LEWIS & ELLIS
Actuaries and Consultants
6600 Chase Oaks Blvd.
Suite 150
Plano, TX 75023
972-850-0850
lewisellis.com

April 4, 2024

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05602

Re: Blue Cross and Blue Shield of Vermont 2025 Large Group Filing (SERFF # BCVT-133971481)

The purpose of this letter is to provide a summary and recommendation regarding the proposed Large Group Filings for Blue Cross and Blue Shield of Vermont (BCBSVT) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides coverage to individuals, small and large group employers, and Medicare enrollees in Vermont.

2. This filing establishes the formula, manual rate and accompanying factors that will be used for Large Group renewals. This filing includes support for key assumptions, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors. The overall impact of this filing was estimated based on the previously approved factors from the prior filings.

3. This filing addresses BCBSVT Insured and Cost Plus large groups. There are approximately 2,446 subscribers and 4,264 covered lives affected by this filing.

4. The most important component of any group's premium is their past claims experience. Group-level premiums for coverage years beginning 1Q 2025, for example, will be based on the most current experience available at the time. For this reason, no group's actual premium increase pursuant to this filing is currently known.

5. As initially filed, the average premium change of a manually rated group was approximately 8.4%[1], or roughly $68.43 PMPM, itemized below.

    a. Change to Projected Claims: +**8.2%**
    b. Change from Projected Pharmacy Rebates: **+0.4%**
    c. Change in Administrative Charges: **-0.7%**
    d. Change in Contribution to Reserve: +**0.3%**
    e. Change in Additional Items[2]: +**0.2%**

[1] The itemized changes are multiplicative and may not add up to the total.

[2] Additional Items include net cost of reinsurance, broker commissions, and payment reform initiative costs.

6. The actual premium increase experienced by a particular group will vary from the average of +8.4%. Each group's rate increase or rate decrease will consider their recent claims experience, changes in the distribution of members enrolled, and changes in benefits. A newly formed large group would experience 1Q2025 premiums that were approximately 8.4% higher than a similar newly formed large group in 1Q2024.

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested 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 law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the proposed methodology used to calculate the Insured and Cost Plus large group premiums for groups renewing after approval of this filing. The Company provided exhibits and support for each component of the premium development, including trend, administrative costs, contribution to reserves, aggregate stop loss and risk charge factors, network changes and large claim factors.

For medical trend development, the Company used claims incurred from October 1, 2019 to September 30, 2023, paid through November 30, 2023. The data includes claims from BCBSVT Cost Plus groups, BCBSVT Administrative Services Only (ASO) groups with less than 1,001 members, BCBSVT Insured Small and Large Groups with greater than 10 members, BCBSVT insured AHPs, and The Vermont Health Plan (TVHP) Insured Large Groups. The Company felt that combining these populations created greater consistency and credibility within the trend factor development. Adjustments were made to the data to reflect network differences between the two companies. Trend for members who have Medicare as their primary coverage was analyzed separately.

Filing Analysis

1. *Updated Experience Base:* For the combined BCBSVT block that is used for rate development, the projected claims are expected to increase 9.0% over what was assumed in the prior filing. Because there are non-claims components of the premium, this translates to an 8.2% premium increase. The claims used were incurred from October 2022 through September 2023, paid through November 2023.

   Total claims were substantially higher than projected during the experience period, resulting in financial losses on this business. However, BCBSVT is choosing not to reflect all of those claims in this filing. Consistent with prior years, the actual claims observed which exceeded $120,000 annually for an individual are replaced by a long-term average "pooling charge" in order to maintain stability in the premiums. The pooling factor assumptions are based on data from Milliman and based on nationwide information. Due to the volatility of these high claims, BCBSVT likely does not have sufficient data to develop their own factors.

   The assumed pooling charge was significantly less than the actual high claims during the base period. L&E notes that this is the third year in a row during which the pooling charge was noticeably lower than actual catastrophic claims. If this pattern continues, BCBSVT will continue to experience significant financial losses on this block. Pooling is a typical industry practice and has been seen in most filings reviewed by the Board.

   If the base period experience were used without any adjustments for outlier claims, L&E estimates that the implied premium increase would be about 4% higher than what is proposed in this filing. See below for our estimate of the impact:

Increase As Filed	+8.4%
L&E-Estimated Increase with no Pooling	+12.5%

L&E believes pooling is reasonable, as this block is small enough that some amount of random fluctuation is likely. BCBSVT's pooling methodology appropriately reduces the volatility in premiums. Thus, a 12.5% increase would not be reasonable in this context. However, we have some concern that the pooling charge has consistently underestimated the amount of catastrophic claims for this block in recent years.

However, it is difficult to know whether the pooling charges used are inadvertently producing a claims estimate which is systematically high or low. We believe the uncertainty created by the recent unfavorable experience with high-cost claimants should impact how the Board considers other assumptions like trend and Contribution to Reserves. This uncertainty makes precise quantification difficult, but an increase to the manual rate projections claims could be reasonable.

2. *Medical Trend Development:* Medical trend varies by plan type due to contracting differences. For all products combined, the Company is requesting a total allowed[3] medical trend of 7.8% per year. This total allowed medical trend amount is broken down into 8.1% for hospital claims, 7.6% for Mental Health professional claims, 6.4% for other professional claims, and 10.7% for outpatient drugs.[4]

Category	Unit Cost	Utilization	Total	Share of Allowed
Hospital	6.2%	1.8%	8.1%	65%
Mental Health Professional	4.5%	3.0%	7.6%	3%
Other Professional	4.5%	1.8%	6.4%	25%
Outpatient Drugs	6.5%	4.0%	10.7%	7%
Total			**7.8%**	

Utilization and Intensity

The Company normalized the allowed costs to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. To reduce fluctuation and capture only trend, the Company also removed outlier claimants. This data was then analyzed by using exponential regression and other methods.

L&E reviewed the data and analysis provided by the Company, which includes:

- Month-by-month claims data;
- Year-over-year rolling PMPMs; and
- Exponential and linear regressions.

[3] Allowed cost trends are based on charges that reflect the total amount of claims paid by both the carrier and the policyholder. Paid trends reflect the actual claim payment made by the carrier only. Paid trends are usually higher because the member's share of the cost is often limited to fixed copays which do not increase with cost trend.

[4] Many specialty drugs, such as certain chemotherapy treatments, are often covered under a policy's medical benefit. These drugs are separate from the Rx experience and trend discussed in the next section but have exhibited similarly high trend in recent years.

BCBSVT's utilization trend analysis breaks medical claims into four broad categories: Hospital Facility, Mental Health Professional, Other Professional, and Outpatient Rx. These classifications are reasonable due to the unique patterns of utilization and response to the COVID-19 pandemic that these claims have exhibited in recent years.

Mental Health utilization rose sharply in 2020, and then rose again more gradually in 2022. BCBSVT selected a utilization trend for mental health professional services of 3% per year. This rate is slightly lower than the average over the post-2020 period and is lower than the observed trend in any year since 2019.

Very similarly, non-mental health professional claims exhibited a sharp increase coming out of 2020 and into 2021, and they have exhibited a much lower but positive rate of utilization trend thereafter. BCBSVT assumed a 1.8% per year prospective utilization trend, which is again slightly lower than the observed trend in recent years.

Facility claims have exhibited a less clear pattern of utilization in recent years, but broadly still show a pattern of increasing utilization since the end of the public health emergency related to COVID-19. The assumed 1.8% annual increase to utilization is, as with the other service categories, slightly lower than has been observed in recent years.

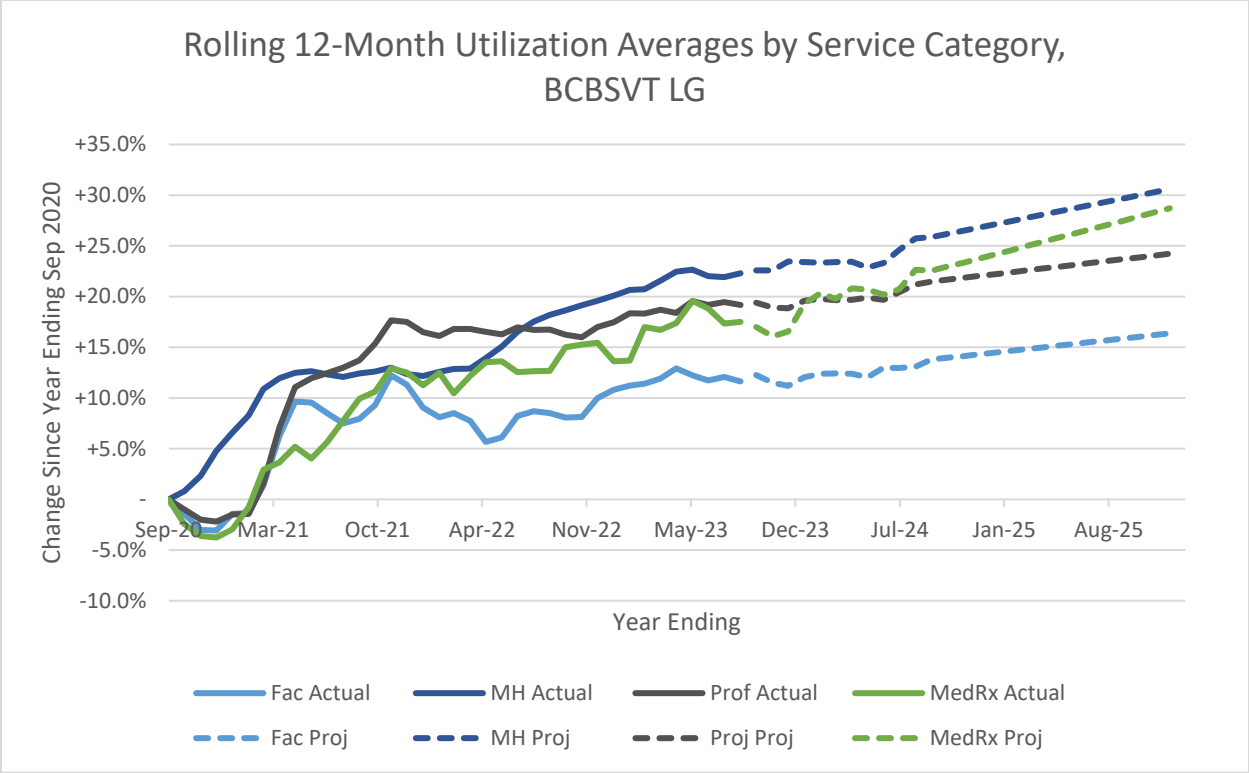
Consistent with last year's filing, BCBSVT has isolated claims related to pharmaceuticals covered by the medical benefit (as opposed to pharmaceuticals dispensed in a retail pharmacy setting). These prescriptions are differentiated from others due to their being subject to medical deductibles and cost sharing rather than the prescription drug benefits. This is often because they are dispensed in an outpatient medical facility. For simplicity, we will refer to these as "Outpatient Rx" in this report.

The utilization of Outpatient Rx has grown each year since 2020. As summarized in BCBSVT's actuarial memorandum, the utilization trend has fluctuated by year as follows:

Year Ending	Utilization Change since prior 12 months
September 2021	+9.9%
September 2022	+2.5%
September 2023	+4.3%

BCBSVT has proposed a utilization trend assumption of +4.0% per year for Outpatient Rx.

The historical utilization and projected utilization for these service categories are summarized in the following chart.



L&E does not recommend any changes to the medical utilization trend assumptions.

Unit Cost

The unit cost trend for medical costs is projected to be 5.7% based on an analysis of the hospital budget increases implemented in recent years as well as other providers in the BCBSVT service area outside of the Board's review.

This projection includes a 5.8% increase for Vermont facilities and providers impacted by the GMCB's hospital budget review and an increase of 5.6% for other facilities and providers. The increase for GMCB-regulated facilities is consistent with the budget orders approved in 2023. The assumed hospital budget increases to be approved in 2024 and 2025 are assumed to be the average of approvals over the last 5 years, excluding mid-year increases. The GMCB has issued hospital budget guidance that could result in lower budgeted increases than in past years. However, given the uncertainty of the impact of this guidance, it appears appropriate to approve the assumptions as filed and review a revised filing should hospital budget increases differ materially from the projections in this filing.

L&E found during our review that a mistake was made in calculating the 5-year average rate change. BCBSVT calculated that the impact of correcting this mistake would be to increase manual rate claims

by 0.01%. This amount does not appear material and L&E does not believe a revision to the filing is necessary to correct this mistake.

Unit cost increases for providers outside the BCBSVT service area were derived from the Blue Trend Survey.[5] L&E does not recommend any changes to the medical unit cost trend assumptions.

Total Allowed Medical Trend

With the combination of the utilization and intensity trends, the unit cost trend, and the outpatient drugs trend, the total medical allowed trend in the filing is 7.8%. The components are shown in the table below:

Medical Cost Type	Cost Trend	Utilization Trend	Total Allowed Trend
Facility	6.2%	1.8%	8.1%
Mental Health	4.5%	3.0%	7.6%
Other Professional	4.5%	1.8%	6.4%
Outpatient Rx	6.5%	4.0%	10.7%
Total			**7.8%**

3. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend, including the impact of contracting changes with the Pharmacy Benefit Manager (PBM), of 11.0%. This aggregate assumption is composed of the following components:
    - Non-specialty utilization trend
    - Generic cost trend, separately for new and established generics
    - Brand cost trend, separately for new and established brands
    - Impact of brand drugs going generic
    - Specialty trend
    - Vaccines, OTC, etc.

    The Company modeled the costs for generic and brand drugs separately; however, they did combine the data to analyze utilization patterns. A separate adjustment was then made to incorporate the impact of brand drug patent expiration, which results in a decrease in cost as lower-cost generics become available.

    The Company modeled separately the total PMPM trends for specialty drugs due to their relatively low utilization and high cost nature. The following table shows the results of the Company's analysis and the requested 11.0% overall allowed pharmacy trend.

[5] The Blue Trend Survey is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend After Contract Changes[6]
Generic	3.3%	3.1%	
Brand	4.5%	3.1%	
Brands Going Generic	N/A	3.1%	
Specialty			14.0%
Total			**+11.0%**

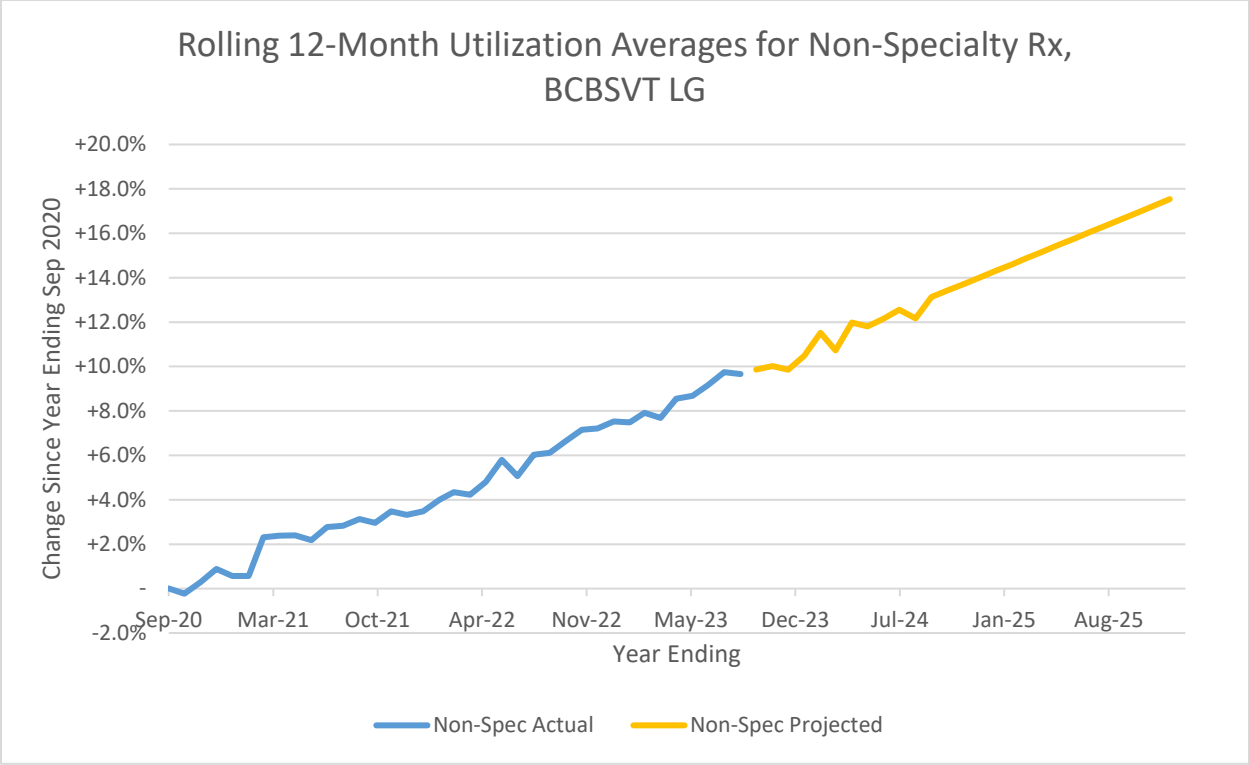
The Company calculated unit cost trends of 3.3% for generic and 4.5% for brand drugs. Both of these are consistent with recent trends in the observed changes in cost for these categories, as demonstrated in the Company's Exhibit 2D.

When the patent expires for a brand drug, lower-cost generic alternatives become available. The Company projected the quantity and reduced cost for drugs which will become genericized during the projection period. These drugs are assumed to reduce substantially in price due to the availability of generic alternatives.

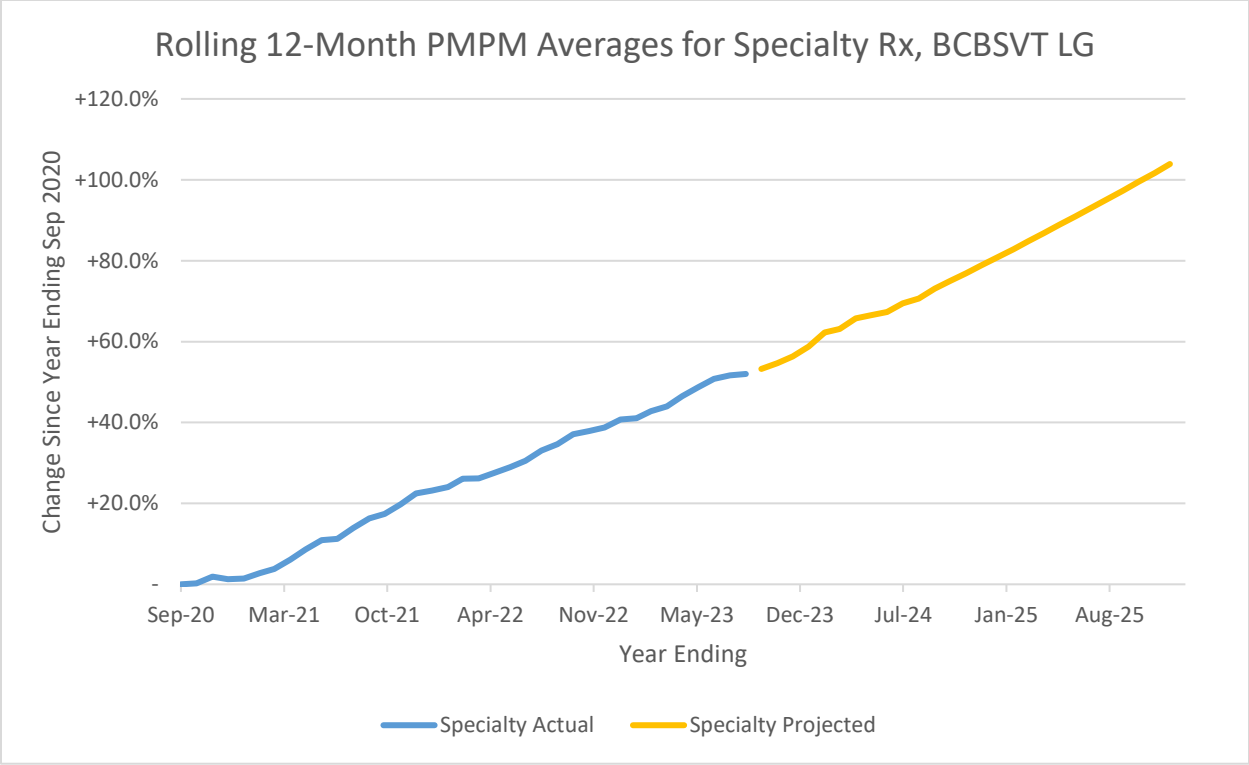
L&E believes the method of projecting brands going generic is reasonable and appropriate. The assumed unit cost trends for generic, brand, and brand-going-generic are reasonable.

The utilization trend for non-specialty drugs is projected to be 3.1% per year. This is based on historical utilization rising steadily between 2018 and 2022. Given the stability of recent trend experience, the selection of a 3.1% utilization trend is reasonable. Below shows the increase in non-specialty drugs dispensed since 2020, as well as the projected increase for 2025.

[6] The total trend may not equal the combination unit cost and utilization trend due to the additional adjustment for projected mix between new and established generics/brand. Some components of this table are suppressed for confidentiality of contract terms.



Due to their high cost and low frequency, specialty drugs are projected based on their allowed cost, without splitting into unit cost and utilization. L&E agrees with the Company's decision to analyze specialty cost trend this way, as the utilization trend would be difficult to assess given the low frequency and wide variance in unit costs. Historical and projected specialty trend is shown below:



Historical costs have increased at a steady, high rate for several years. The years ending in September of 2021, 2022, and 2023 exhibited cost increases of 16.3%, 15.8%, and 12.9% respectively. The assumed specialty trend is 14.0%, based on regression analysis of historical claims. The Company's selection of a 14.0% trend assumption is reasonable in light of the historical increases in cost observed.

The Company projects overall pharmacy allowed trend to be about 11.0% per year. This reflects not only unit cost and utilization changes but also contracting changes with the PBM (Pharmacy Benefit Manager). This total pharmacy allowed trend is reasonable in aggregate as well as when analyzed by the components described above.

After calculating this trend based on historical data, BCBSVT applies a separate adjustment to reflect a component of the American Rescue Plan Act which removed the cap on Medicaid rebates. This legislation is expected to reduce drug costs and rebates. With this adjustment, which is documented in Exhibit 2H and based on projections from BCBSVT's Pharmacy Benefit Manager, the overall prescription drug trend reduces from 11.0% to 9.4%. It is worth noting that this reduction is coupled with a projected decrease in prescription drug rebates. The combined effect of these two changes is an approximate 0.3% increase to the full manual premium.

4. *Total Allowed Trend:* Total allowed costs are projected to increase at 8.1% per year.

Category	Allowed Trend	Approx. Percent of Claims
Medical	7.8%	82%
Rx	9.4%	18%
Total	**8.1%**	**100%**

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends, as this is the clearest way to view changes in cost and utilization. However, plan liability increases at the paid trend rate, not the allowed trend rate. Therefore, an adjustment was made to the calculated allowed trends to reflect expected paid trends given the mix of benefits enrolled in the program.

   The leveraged trend values were determined using the Company's Benefit Relativity models[7] by calculating the change in paid claims with and without the allowed trends. The paid trends are summarized in the table below.

	Allowed Trends	Paid Trends	Approx. Percent of Claims
Medical	7.8%	9.2%	82%
Rx	9.4%	10.0%	18%
Total	**8.1%**	**9.4%**	**100%**

   The methodology of using the Benefit Relativity models to estimate the impact on paid claims with and without the allowed trend is consistent with last year's filing. The approach that the Company used to adjust allowed trends to paid trends is reasonable and appropriate.

   Administrative Costs: As with last year's filing, the non-benefit (administrative) components of the premium rate are developed on a per-member per-month basis based on historical administrative costs. The administrative experience period for this filing is January 2022 through December 2022. Transitional costs related to one-time events such as enabling full-time remote work, which will not recur in the future, were removed.

   The administrative charge proposed in the last filing was $60.41 PMPM. The proposed administrative charge is $55.03 PMPM. This decrease of $5.38 PMPM is attributable to the following factors:

   - *Updated Experience:* The actual 2022 administrative costs differed from anticipated in the prior filing. Reflecting this updated information resulted in a decrease to admin costs of about $1.50 PMPM. This decrease in administrative cost flows through to the projected 2025 administrative costs. This amount includes the $0.61 PMPM impact of the savings expected from BCBSVT's affiliation with Blue Cross Blue Shield of Michigan, which is producing administrative savings that were not present in the base period 2022 administrative costs.
   - *Administrative Cost Inflation:* The proposed administrative costs will be incurred in 2025. The assumed cost inflation reflects the Company's assumption that administrative costs will increase at 4.0% per year. This is the same as the prior filing's assumption.

[7] The Company uses the Benefit Relativity models to calculate the impact of cost sharing for each of the plans that they offer.

- *Decrease in Total BCBSVT Membership:* BCBSVT is projecting an increase in overall membership across all lines of business between 2022 and 2025. Since fixed expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charges results. While it is not practicable for BCBSVT to reduce staffing as rapidly as enrollment has fallen, BCBSVT has developed the administrative charge as if they did.[8] Under the assumption that 30% of costs are variable costs, this means that the impact on administrative costs is a decrease of about 3.4%, or $3.85 PMPM relative to last year's filing.

The premiums will also include allowances for the following state mandates and assessments. Some values are provisional until the relevant agencies announce the final assessment values.

- The Vermont Vaccine Purchasing Program is estimated to cost $2.50 PMPM.
- The New Hampshire Purchasing Program is expected to cost $12.50 PMPM for each child that is a resident of New Hampshire.
- New York State Health Reform Act applies an assessment based on county of residence within New York.
- The Maine Guaranteed Access Reinsurance Association produces an assessment per Maine resident.
- The Vermont Health Care Claims Tax of 0.999% of claims for all Vermont residents.
- The Health IT-Fund assessment of 0.199% has been routinely extended, so the current rate manual reflects a continued assessment. It will be updated if new information becomes available.
- BCBSVT projects that the total assessments for Vermont Blueprint for Health will be $2.77 PMPM for the Community Health Team and $3.00 for the PCMH team. Actual rates charged will reflect any updates made to the Blueprint Manual in renewals.
- The Green Mountain Care Board assess a billback, projected to be $2.08 PMPM for the coverage period.

The admin assumptions used in the each of the components appear to be reasonable and appropriate.

6. *Federal Fees:* The projected Patient-Centered Outcomes Research Institute (PCORI) fee is approximately $0.29 PMPY. This value is reasonable.

7. *Contribution to Reserves (CTR):* The proposed CTR is 3.0% for BCBSVT Insured Large. This assumption is the same as the CTR proposed in the previous Large Group filing.

   L&E notes that the last few years have resulted in contributions to reserve that were lower than projected in the filing.

Year	Fully Insured Actual CTR
2018	-8.5%
2019	-6.0%
2020	0.7%
2021	-12.0%
2022	-12.9%
2023	-3.9%

[8] By rebasing to 2022 costs, BCBSVT is fully reflecting all enrollment changes that occurred prior to 2022. The method they have used in recent years to dampen the effect of enrollment changes on premiums partially delays recognition of enrollment changes for two years.

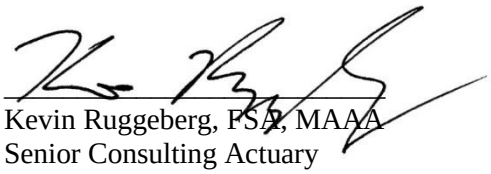
This is due in part to the high pooled claims experienced on this block. If those high pooled claims continue, the actual CTR experienced by BCBSVT will be substantially lower than the 3.0% proposed this filing and may be negative.

The results of the Department of Financial Regulation's Solvency Analysis should be considered in the approval of this assumption.

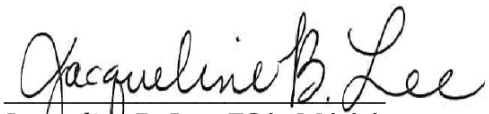
Recommendation

L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing, resulting in an anticipated average premium change of approximately 8.4%. We urge the Board to require that BCBSVT agree to submit a supplementary filing to modify the unit cost trend should hospital budget submissions differ materially from those assumed in this filing.

Sincerely,



Kevin Ruggeberg, FSA, MAAA
Senior Consulting Actuary
Lewis & Ellis, LLC.



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

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[9], 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[10], 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 Actuary
The responsible actuaries are:

- Kevin Ruggeberg, FSA, MAAA, Senior Consulting Actuary at Lewis & Ellis, Inc.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc.

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents
The date of this document is April 4, 2024. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 4, 2024.

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 Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing 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 the issuers for reasonableness, but L&E has not audited it. L&E nor the responsible actuaries assume responsibility for these 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.
- 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.
- The findings of this report are enclosed herein.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

Methods, Procedures, Assumptions, and Data

[9] 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.

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

The methods, procedures, assumptions and data used by the actuary 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 an applicable ASOP.