT is projecting that a substantial portion of members in 2023 will come from current Medicaid enrollment and will enroll in Silver plans to take advantage of premium subsidies and cost sharing reductions. This results in a net shift towards Silver plans from richer benefit levels, resulting in a decrease to overall claims and therefore premium. L&E considers the projected actuarial values reasonable and does not recommend changes to this assumption.

   During L&E's review, the plan design for some plans was changed slightly to comply with updated IRS guidelines regarding High-Deductible Health Plans. We recommend that the rates for these

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

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

plans be reduced slightly, producing a reduction to the overall rate level of less than 0.1%. L&E considers this change to be reasonable, and L&E recommends it be applied in the final filing.

10. **CHANGES IN ADMINISTRATIVE COSTS:** The 2023 administrative costs are projected to be 1.0% lower than 2022 on a percentage of revenue basis. That is, administrative costs are projected to grow by 1.0% less than premiums.

 The 2023 projected administrative cost is based on the following analysis:

 - *Base Administrative Charges:* A base administrative cost of $55.02 PMPM is included equally in all plans' rates to cover BCBSVT's operating costs. This amount reflects actual 2021 administrative costs of $49.25 adjusted for two factors, as outlined in the following table.

DEVELOPMENT OF BASE ADMINISTRATIVE CHARGES

Line Item	Impact PMPM	Updated Admin Cost PMPM
Actual 2021 Admin Cost	-	$49.25
Administrative Cost Trend	$4.02	$53.27
Impact of Membership Changes	$1.75	$55.02

 - *Administrative Cost Trend*: Costs are projected forward to 2023 using a 4% annual trend. In past filings, a lower rate was applied solely to personnel costs. However, in light of the current inflation environment, we believe an assumption of 4% increase per year is reasonable.
 - *Impact of Membership Changes*: BCBSVT estimates that 70% of the allocated base administrative expenses are fixed costs, and therefore changes in enrollment cause changes in administrative costs PMPM. While total enterprise enrollment is growing, there is also a shift towards Medicare Advantage and other lines of business whose administrative costs are distinct from BCBSVT's core business. As a result, the fixed costs for their core business are expected to be spread over fewer members in 2023 than in 2021. The result is a 3.3% increase to the projected administrative costs on a per member basis.

 - *Administrative Charges for Outside Vendors:* Dental and vision benefits are administered by third parties. In addition, an external vendor provides HSA and HRA integration services. The fees charged for these programs are equivalent to a $0.21 PMPM in the individual market. No adjustment was made to the base period data for this item.

 - *VHC Billing*: As of 2022, BCBSVT is responsible for billing members enrolled through VHC. The difference between projected admin costs and the preparatory expenses included in the 2021 base period is equivalent to $3.48 PMPM.

- *Credit Card Fees:* BCBSVT members can pay their premiums with debit and credit cards. Based on the first three months of 2022, 0.25% of total premiums in the individual market were charged as transaction fees. BCBSVT has appropriately reflected this amount in the premiums.

In addition to reviewing each of BCBSVT's specific proposed modifications, L&E also compared BCBSVT's administrative costs for the individual and small group markets to other nationwide BCBS plans. The comparison was based on a review of the 2021 National Association of Insurance Commissioners (NAIC) Annual Statements.

BCBSVT's administrative costs on a percentage of premium basis ranked 31st out of 62 plans assessed. That is, on a percentage of premium basis, BCBSVT had lower expenses than approximately 50% of the Blues plans who sold individual and small group products.

BCBSVT's administrative costs on a PMPM basis ranked 10th out of 62 plans assessed. That is, BCBSVT had higher PMPM expenses than approximately 85% of Blues plans.

While we note that BCBSVT was previously on the low end of administrative costs for Blues plans nationally, it is important to note that Vermont is a relatively small state and has fewer members to spread fixed cost over than most other Blues plans. As such, we do not think that being at the 85th percentile for administrative costs PMPM is unreasonable for BCBSVT.

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

11. **CHANGES IN TAXES & FEES:** The 2023 taxes and fees provision are projected to be 0.1% lower than 2022 as a percentage of premium revenue. The decrease is due to some fees, such as the federal PCORI assessment and the Risk Adjustment user fee, being fixed as PMPM values and therefore shrinking relative to the proposed premiums. The projected taxes and fees appear reasonable and appropriate.

12. **CHANGES IN CONTRIBUTION TO RESERVES:** The Company has proposed an aggregate contribution to reserve of 1.0% which consists of:
    - A base CTR of 1.5%,
    - A reduction of 0.7% to remove projected direct COVID treatment costs from the proposed rates, and
    - An additional 0.2% to account for uncollected premiums and bad debt.

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

ACTUAL-TO-EXPECTED BASE CTR

Year	Company Expected	Company Actual[19]
2014	-0.1%	1.0%
2015	1.0%	-2.5%
2016	0.8%	-3.8%
2017	1.0%	1.0%
2018	-3.8%	-1.8%
2019	0.0%	-0.7%
2020	1.5%	5.5%
2021	1.5%	0.7%
Cumulative	0.6%	-0.2%

As a reasonableness check of the proposed CTR provision, L&E reviewed the Center for Consumer Information & Insurance Oversight (CCIIO) public use files (PUFs). In 2022, there were 442 carriers who submitted individual or small group ACA filings nationally. The filed CTR varied from -17% to +9%, but most often fell between 0% and 5%. The mode is between 2% and 3%, and the premium-weighted average CTR for all carriers was filed as 2.4%. BCBSVT's filed base CTR of 1.5% would place it at around the 27th percentile for all QHP carriers.

In addition to considering the CTR across the other carriers nationally, L&E considered BCBSVT's projected RBC position. To model projected RBC levels, BCBSVT used stochastic modeling which generated 10,000 scenarios based on membership, claims, and other assumptions across BCBSVT's lines of business. L&E reviewed these assumptions and believe they are reasonable inputs for projecting 2023 RBC.

L&E believes the range of potential RBC positions and their resulting likelihoods from BCBSVT's stochastic modeling is reasonable. Given the RBC positions modeled, along with ongoing uncertainty surrounding several items that could negatively impact the Company's overall RBC position, such as the expiration of the enhanced subsidies from ARPA and the impact of COVID on utilization trends, L&E does not recommend a change from the base CTR of 1.5%.

BCBSVT is reducing the requested load for CTR to remove the direct costs of COVID treatment from the projected premiums. This results in a reduction to the CTR of 0.7%. L&E notes that this means expected "true" CTR would be negative if the base CTR were reduced below 0.7%. Additionally, a base CTR of 3.0% would be in line with typical individual and small group filings nationally. L&E believes a reasonable range for the base CTR is 0.7% to 3.7%.

Due to the required grace period under the Affordable Care Act, the Company included an additional risk margin provision for bad debt of 0.2% to pay for the claims for members for which premiums are never collected. The average amount of non-paid premiums due to the grace period

[19] 2015 and 2016 actuals are adjusted to remove risk corridor payments. Risk corridor payments exist to correct for mispricing, and therefore should be excluded when evaluating pricing performance.

provision over the last four years was consistently 0.2%. L&E deems the addition of 0.2% for the grace period to be reasonable.

13. **CHANGES IN SINGLE CONTRACT CONVERSION FACTOR:** A conversion factor[20] adjustment is used to convert and allocate the gross claim costs to premiums based on state-mandated tier factors. The single conversion factor is decreasing by 0.7% from the prior filing. This corresponds roughly to a slight decrease in the number of covered children per policy and is based on emerging 2022 membership data. This is considered reasonable and appropriate.

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

RECOMMENDATIONS

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

- **CONSIDER UPDATED HOSPITAL BUDGET INFORMATION:** If updated information regarding unit cost trends is known at the time of the Board order, L&E recommends updating the assumed unit cost trends in the 2023 premium rate calculations. The impact of such a change cannot be estimated at this time, but it appears likely this will result in an increase to premiums.

- **CORRECT UNIT COST TREND CALCULATION:** As BCBSVT acknowledged during L&E's review, the unit cost calculation for one facility was applied incorrectly. Correcting this mistake results in approximately a 0.1% reduction to premiums.

- **CORRECT URRT FOR ARPA ADJUSTMENT:** As BCBSVT acknowledged during L&E's review, the adjustment for the American Rescue Plan Act (ARPA), labeled adjustment b7 in the filing, was applied in the wrong section of the Unified Rate Review Template. This correction has no premium impact.

- **REFLECT UPDATED RISK ADJUSTMENT TRANSFERS:** L&E recommends that the projected risk adjustment receivable be changed to reflect the final market-wide figure announced by CMS and the market-specific risk transfers estimated by L&E. This will decrease rates by approximately 0.1%.

- **REFLECT FINAL PLAN COST SHARING:** L&E recommends that the rates be updated to reflect IRS-required changes to the HDHP benefit designs. This change produces an immaterial reduction to the overall rates.

- **REDUCE MEDICAL UTILIZATION TREND:** L&E recommends that the medical utilization trend assumptions be modified such that the average medical utilization trend is 1.5% per year. This change reduces overall rates by approximately 0.7%.

After the modifications, the anticipated rate changes will change from +12.3% to +11.3%, plus any impact from updated hospital budget information.

2023 RECOMMENDED RATE CHANGES

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

Rating Component	BCBSVT Filed	L&E Recommendation
1. 2021 Actual/Projected Claims Experience	+1.8%	+1.8%
2. Difference in Trend from 2021 to 2022	+1.4%	+1.1%
3. Trend from 2022 to 2023	+10.8%	+10.4%
4. Changes to Population Morbidity Adjustment	-1.5%	-1.6%
5. Demographic Shift	-0.6%	-0.6%
6. Plan Design Changes	-0.2%	-0.2%
7. Changes to Other Factors	+0.8%	+1.0%
8. Changes to Risk Adjustment	+1.9%	+1.7%
9. Changes in Actuarial Value	-0.2%	-0.2%
10. Changes in Administrative Costs	-1.0%	-1.0%
11. Changes in Taxes & Fees	-0.1%	-0.1%
12. Changes in Contribution to Reserves	-0.3%	-0.3%
13. Changes in Single Contract Conversion Factor	-0.7%	-0.7%
Total Proposed Rate Change	**+12.3%**	**+11.3%**

Sincerely,

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

Jacqueline B. Lee, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 DISCLOSURES

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

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

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Kevin Ruggeberg, FSA, MAAA, Vice President & Consulting Actuary.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal.
- Jason Doherty, ASA, MAAA, Consulting Actuary

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 5, 2022. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is June 30, 2022.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

- Lewis & Ellis is financially and organizationally independent from BCBSVT. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.

- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.

- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

- Lewis & Ellis has reviewed the data provided by BCBSVT for reasonableness; however, not every aspect of the data has been audited. Neither L&E, nor the responsible actuaries, assume responsibility for the items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

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

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

- Notwithstanding the ongoing COVID-19 pandemic, L&E is not aware of any subsequent events that may have a material effect on the findings.

- There are no other documents or files that accompany this report.

ACTUARIAL FINDINGS
The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA
The methods, procedures, assumptions, and data used by the actuaries can be found in body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW
This report was prepared as prescribed by applicable law, statues, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS
The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP
The actuaries have not deviated materially from the guidance set forth in the applicable ASOPs.