BLUE CROSS BLUE SHIELD OF VERMONT
2024 VERMONT ACA MARKET RATE FILINGS
ACTUARIAL MEMORANDUM

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1. GENERAL INFORMATION

1.1. Company Identifying Information

Company Legal Name: Blue Cross and Blue Shield of Vermont
State: Vermont
HIOS Issuer ID: 13627
Markets: Individual and Small Group markets
Effective Date: January 1, 2024

1.2. Company Contact Information

Primary Contact Name: Martine B. Lemieux, FSA, MAAA
Primary Contact Telephone Number: 1-(802)-371-3285
Primary Contact Email Address: brissonlm@bcbsvt.com

1.3. Scope and Purpose

The purpose of this rate filing is to provide the rates and a description of the rate development for the ACA-compliant plans for the Vermont individual and small group markets that Blue Cross and Blue Shield of Vermont (Blue Cross VT) proposes to offer for the 2024 benefit year. This rate filing applies to plans both On-Exchange and Off-Exchange.

This filing is intended to comply with the following laws, regulations, orders, and guidance:

- Vermont State Law 8 V.S.A. § 4062
- Vermont State Law 8 V.S.A. § 4512
- Vermont State Law 33 V.S.A. § 1806
- Vermont State Law 33 V.S.A § 1811
- Vermont State Law 33 V.S.A. § 1812
- Vermont State Law 18 V.S.A. § 9375(b)(6)
- DFR Order establishing tier rate structure and multipliers (Docket No. 13-002-I)
- Vermont Agency of Human Services Health Benefits Eligibility and Enrollment Rule, Parts 1 and 2
- Green Mountain Care Board, Rule 2.000
- Green Mountain Care Board Guidance on Silver Loading (effective March 15, 2023)
- Federal Regulation 45 C.F.R. Part 147
- Federal Regulation 45 C.F.R. Part 153
- Federal Regulation 45 C.F.R. Part 154
- Federal Regulation 45 C.F.R. Part 155
- Federal Regulation 45 C.F.R. Part 156
- Federal Regulation 45 C.F.R. Part 158
- Federal Regulation 26 IRC § 223

1.4. Proposed Rate Change(s)

1.4.1. Individual Market

The average rate change is 15.5 percent. Changes for specific plans range from 12.4 percent to 15.2 percent for non-loaded silver plans and from 18.8 percent to 21.1 percent for loaded silver plans. The range of changes is due to changes to the actuarial values, plan designs, and the new guidance on silver loading.

1.4.2. Small Group Market

The average rate change is 14.5 percent. Changes for specific plans range from 13.2 percent to 15.8 percent. The range of changes is due to changes to the actuarial values and plan designs.

1.5. Reason for Rate Change(s)

The starting point of any renewal rate analysis is an assessment of actual to expected experience results. The basis for this rate filing is calendar year 2022 experience. The claims experience for 2022 was slightly under the expectation embedded within the 2023 filing for small groups and individuals. This was offset by unfavorable population changes during 2023 open enrollment. With the addition of an expected favorable risk adjustment transfer, the overall change to 2023 rates due to experience and population changes is negative 0.3 percent for individual and 0.1 percent for small groups.

Similar to last year, trend is the most significant driver of the change in rates (see section 3.4.7). The 2023 approved rates included assumptions for projecting 2022 to 2023 which must be re-examined because the 2024 filing is based on updated actuarial assumptions that reflect current data. Also, an additional year of projected trend applies from 2023 to 2024. The overall anticipated increase in rates due to trend is 9.0 percent for individual and 8.6 percent for small groups:

2024 Rate Impacts of Trend		
Trend Component	**Individual**	**Small Group**
Restatement of 2022 to 2023 Trend	-0.7%	-0.6%
Additional Year of Medical Utilization Trend	0.7%	0.7%
Additional Year of Medical Unit Cost Trend	5.0%	4.8%
Additional Year of Retail Pharmacy Trend	3.5%	3.3%
Additional Year of Dental Trend	0.0%	0.0%
Additional Year of Vision Trend	0.0%	0.0%
Leap Year	0.3%	0.3%
Total	**9.0%**	**8.6%**

As noted in Attachments A and B, the claims underlying the federal Actuarial Value Calculator (AVC) were trended forward to 2024 and the underlying claims distributions were updated. This caused some plans to fall outside of the de minimis metal ranges. For both the standard plans and non-standard plans, deductibles and out-of-pocket limits were changed to comply with the AVC ranges. This means that benefit changes made by the Department of Vermont Health Access for standard plans and by Blue Cross VT for non-standard plans partly offset the impact of benefit leverage. Altogether, factors related

to plan design, actuarial value, silver loading and induced utilization increases rates by 0.4 percent for individuals and increased rates by 0.1 percent for small groups.

In previous filings, Blue Cross VT did not include the expected cost of covering COVID-19 testing, treatment, and vaccines in premiums. With the end of the federal Public Health Emergency (PHE), Blue Cross VT will treat COVID-19 the same as any other respiratory virus and include the projected costs in premiums, resulting in an increase of 1.0 percent for individuals and 1.3 percent for small groups.

The 340B Drug Pricing Program sets a ceiling price for manufacturers on drug sales to certain healthcare facilities, and participation in the program is required in order for drugs to be covered by Medicaid and Medicare Part B. Manufacturers often do not consider the drugs purchased through this program to be rebate-eligible, since they were purchased at a cost well below the average sales price. As certain hospitals, especially academic medical centers with specialty pharmacies, have expanded efforts to provide drugs purchased under the 340B program to their patients, the number of rebate-eligible drug claims have been correspondingly lower for payers. This has resulted in pharmacy rebates being less than expected, since drugs that were previously rebate-eligible transitioned to a 340B setting, increasing individual rates by 1.5 percent and small group rates by 1.2 percent.

Blue Cross VT base administrative charges are increasing as compared to the 2023 approved rates, mostly due to inflationary pressures (see section 3.8.7), increasing premiums by 0.1 percent for individuals and 0.3 percent for small groups.

Blue Cross VT must comply with all regulatory requirements from both state and federal agencies. The Department of Financial Regulation (DFR) has ordered Blue Cross VT to be within a specific Risk-Based Capital (RBC) range.[1] Blue Cross VT's RBC at year-end 2022 was well below the mandated range. Therefore, Blue Cross VT is increasing its contribution to member reserve (CTR) from 1.5 percent to 3.0 percent as part of the plan to move towards its RBC range. Due to the effective CTR of -0.3 percent approved in the 2023 rates, the total increase to premiums is 3.3 percent. Other federal and state taxes and fees will remain stable from 2023 to 2024.

Blue Cross VT continues to find innovative ways to mitigate premium increases. Blue Cross VT members continue to see premium reductions due to the ongoing work of Vermont Blue Rx and a new partnership with CivicaRx (see sections 3.4.7.1 and 3.4.6). Through these programs, Blue Cross VT has achieved rate relief of 0.4 percent in the individual market and 0.5 percent in the small group market.

[1] *See* Vermont DFR, BCBSVT Risk-Based Capital Order (Feb. 7, 2019), *available at* https://dfr.vermont.gov/reg-bul-ord/bcbsvt-risk-based-capital-order.

1.6. Historical Financial Performance

Blue Cross VT has offered ACA products since the start of the program in 2014. Prior to offering ACA plans, Blue Cross VT offered individual and small group products. All Vermonters who previously purchased individual and small group products were required to move to an ACA product in 2014. The State allowed individuals and small groups to remain in their 2013 products through the first quarter of 2014. All financial information below includes only the ACA experience in 2014.

Statutory financial reporting is not the best tool for assessment of pricing assumption performance. The pricing in this and prior filings for these markets reflect claims, premium, and expenses based on the date of service. Financial reporting, on the other hand, is based on the date that payments are made to providers along with a change in estimated unpaid liabilities. Statutory financials also include events that are unrelated to the reasonableness of pricing assumptions, such as payments from the federal risk corridor program. To assess the performance of pricing assumptions most accurately, we restated financial results to include the impacts of transitional reinsurance, risk adjustment, and other prior year events in the year in which they were incurred, rather than the year in which they were booked into financials.

The tables below show actual contribution to reserve and operating results with and without the impact of the risk corridor payments. Risk corridor payments impact the true financial performance, so they are included in the column labeled “Actual Contribution to Reserve (Financial).” However, these payments exist to mitigate pricing inaccuracies; therefore, it is best to exclude them when assessing pricing performance, which is the purpose of the column labeled “Actual Contribution to Reserve (Pricing).”

Year	Member Months	Filed Contribution to Reserve	Approved Contribution to Reserve[2]	Actual Contribution to Reserve (Financial)	Actual Contribution to Reserve (Pricing)
2014	638,492	1.0%	-0.1%	1.0%	1.0%
2015	768,293	1.0%	1.0%	-1.1%	-2.5%
2016	835,541	2.0%	0.8%	-2.3%	-3.8%
2017	820,156	2.0%	1.0%	1.0%	1.0%
2018	630,163	2.0%	-3.8%	-1.8%	-1.8%
2019	520,854	1.5%	0.0%	-0.7%	-0.7%
2020	453,744	1.5%	1.5%	5.5%	5.5%
2021	411,961	1.5%	0.5%	0.4%	0.4%
2022	430,399	1.5%	1.0%	-4.5%	-4.5%
Cumulative	5,079,204	1.6%	0.5%	-0.3%	-0.7%

The cumulative operating margin on ACA business since inception is a loss of $9.4 million, including federal risk corridor recoveries of $10.0 million. Overall, the performance of actual results to expected indicate a consistent absence of conservatism in the factors underlying the filing.

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

1.7. Environmental Factors

Affiliation with Blue Cross Blue Shield of Michigan

Blue Cross VT intends to affiliate with Blue Cross Blue Shield of Michigan (BCBSM) so we can best meet the needs of the people we serve.

The 2024 premiums are unaffected by this proposed affiliation. Here in Vermont, the Department of Financial Regulation must review and approve the proposed affiliation. The regulatory approval process, which will begin once both entities file with their respective state regulators, does not have a specific timeline. Moreover, after this transaction is approved, it will take some time for the two companies to align their operations.

This is a strategic partnership that will allow us to work together to access new technology, expertise, and operational resources – while minimizing the future administrative cost impact. BCBSM is an industry leader in developing new technology and innovative products, and like us is a mission-driven nonprofit Blue Plan.

With these new resources, we will be positioned to streamline our interactions with providers, facilitate the exchange of information to drive health care reform, and improve our members' experience as they navigate the system of care.

Blue Cross VT will continue to be a Vermont organization with policy, governance, and operational decisions made locally, focused on the best interest of members and the community, all while keeping member reserves and health care decisions in our state. Our members and customers will continue to experience the same excellent health coverage, benefits, extensive network of providers, and award-winning local customer service.

OneCare Vermont

It was a difficult decision for Blue Cross VT to pause its contract with OneCare Vermont (OCV) for 2023, and we stayed at the negotiating table until it was clear that we would not be able to come to an agreement that would measurably improve health quality outcomes, lower the total cost of care for Vermonters, and ensure the protection of our members' health care data. Since the announcement, we have worked to support primary care providers by continuing care management payments and through our efforts in the Vermont Blue Integrated Care pilot. It remains to be seen whether OCV will bring a proposal to the negotiating table that will bring clear value to our members for 2024.

Unmerging the Market

Blue Cross VT led advocacy efforts to unmerge the individual and small group market through 2025. Unmerging the markets allows those holding small group plans to benefit tangentially from the expanded Advanced Premium Tax Credit, by shifting the subsidy of the individual market from Vermont's smallest employers to the federal government.

Vermont Legislature

The Vermont Legislature is currently in session, and it remains to be seen how the bills being considered will impact 2024 rates. Blue Cross VT advocates in the State House with the single-minded intention of improving the health and wellbeing of our members, our neighbors, and our community. Our advocacy decisions are based on three factors: measurably improving quality and access to care, impact on premiums, and impacts on the security of our members' health care data and privacy.

COVID-19 and the end of the Public Health Emergency

COVID-19 continues to have a significant impact to the health system in our state. As we near the end of the federal Public Health Emergency on May 11, 2023, we will shift toward covering all covid testing, treatment, and vaccinations as we do all other respiratory viruses. As it was intended, our reserves covered these costs as our members endured three long years of the pandemic but starting in 2024, we must include these costs in our premiums.

1.8. Vermont Statutory Rate Review Criteria

When reviewing a proposed rate, the GMCB must consider:

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

8 V.S.A. § 4062(a)(3). The GMCB expressly incorporated actuarial review standards into the process, tasking itself with "determin[ing] whether the requested rate is…not excessive, inadequate, or unfairly discriminatory." GMCB Rule 2.000 §2.401. The Board must also consider the Vermont Department of Financial Regulation's ("DFR") "analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves." *Id*. § 4062(a)(2)(B). The purpose of this memorandum is to provide the actuarial basis for the proposed rate. Although a number of the rate review criteria are not technically actuarial in nature, this section briefly explains how the Blue Cross VT actuarial calculations relate to the criteria, with the understanding that (consistent with Board practice) these issues will be more fully developed during the rate review process.

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

Unlike quality care and access to care, "protection of insurer solvency" is demonstrably *not* in tension with affordability. DFR considers insurer solvency to be the most fundamental aspect of consumer protection.[3] Insurer solvency is a necessary pre-condition for affordability, because reducing rates to levels that result in insurer insolvency would place the entire burden of the cost of care on consumers.

[3] See, for instance, DFR solvency opinion in filing BCVT-132829562.

Because members likely cannot afford the full cost of their care without insurance, this result would restrict patient access and impede providers' ability to provide high-quality care. Furthermore, reductions producing rates that are inadequate to any extent do not promote long-term affordability, as it simply shifts costs from current policyholders to future policyholders. The full funding of adequate rates is thereby critical to both insurer solvency and affordability.

The federal rate review criteria of "not excessive" and "not inadequate" are tested by actuarial analysis. Actuarial Standard of Practice No. 8[4] provides guidance to actuaries preparing regulatory filings for health insurance premium rate requests. It defines rates as "adequate" if they "provide for payment of claims, administrative expenses, taxes, [and] regulatory fees and have reasonable contingency or profit margins." Similarly, rates are "excessive" if they exceed the amount necessary for these items. As documented in Section 5.2, the rates filed herein are neither excessive nor inadequate. It follows that rates that are adequate but not excessive cannot jeopardize insurer solvency or be deemed to be unjust, unfair, inequitable or misleading. Nor are the rates contrary to Vermont law.

Increases in prices for services at hospitals and other providers result in 4.9 percentage points of the overall 15.5 percent premium increase for individuals and 4.6 percentage points of the overall 14.5 percent premium increase for small groups. Approved rates must incorporate information about the upcoming GMCB hospital budget review process to ensure rate adequacy while maximizing affordability and access to care.

Spending on specialty pharmaceuticals, through both the retail pharmacy and medical benefits, along with the shift to hospital dispensed specialty pharmacies, is driving 4.3 percentage points of the total individual rate increase and 3.8 percentage points of the total small group rate increase. Blue Cross VT supports and protects our members by ensuring access to medications that significantly improve quality of life, and in many cases save lives. The cost of these drugs is an appropriate topic for public policy discussion, particularly given their impact on rates. However, given the clinical need to provide access to this care and in the absence of mitigating federal or state legislation, Blue Cross VT must include the very high cost of these drugs in this year's rate development. The additional cost of providing these life-altering therapies is expected to lead to greater affordability and/or quality of life in the long term.

Blue Cross VT has invested in CivicaRx, a non-profit enterprise that will bring to market lower cost options for prescription drugs. While its impact on pharmacy spend is not expected to be significant in 2024, the investment in CivicaRx demonstrates Blue Cross VT's commitment to taking action to make medications more affordable for Vermonters.

In summary, these rates strike the best balance available among affordability, access to care, and quality of care by providing coverage for necessary medical services that improve Vermonters' quality of life at a cost of insurance that is far lower than that allowed by federal and State medical loss ratio requirements (see section 3.8.9). Blue Cross VT is increasing base administrative costs (see section 3.8.7), which has the effect of increasing the premiums by 0.1 percent for individuals and 0.3 percent for small groups. This modest increase reflects current and expected inflationary levels. Since 2019, Blue Cross VT has implemented a variety of programs and services that have the cumulative impact of mitigating 2024 premiums by 13.9 percent, or approximately $61 million based on projected membership.

[4] http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop008_100.pdf

2. PROPOSED BENEFITS

2.1. Description of Benefits

Blue Cross VT will offer two types (Standard and Non-Standard) of plans to the individual and small group markets in 2024. These plans include coverage for all Essential Health Benefits (EHBs). All plans are on the Exclusive Provider Organization (EPO) network and offer members access to a nationwide network of providers, including over 97 percent of the providers in Vermont. The majority of providers not in the EPO network are dentists, ambulance services, and mental health providers.

Blue Cross VT Standard Plans: Blue Cross VT is providing rates for the Standard plans with benefits as approved by the Green Mountain Care Board, which are outlined in Exhibit 1A – "State of Vermont Standard Plan Designs." The form filing for these products can be found under BCVT-133595113 for deductible plans and BCVT-133595280 for Consumer Driven Health plans (CDHP). Blue Cross VT is also providing rates for the catastrophic plan, also outlined in Exhibit 1A. The form filing for this plan can be found under BCVT-133595253.

Blue Cross VT Non-Standard Plans: Blue Cross VT is providing rates for two non-standard products. The first product, Vermont Select, offers HSA compatible plans with the deductible at the same level as the out-of-pocket. The second product, Vermont Preferred, offers plans with zero cost share for some primary care or mental health visits and some specialist visits to manage diabetes and heart disease. Both products waive deductibles for wellness drugs. Please see Exhibit 1B – "Non-Standard Plan Designs" for details on the benefit structure. The form filing for these products can be found under BCVT-133595201 for Vermont Preferred and BCVT-133595237 for Vermont Select.

Reflective Silver Plans
Pursuant to Act 88, Blue Cross VT will offer certain silver plans only off-exchange for the 2024 plan year. These plans are "reflective" of the Exchange plans, with only a $5 copayment, 5 percent coinsurance or $25 deductible difference from the Exchange plan.

Uniform Compliance
Benefits of all Standard, Vermont Preferred, and Vermont Select plans are in compliance with 45 CFR §147.106. Specifically, the benefits continue to be offered on the Blue Cross VT Exclusive Provider Organization (EPO) network and continue to cover the same service area. Some cost sharing levels were modified to maintain the same metal tier levels. Each product covers the same benefits as covered for plan year 2023.

2.2. AV Metal Values

Standard plans are designed by the State of Vermont and offered by all issuers in the individual and small group markets. Please see *Attachment A – Standard Plans AV Certification - 2024* for the certification provided by the State.

Non-Standard plans are designed by Blue Cross VT. The metal values included in the Unified Rate Review Template (URRT) were calculated using an alternate methodology, as allowed by 45 CFR §156.135. Multiple benefit designs offered in the Blue Cross VT Non-Standard plans are not supported by the AV Calculator. Please see *Attachment B –Non-Standard Plans AV Certification - 2024*[5], for the actuarial certification, which includes the process used to develop the AV Metal Values.

3. EXPERIENCE RATING

3.1. Experience Period Premium and Claims

Our analysis begins with the 2022 experience of Blue Cross VT individual and small group markets. Starting in 2021, Vermont unmerged the individual and small group markets.

We analyzed claims incurred January 1, 2022 through December 31, 2022 and paid through February 28, 2023. We completed both the paid claims and the allowed charges using the Blue Cross VT monthly reserving models that underpin the financial statement reserves (best estimates before margin) for claims incurred but not reported (IBNR). These methods are subject to review by independent auditors and examination by Vermont Department of Financial Regulation (DFR). For the purpose of calculating completion factors, the reserving method categorizes claims by reporting/payment process (Local, BlueCard, Retail Pharmacy, Medicare Supplement, etc.). We calculate completion factors separately for each category. We also included an estimate of outstanding pharmacy rebates.

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

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

[5] While the Final Actuarial Calculator was released on April 17, 2023, the IRS has yet to release the HSA deductible limits for 2024. Once those are available, we will update Attachment B to reflect all final values for both AV and Rx out-of-pocket maximum.

Calculation of Experience Period Claims Per Member Per Month (PMPM) – Individual Market		
	Incurred Claims	**Allowed Claims**
Claims incurred January 1, 2022 through December 31, 2022 and paid through February 28, 2023	$140,728,886	$165,971,729
Estimate of IBNR for claims incurred January 1, 2022 through December 31, 2022 as of February 28, 2023	$913,512	$774,522
Estimate of IBNR pharmacy rebates incurred January 1, 2022 through December 31, 2022 as of February 28, 2023	($4,264,605)	($4,264,605)
Total completed experience period claims	$137,377,793	$162,481,646
Member months	194,869	194,869
Total claims per member per month (PMPM)	$704.98	$833.80

Calculation of Experience Period Claims Per Member Per Month (PMPM) – Small Group Market		
	Incurred Claims	**Allowed Claims**
Claims incurred January 1, 2022 through December 31, 2022 and paid through February 28, 2023	$142,897,165	$169,904,621
Estimate of IBNR for claims incurred January 1, 2022 through December 31, 2022 as of February 28, 2023	$830,163	$982,642
Estimate of IBNR pharmacy rebates incurred January 1, 2022 through December 31, 2022 as of February 28, 2023	($5,105,580)	($5,105,580)
Total completed experience period claims	$138,621,747	$165,781,682
Member months	235,406	235,406
Total claims per member per month (PMPM)	$588.86	$704.24

In the experience period, the earned premium was $133,369,892 for the individual market and $143,656,384 for the small group market. Blue Cross VT will not be required to pay minimum loss ratio (MLR) rebates for the 2022 calendar year. Vermont does not currently have a 1332 waiver for a Reinsurance program. The estimated 2022 risk adjustment receivable, according to the information from the Interim Report, is $13,309,300 for the individual market (including Catastrophic) and $9,579,344 for the small group market.

3.2. Benefit Categories

Medical claims are initially categorized into two categories based on the type of claim form the provider submitted: UB-04/CMS 1450 (Facility Inpatient/Outpatient) or HCFA/CMS 1500 (Professional/Other). We then separate facility claims into the Inpatient and Outpatient categories in Worksheet 1, Section II of the URRT by the place of service listed on the UB-04 claim form. Professional and Other medical claims are subdivided based on whether the provider is a medical professional or medical supplier as submitted on the HCFA 1500 claim form. We populate the prescription drug benefit category for claims processed through our pharmacy benefit manager. We populate the capitation benefit category with claims that run through our internal capitation system. The capitation category uses "Benefit Period" as a utilization description and the units represent the number of capitations in a given year.

3.3. Index Rate

The Index Rate is equal to the experience period allowed charges for Essential Health Benefits (EHB). In 2017, Blue Cross VT removed an exclusion for routine circumcision (see section 3.8.3 for details). Those services are not considered EHB and must be removed from the experience to calculate the Index Rate.

Calculation of the Experience Index Rate PMPM – Individual market	
Allowed Claims in section 1 of worksheet 1 of URRT	$851.71
Allowed Claims for Non-EHB	$0.04
Experience Index Rate in section 2 of worksheet 1 of URRT	**$851.67**

The experience index rate for 2022 for the individual market is $851.67.

Calculation of the Experience Index Rate PMPM – Small Group market	
Allowed Claims in section 1 of worksheet 1 of URRT	$721.75
Allowed Claims for Non-EHB	$0.09
Experience Index Rate in section 2 of worksheet 1 of URRT	**$721.66**

The experience index rate for 2022 for the small group market is $721.66.

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

Blue Cross VT has access to the detailed claims information underlying capitated claims. We use the fee-for-service (FFS) equivalent rather than the capitation.

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

Reconciliation of Allowed Claims from section 1 of URRT to Line A1 of Exhibit 5 – Individual Market		
	Total Dollars	**PMPM**
Allowed Claims in section 1 of worksheet 1 of URRT	$165,971,729	$851.71
Remove BlueCard Fees	($423,824)	($2.17)
Remove Pharmacy Rebates	$8,353,380	$42.87
Remove Payments to Blueprint Program	($572,179)	($2.94)
Replace Capitation with FFS equivalent	$14,889	$0.08
Line a1 of Exhibit 5 - IND	$173,343,994.41	$889.54

Reconciliation of Allowed Claims from section 1 of URRT to Line A1 of Exhibit 5 – Small Group Market		
	Total Dollars	**PMPM**
Allowed Claims in section 1 of worksheet 1 of URRT	$169,904,621	$721.75
Remove BlueCard Fees	($695,303)	($2.95)
Remove Pharmacy Rebates	$10,061,816	$42.74
Remove Payments to Blueprint Program	($939,071)	($3.99)
Replace Capitation with FFS equivalent	($48,735)	($0.21)
Line a1 of Exhibit 5 - SMG	$178,283,328	$757.34

3.3.1. Pooling experience claims

Starting in 2020, Blue Cross VT purchased reinsurance coverage for the ACA market that covers the portion of claims above one million dollars that is not reimbursed by the High Cost Risk Pool (HCRP). To project the claims above the pooling point, we cap the claims and include the full cost of reinsurance and HCRP. To cap the projected claims, we calculate the de-trended pooling level by removing the total trend (see section 3.4.7 for details) from the attachment point of one million dollars. We then exclude the claims above the resulting de-trended limit. In 2022, Blue Cross VT had a member in the individual market with almost $2 million in claims, with the majority of claims paying for a drug that treats a rare disease. This type of drug is excluded from the Blue Cross VT reinsurance agreement. We excluded the total allowed charges from the experience period, as none of the projection factors described below apply to this specific member. The net expected allowed charges after recoveries from the HCRP are included in the reinsurance component (see item e_5 on Exhibits 5).

Calculation of the Impact of Capping Claims – Individual Market		
CY 2022 total allowed claims	A1	$173,343,994
Allowed charges for drugs not included in the Blue Cross VT reinsurance agreement	A2	$1,759,400
Net allowed charges	A = A1 – A2	$171,584,594
Claims above $825,942	B	$812,087
Capped Claims	C = A - B	$170,772,508
Impact of capping claims (a_5 on Exhibit 5 - IND)	D = C / A	0.9953

Calculation of the Impact of Capping Claims – Small Group Market		
CY 2022 total allowed claims	A1	$178,283,307
Allowed charges for drugs not included in the BCBSVT reinsurance agreement	A2	$0
Net allowed charges	A = A1 – A2	$178,283,307
Claims above $826,871	B	$710,532
Capped Claims	C = A - B	$178,283,307
Impact of capping claims (a_5 on Exhibit 5 - SMG)	D = C / A	0.9959

3.4. Projection Factors

3.4.1. Membership Projections

As of February 2023, Blue Cross VT had 40,460 members enrolled in the Vermont ACA markets, with 18,517 enrolled individually through Vermont Health Connect or directly through Blue Cross VT and 21,943 small group employees and their dependents.

We used this information as the starting point to project the 2024 enrollment and the distribution by plan.

Starting in April 2023, Medicaid started their "unwind" plan[6] to redetermine eligibility for all Vermonters on Medicaid. Since March 2020, states were not allowed to disenroll members from Medicaid. Through this redetermination process, we expect a portion of members previously in Medicaid will become ineligible and will need to select a new insurance plan or choose to become uninsured. To estimate the number of members expected to enroll in an ACA market plan, we relied on a study from NORC at the University of Chicago[7]. This study projected the number of members expected to become ineligible for Medicaid and their new source of coverage.

[6] https://dvha.vermont.gov/unwinding
[7] https://www.ahip.org/resources/medicaid-redetermination-coverage-transitions

Using these data points, our current ACA market share of 60 percent, and an estimate that small groups cover approximately 16.4 percent[8] of members with employer sponsored coverage, we project that Blue Cross VT enrollment will increase by 1,609 individual members and 1,711 small group members by the beginning of 2024.

For the individual market, we assume that members previously on Medicaid will enroll in On-Exchange Silver plans, with the same proportion by plan as current enrollment, after CSR membership movement (described below). In the small group market, we assume that members previously on Medicaid will enroll in all plans with the same proportion by plans as current enrollment.

With the new guidance from the GMCB on Silver Loading[9], On-Exchange Silver plans have higher increases than all other plans. With this shift, we expect that a portion of the members currently enrolled in an On-Exchange Silver will select a different benefit for 2024.

The table below shows the February 2023 enrollment in On-Exchange Silver plans by CSR level, the assumed percentage of member moving to another metal and the remaining CSR membership.

On-Exchange Silver Plans Membership				
Plan	**February 2023 Membership**	**Percentage of Members Moving to Another Metal**	**Total Members Moving to Another Metal**	**Total Members Remaining in On-Exchange Silver**
70% plan	1,415	75%	1,061	354
73% plan	631	50%	315	316
77% plan	1,085	25%	271	814
87% plan	1,693	0%	0	1,693
94% plan	594	0%	0	594

We assume that members moving to another metal would be distributed in proportion with current enrollment in the Gold, Silver-Reflective, and Bronze plans.

Exhibits 2A shows the 2024 Blue Cross VT individual and small group projected population by plan and market.

Blue Cross VT expects to cover 513,718 member months in the Vermont ACA combined market in 2024, with 229,870 member months in the individual market and 283,848 in the small group market.

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

[8] Based on the proportion of total Blue Cross VT employer membership comprised by members in the small group market.
[9] See section 3.8.2 for details

3.4.2. Changes in the Morbidity of the Population Insured

Changes in pool morbidity due to voluntary cancelations ($1+b_9$)
This factor measures morbidity differences between the experience period population and projection period population due to choices made by small groups and individuals to voluntarily disenroll from Blue Cross VT ACA market coverage. The impact is measured by observing experience period claims costs for groups and members known to be no longer enrolled as of February 2023.

The base for our experience period is calendar year 2022. Using February 2023 enrollment, we group members into broad categories of active and canceled. We can further divide canceled members into two categories: voluntary cancelation and cancelation due to death. We can further break down voluntary cancelations by aging out, cancellations from normal group turnover, and individual cancellations. We capture individuals aging out in our demographic adjustment (see section 3.4.5).

We adjust for small group members leaving the Blue Cross VT ACA market. If all members in a group are no longer enrolled in Blue Cross VT ACA market, we exclude them under the assumption that the entire group moved to a different carrier or different product. If members that canceled were part of a group that is still in the Blue Cross VT ACA market and the disenrollment reason was not death or retirement (defined as leaving after age 64), we assume that the members voluntarily left the Blue Cross VT ACA market. As part of last year's filing, we completed an experience study comparing claim costs for retiring members to claim costs for members of the same age who continue to be actively employed. The study showed that the retiring cohort had significantly higher claim costs, leading us to conclude that retirement can be driven by deteriorating health. It is therefore appropriate to include an experience adjustment reflecting the expectation that some members of retirement age will experience increased morbidity that will lead to a decision to retire. This is analogous to the adjustment we make for death. Functionally, we achieved the adjustment by excluding member months and claims for members who retired, but only up to the average claim cost of members of the same age bracket who remained enrolled.

We split the experience claims costs based on these categories in order to compare the different populations. We adjust the allowed charges from the experience period to reflect the average claims cost of members who did not voluntarily terminate from the individual market prior to February 2023, and to reflect the average claims cost of small group members as described above.

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

As shown on Exhibits 2C, the factor ($1+b_9$ on Exhibits 5) to adjust for the change in pool morbidity is 1.0159 for the individual market and 1.0156 for the small group market.

3.4.3. Changes in Benefits

Impact of changes in benefits ($1+c_1$)

The impact of benefit changes ($1+c_1$ line on Exhibits 5) represents the anticipated change in the average utilization of services due to the change in average cost sharing in the projection period compared to the experience period. Based upon ACA rating rules, it is appropriate to use the HHS induced utilization factors by metal to limit the quantification to only the impact of varying cost shares between the experience plan distribution and the projected plan distribution. Using the experience member months for members included in the "remaining members" category of the morbidity factor described above and the projected membership by metal, we calculate an average induced utilization factor for each and compare the two averages to generate the impact of changes in benefits.

As shown on Exhibits 2D, the impact of the movement among benefit plans ($1+c_1$ on Exhibits 5) is 0.9960 for the individual market and 0.9976 for the small group market.

Impact of the addition on Hearing Aids to the EHB benchmark ($1+c_6$)

Since we do not have credible experience for hearing aid costs, we develop an estimated allowed charge from demographic data and average market costs. We add the estimated allowed PMPM of $1.30 to the trended professional PMPM to calculate the overall projected professional PMPM.

Calculation of impact of addition of Hearing Aids			
		Individual	**Small Group**
Trended Professional PMPM, excluding hearing aids	A	$209.80	$181.19
Projected Hearing Aids PMPM	B	$1.30	$1.30
Trended Professional PMPM, including Hearing Aids	C = A + B	$211.11	$182.49
Factor $1+c_6$ on Exhibits 5 for Professional Claims	D = C / A	1.0062	1.0072

Details of the assumptions and calculations supporting the $1.30 PMPM are in Attachment D.

3.4.4. Changes in Demographics

Impact of changes in demographics ($1+c_3$)

We calculate separate factors for small groups and for individuals.

For both market segments, we use the age-gender factors from the SOA's report Health Care Cost – From Birth to Death[10] to calculate the age-gender factors for the experience membership and compare to those of the projected 2024 membership.

For small groups, we first observe the actual change in average age-gender factors from the experience period to February 2023. We observed a consistent seasonal pattern in the age-gender factors for small groups. We therefore adjust the year-to-date February observation to reflect a full calendar year age-gender factor. We divide the full year 2023 age-gender factor by the experience age-gender factor to

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

calculate a projection factor from 2022 to 2023. We then use a three-year average impact of the demographic changes for renewing groups to project from 2023 to 2024..

For individuals, we first split the population into VHC-enrolled and direct-enrolled members. We then categorize each member into the following sub-categories: continuing, retired, newborn, moved to other Blue Cross VT line of business, and voluntarily canceled. For continuing members, we age all members by one year starting with their February 2023 age and calculate the average duration by age. We assign the age one duration to members age zero in 2023. We assessed historical persistency by age for members who are eligible for Medicare. Based on historical patterns, we assume that 27 percent of members age 64 in 2023 will remain enrolled through 2024, and that 58 percent of members age 65 and over in 2023 will remained enrolled through 2024. Finally, in order to complete the age distribution, we add new members age zero in 2024. Again, we examined historical patterns to develop newborn assumptions. For the VHC enrolled population, we expect newborns to comprise 0.64 percent of the total population with an average duration of 3.97 months. For direct enrolled members, we expect the newborns to comprise 0.56 percent with an average duration of 4.51 months. We apply these percentages to the in-force 2023 enrollment to estimate the newborns in 2024. We then compare the experience period average age-gender factor to the projected period average age-gender factor.

As shown on Exhibits 2E, the demographic adjustment ($1+c_3$ on Exhibits 5) is 0.9956 for the individual market and 0.9998 for the small group market.

3.4.5. Other Adjustments

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

In early 2020, Blue Cross VT announced[11] a partnership with CivicaRx on an initiative to reduce the cost of prescription drugs in Vermont by introducing new generics at a much lower cost than currently available generic drugs. The first generics available through CivicaScript are Abiratone and Imatinib. To estimate the impact of moving individual and small group members from the current generic available to the CivicaScript version, we worked with CivicaRx to understand the expected number of prescriptions that would switch and the cost of the new drugs. We calculate the impact on specialty drugs to be 0.9982 for the individual market and 0.9962 for the small group market.

In the spring of 2023, many insulin manufacturers announced reductions in the ingredient cost of some of their products. Working closely with the pharmacy team, we estimate the change in ingredient cost for the Blue Cross VT ACA market and apply to the experience period claims for each impacted insulin drug. We adjust the pharmacy non-specialty allowed charges to reflect these lower costs. We calculate the impact on non-specialty drugs to be 0.9525 for the individual market and 0.9474 for the small group market.

[11] https://www.bluecrossvt.org/news/blue-cross-blue-shield-vermont-partners-with-civica-rx

Impact of the ACO program ($1+b_4$)
In 2022, Blue Cross VT and OCV had a shared-risk/shared-savings agreement covering on average 19,150 lives within the ACA market. The agreement provides for 50/50 sharing of savings or risk up to six percent above or below the expected medical spend, which is derived from the final 2022 GMCB rate order for the ACA market. Due to the COVID-19 pandemic, the contract between OCV and Blue Cross VT limited the shared savings and risk to $50,000. Our current best estimate of the 2022 transfer is $50,000 from OCV to Blue Cross VT. As per the contract with OCV, this payment is to be invested in population health programs. Therefore, the factor for this program ($1+b_4$ on Exhibit 5) is 1.000.

3.4.6. Non-System Claims

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

- Pharmacy Rebates (e_1):
  To estimate the 2024 rebates, we start with actual calendar year 2022 rebates (including IBNR for the quarters where actuals are not yet available). We trend the rebates using the total trend for brand eligible rebates (see table below).

Calculation of the trend for Rebates		
Claim Type	**Experience Period Allowed Charges (Gross of Rebates)**	**Projected Allowed Charges (Gross of Rebates) after Contract Changes**
Brand Going Generic	[redacted]	[redacted]
Brand	[redacted]	[redacted]
Specialty	[redacted]	[redacted]
Total	[redacted]	[redacted]
Total Trend for Drugs Eligible for rebates	[redacted]	

The emergence of biosimilar for specialty drugs with high utilization is expected to yield additional rebates as manufacturers compete to maintain their market share. We adjusted the rebates for the inflammatory conditions drug class to reflect this. As mentioned above, many insulin manufacturers announced a reduction in the ingredients cost of their products. We expect that they will not continue to pay rebates for these lower costs insulins and reflected this in the projected rebate PMPM.

The projected pharmacy rebates PMPM are $56.55 for the individual market and $56.96 for the small group market.

- Blueprint Payments (e_2):
  Blue Cross VT participates in the Vermont Blueprint for Health[12] program. The Vermont Blueprint for Health Manual, effective July 1, 2022, details the funding for both portions of the program: Community Health Teams (CHT) and Patient Centered Medical Homes (PCMH). The experience PMPM for Blueprint payments has been stable from year to year. We therefore do not expect the funding for either CHT or PCMH to change in 2024. and instead assume that the experience period PMPM would continue to 2024.

Calculation of projected Blueprint payments PMPM		
	Individual	**Small Group**
Experience Member Months	194,869	235,406
Experience Blueprint Payments	$572,179	$939,071
Blueprint Payments PMPM	$2.94	$3.99

- Interplan Teleprocessing System (ITS) (e_3):
  The BlueCard® Program gives Blue Cross VT members healthcare coverage wherever they go across the country and around the world. The fees associated with this program are independent of the dollar amount of the claims and therefore solely dependent on utilization of BlueCard participating providers. These fees are assumed to increase at the annual medical utilization trend, before the impact of the fraud, waste, and abuse program (see section 3.4.7.2).

Calculation of projected ITS fees PMPM		
	Individual	**Small Group**
Experience Member Months	194,869	235,406
Experience ITS fees	$423,428	$694,698
ITS fees PMPM	$2.17	$2.95
Trend (for 2 years)	1.008	1.008
Projected ITS fees PMPM	$2.21	$3.00

- Vermont Vaccine Purchasing Program Payments (e_4):
  The Vermont Vaccine Purchasing Program[13] (VVPP) offers health care providers state-supplied vaccines at no charge by collecting payments from health plans, insurers and other payers. This assessment is a PMPM charge applied to members residing in Vermont who are under age 65. On May 2, 2023, the Vermont Vaccine Purchasing Program met and approved the rates for SFY2024[14]. We used these rates for CY2024, as we do not have information about the SFY2025 rates.

[12] http://blueprintforhealth.vermont.gov/
[13] http://www.vtvaccine.org/
[14] https://www.vtvaccine.org/data/get_doc/1448a692c8852f8c112b673a6371a1ed

Calculation of the VVPP PMPM - Individual			
Market	**Age Category**	**Weighted Rate for CY 2024**[15]	**Projected Membership**
Individual	Child	$13.54	1,520
Individual	Adult	$2.74	18,359
Individual	Over 65	$0.00	247
Total		**$3.52**	**20,126**

Calculation of the VVPP PMPM – Small Group			
Market	**Age Category**	**Weighted Rate for CY 2024**	**Projected Membership**
Small Group	Child	$13.54	3,449
Small Group	Adult	$2.74	19,394
Small Group	Over 65	$0.00	811
Total		**$4.22**	**23,654**

- Cost of Reinsurance (e_5):
  Blue Cross VT uses reinsurance to protect itself against very high claims. Starting in 2020, Blue Cross VT purchased reinsurance for 40 percent of claims above $1 million. When combined with the High Cost Risk Pool (HCRP) program, Blue Cross VT is fully reinsured at an attachment point of $1 million. Since we capped claims in the projected period allowed claims for EHB (line D of Exhibits 5) at $1 million, we include the full cost of reinsurance. The projected rate for this coverage in 2024 is $[redacted] PMPM, which is the 2023 cost of coverage with expected increases due to trend leveraging. As mentioned in section 3.3.1., Blue Cross VT has a member in the individual market with ongoing high-cost pharmacy claims that are not covered by Blue Cross VT reinsurance. We include these claims, net of HCRP recoveries, in this component.

- Payment Reform Initiatives (e_6):
  Blue Cross VT is committed to continuing its effort in payment reform. In late 2022, Blue Cross VT developed an innovative care model for primary care practices. The model, Vermont Blue Integrated Care (VBIC), is intended to improve value and outcomes for members. The program includes participation payments which support enhanced care coordination, population health management, an electronic medical record overlay that offers a more comprehensive look at the members' care across providers, and other resources. While Blue Cross VT paused its relationship with OCV for 2023, we will continue to support primary care providers in 2024 either with a renewed relationship or expansion of our own programs. We estimate the monthly PMPM needed for our payment reform efforts as $2.25 PMPM.

[15] Using the SFY2024 rates for Q1 2024 and the SFY2025 for Q2 2024 through Q4 2025.

- Retail Pharmacy Clinical Management Fees (e_7):
  Vermont Blue Rx provides clinical management services to reduce waste and improve the quality of the prescription drug benefit. These programs, which are subject to fees per use, include prior authorizations, step therapy, quantity reviews, copay reviews, and pharmacy vaccination programs, as well as a safety management program, which protects patients against potentially harmful drug interactions. The total PMPM in the experience period under Vermont Blue Rx was $[redacted] PMPM for individuals and $[redacted] PMPM for small groups. We project this cost to be the same in 2024.

- Accordant Health Services Fees (e_8):
  Blue Cross VT partners with Accordant Health Services to provide members support with managing their rare diseases. The program targets patients with complex, chronic diseases in neurology, rheumatology, hematology and pulmonology. Accordant provides early intervention and patient compliance services to support the Blue Cross VT care management strategies, improve patient health and strengthen physician-patient relationships. The total PMPM in the experience period was $[redacted] PMPM for these services. We project the PMPM to be the same in 2024.

3.4.7. Trend Factors (cost/utilization)

3.4.7.1. Data and Population

The source of the data is the Blue Cross VT data warehouse, except where noted below. To ensure accuracy of claims information, we reconciled the data against internal reserving, enrollment, and other financial reports. The analysis examines claims incurred between January 1, 2019 and December 31, 2022, paid through February 28, 2023. We apply completion factors, based on best estimates from financial reporting before margin for conservatism, to estimate the ultimate incurred claims for each period shown in the exhibits.

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

Blue Cross VT experienced large membership movement out of the ACA small group and individual markets in 2019, 2020 and 2021. To ensure that the trend factors do not implicitly reflect changes in the Blue Cross VT population, we create a matched population specific to each benefit year. This methodology ensures that the mix of age, gender, metal level, market, duration, and health conditions is the same over the four years of data.

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

Using pharmacy claims, we then assign condition categories based on drug utilization. We assign each category a 1 or 0 value. Members can have multiple condition categories. Using medical claims, we assign pregnancy indicators, and newborn condition indicators following the categories used in the HHS-HCC risk adjustment model. Finally, we assign a high claimant indicator for members with annual claims above $500,000. We excluded high claimants from the matching process[16].

Starting with calendar year 2022, we match backward to the 2021, 2020 and 2019 populations. Page 1 of Exhibit 3B shows the summary statistics of the full Blue Cross VT ACA small group and individual markets and AHP population, as well as the matched population.

We use the full population for the medical cost trend calculation and the matched population for all other trend estimates[17].

3.4.7.2. Medical Trend Development

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

Unit Cost

Observations of recent contracting and provider budgetary changes are the main source of unit cost trend. We use calendar year 2022, excluding direct COVID costs, as the base for mix of site of care and project costs two years to 2024.

During calendar year 2022, about 52 percent of total medical claims dollars occurred at Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board (GMCB). For hospitals under the jurisdiction of the GMCB, we start with the assumption that the GMCB will approve hospital budgets for the 2023 cycle that are equal to the commercial increases approved in the 2021 cycle[18].

Based upon the above assumptions concerning hospital budget and fee schedule changes, the provider contracting and actuarial departments worked together to assess the impact such an increase would have on contract negotiations specific to the network used for the ACA markets.

We assumed for other providers within the Blue Cross VT service area that overall 2023 and 2024 budget increases would be the average of the increases implemented during the 2021 cycle and the 2022 cycle, with the exception that we have reflected any more recent information gleaned from our early negotiations with providers.

[16] The utilization component includes intensity, so an increase in high-cost claimants can disproportionately impact the year-over-over and regression calculations.
[17] Using the full population for the cost trend base ensures that the weights among facilities and other providers reflect the most accurate weights for the ACA population.
[18] We expect to update the unit cost trend assumptions upon review of the June 30, 2023 hospital budget submissions.

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

Finally, we derive unit cost increases for providers outside the Blue Cross and Blue Shield of Vermont service area from the Fall 2022 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

The chart below summarizes the results of the analysis:

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in 2022	Cost Trend from 2022 to 2023	Cost Trend from 2023 to 2024	Total Annual Cost Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	52.2%	13.5%	5.3%	9.3%
Other facilities and providers[19]	47.8%	5.9%	6.6%	6.2%
Total	100.0%	9.8%	5.9%	7.9%

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

Utilization & Intensity

To examine historical utilization trend patterns, we first normalize for unit cost increases for each of the facilities and provider groups included in Exhibit 3A. The historical cost increases reflect the approved or negotiated commercial increases for each group.

We derive contracting changes for out-of-area services from the Fall 2022 Blue Trend Survey, which is a proprietary and confidential dissemination of the Blue Cross and Blue Shield Association.

We normalize claims to the December 2022 contract at each unique provider by applying a factor equal to the product of the impact of each contracting change from the experience month through December 2022. We assume the derived trend for other claims is continuous.

Blue Cross VT continues to implement many payment integrity programs to combat fraud, waste and abuse (FWA). To control for the changes in payment integrity recoveries, we normalize claims to the recovery levels achieved in 2022[20] in accordance with the following chart:

[19] Vermont facilities with professional reimbursement on the Blue Cross VT Community fee schedule are included in this category.
[20] The impact of projected changes to the FWA programs is described in the projected payment integrity impacts section on page 32.

Incurred Period	Percent of claims recovered as part of FWA programs[21]
CY 2019	0.34%
Q1-Q3 2020	0.62%
Q4 2020	1.27%
CY 2021	2.59%
CY2022	2.45%

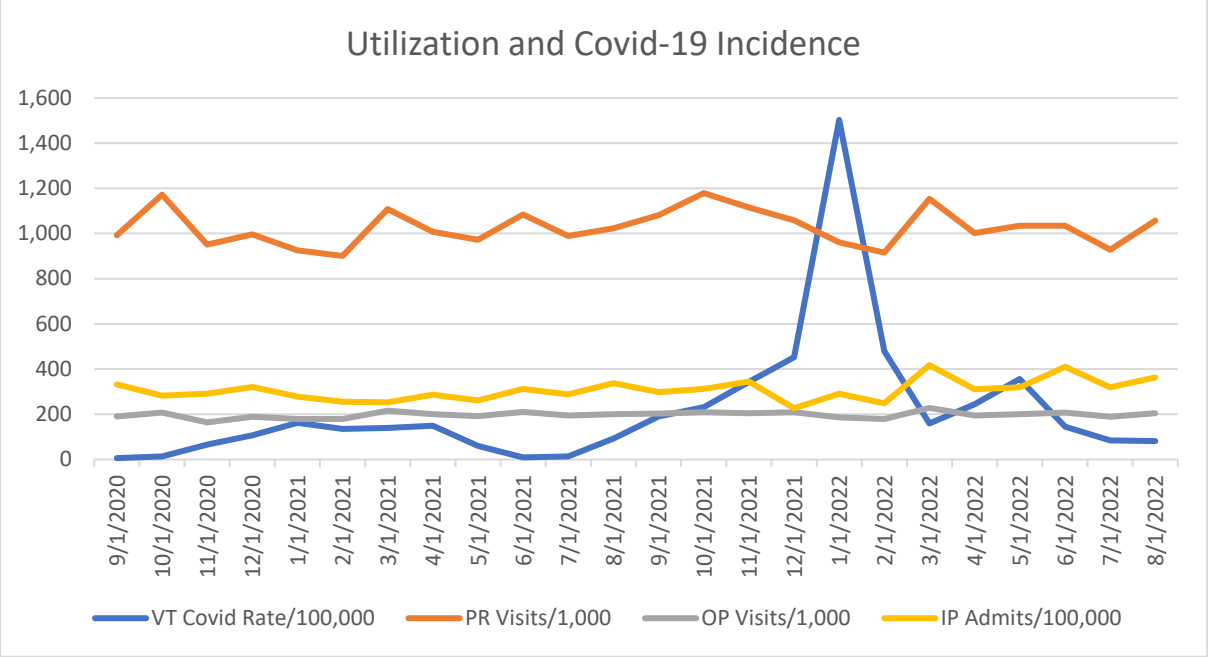
We further normalize the claim costs such that each month reflects the average number of working days per month in 2022, as defined by our reserving models.

Page 2 of Exhibit 3B shows the calculation and resulting factors for these adjustments for the matched population.

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

The COVID-19 pandemic greatly impacted medical claims, with a slowdown in services in the spring of 2020 and a return of care into 2021. In the fall of 2020, the cyberattack on the University of Vermont Health Network (UVMHN) also impacted medical claims as some services needed to be rescheduled in the first quarter of 2021, further dampening 2020 and amplifying 2021 claims. While COVID-19 is still in our communities, its impact on the utilization of medical care was limited, if non-existent in 2022, as shown in the graph below.

[21] Programming slowed in 2019 due to Blue Cross VT's migration to a new operating platform. The Vermont Department of Financial Regulations (DFR) ordered the suspension of all routine provider audits from March 18, 2020 through August 3, 2020. In the fourth quarter of 2020, Blue Cross VT did not engage in routine audits of the University of Vermont Health Network providers as they dealt with a cyberattack. In 2021, Blue Cross VT was able to return its internal payment integrity efforts to pre-migration and pre-pandemic levels while working with new vendors to increase the recoveries beyond historical levels.



Facility Claims

For facility claims, we select a 0.5 percent utilization trend.

The table below shows the PMPM claims costs, adjusted for cost increases, FWA programs, and number of working days for the matched population for facility claims.

Facility Claims		
Year	**PMPM**	**Trend**
2019	$309.04	
2020	$276.12	-10.7%
2021	$326.65	+18.3%
2022	$324.55	-0.6%

Comparing 2022 to 2019, the last calendar year prior to the COVID-19 pandemic, we observe a 1.6 percent annualized trend.

As mentioned above, calendar year 2021 was elevated due to deferred care from 2020, which dampens some 24-month measures such as the year-over-year trend. The Holt-Winters time series model forecasts both the trend and seasonality aspects of the underlying data and aligns with the year-over-year trend. The regressions on the other hand clearly suggest an emerging positive trend.

Summary of Statistics for Periods Ended December 2022 for Facility Claims		
Method	**Trend**	**RMSE**[22]
Year-over-year trend	-0.6%	
24-Month Logistic Regression	2.4%	26.46
24-Month Linear Regression	2.6%	26.44
24-Month Holt-Winters' Multiplicative	0.6%	22.34
24-Month Holt-Winters' Additive	-0.4%	16.23

The average of these measure is 0.9 percent.

While the year-over-year trend is negative, there are external forces that may impact facility utilization between 2022 and 2024. Notably, hospital budget submissions assumed an increase in utilization during the 2023 cycle, which supports a selection modestly higher than the year-over-year trend[23]. We consider a 0.5 percent trend rate to be a reasonable selection through 2024 for facility claims.
The Green Mountain Surgery Center (GMSC) opened in July 2019 and the experience used in this filing reflects the lower cost for the surgeries performed at GMSC. We did not adjust the experience to reflect this change; such an adjustment would have increased each statistic in the table above by 0.2 percent. By not adjusting for this change, we are implicitly expecting that trend will continue to be dampened as more services shift from more expensive settings to the GMSC.

Details on facility trends are shown on Exhibit 3C.

Professional and Ancillary

We select a 1.0 percent utilization trend for non-mental health and substance use disorder (MHSUD) professional claims and for MHSUD services.

In prior filings, we selected utilization trend specifically for the change in number of services and mix of services between the different types of professional services. This was done to address one-time events that impacted professional claims in 2019. Professional claims were also impacted by the COVID-19 pandemic reducing the number of visits in 2020 and increased visits in 2021 due to care returning.

For this filing, we opted to use the same methodology as for facility claims and use the array of PMPM claims costs, net of high claimants, and adjusted for number of working days and FWA to perform regressions and time series calculations.

[22] Root Mean Square Error (RMSE) is the standard deviation of the prediction errors. It measured the delta between the residuals and line of best fit.
[23] UVMMC's hospital budget submission notes that "(w)orkforce challenges continue to create access issues across multiple service lines" (p. 13), but they "assume a stabilization of the long-term care and skilled nursing facility system," which is needed to address "significant backlog of patients" seeking care (p.39). UVMMC also notes that, "Pandemic impacts on [UVMHN] during the Omicron wave" included decreased volumes "for higher margin services … due to inpatient capacity and outpatient surgery constraints" (p.41).
https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMHN_FY_2023_UVMHN_Budget_Narrative_07-01-2022_-_Final.pdf

Due to the large change in MHSUD utilization patterns in 2020 and 2021, as compared to non-MHSUD services, we separate utilization trends for MHSUD from non-MHSUD professional services. The table below shows the annual PMPMs and trends for both categories of professional claims.

Professional Claims PMPM				
	Non-MHSUD		MHSUD	
	PMPM	Trend	PMPM	Trend
2019	$128.10		$15.32	
2020	$109.42	-14.6%	$16.73	9.2%
2021	$136.78	25.0%	$18.13	8.3%
2022	$136.40	-0.3%	$18.56	2.4%

For non-MHSUD services, services deferred in 2020 continue to return in 2021. As with facility claims, 2021 was elevated compared to 2022 due to these returning services.

Summary of Statistics for Periods Ended December 2022 for Non-MHSUD Professional Claims		
Method	**Trend**	**RMSE**[24]
Year-over-year trend	-0.3%	
24-Month Logistic Regression	2.8%	8.15
24-Month Linear Regression	2.7%	8.15
24-Month Holt-Winters' Multiplicative	-0.3%	5.37
24-Month Holt-Winters' Additive	-0.3%	4.10

The average of these measures is 0.9 percent.

As with facility trend, the negative year-over-year trend is partly due to the elevated 2021 experience, and the regressions clearly suggest a positive emerging trend.

Blue Cross VT, through programs like VBIC, continues to work with providers to increase the access to primary care and ensure that members get the appropriate screenings and follow up care for their conditions. By increasing primary care services in the short-term, we can expect long-term returns on the overall health of Vermonters.

We therefore believe that a 1.0 percent trend for non-MHSUD providers, which is slightly above the average of the metrics shown above, reflects both the recent experience and expectation of increased utilization in the short-term.

Based on the historical patterns and the work in Vermont to expand access to mental health services, especially during and after the pandemic, MHSUD services trended at a higher rate than other professional services through 2021. In prior filing, we based the overall utilization trend for MHSUD services on only the changes in number of services. That methodology does not account for the increase

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

in the intensity and mix of services in this category. To account for this, we used the same methodology as for non-MHSUD claims and use the array of PMPM claims costs, net of high claimants, and adjusted for number of working days and FWA to perform regressions and time series calculations.

Summary of Statistics for Periods Ended December 2022 for MHSUD Professional Claims		
Method	**Trend**	**RMSE**[25]
Year-over-year trend	2.4%	
24-Month Logistic Regression	0.4%	8.15
24-Month Linear Regression	0.3%	8.15
24-Month Holt-Winters' Multiplicative	2.3%	5.37
24-Month Holt-Winters' Additive	0.7%	4.10

The average of these measure is 1.2 percent.

After the large increases observed in 2020 and 2021, the utilization of MHSUD services has leveled off and is now trending at a similar rate as non-MHSUD services. We therefore select the same trend, 1.0 percent, for MHSUD services.

Exhibit 3D shows the normalized professional PMPM, for MHSUD and non-MHSUD, along with the regressions and time series.

Pharmaceuticals

We select a 2.0 percent utilization trend for pharmaceuticals processed through the medical benefit.

The recent acceleration in cost for pharmaceuticals processed through the medical benefit warrants a separate analysis for these claims. Pharmaceuticals processed through the medical benefits include a wide variety of drugs. In prior filings, we included all types of pharmaceuticals in this separate analysis, but ultimately trended non-injections at the selected facility trend. To simplify the analysis, we only included injections in this analysis and retained non-injections in the facility trend analysis.

We split the injection experience into four categories: Injections with a biosimilar option, biosimilars, other injections costing at least $1,000, and all other injections. The introduction of biosimilars considerably changes the cost per service for injections. To reflect this change in mix, we project the overall number of services for injections and their biosimilar options and project the growth in the share of services that will be with a biosimilar. We apply the overall outpatient cost trend to each category to project the cost per service. By using varying trends for services per member for each category, the average projected cost per service for all pharmaceuticals processed through the medical benefit reflects a projected change in mix. This change in mix is included in the total utilization trend below.

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

Exhibit 3E, pages 1 to 2 show the experience services per 1,000 members for each of the four injection categories, total allowed charges, and the 24 and 36-month regressions. Exhibit 3E, page 3, shows the result of this calculation.

Injections have been increasing steadily, with the expected slowdown and return due to the COVID-19 pandemic (while less pronounced than for other types of claims) and we expect it to continue to grow at a 2.4 percent rate through calendar year 2024.

Trend for Injections	
Most Recent Year over Year	-3.3%
Three-Year	2.6%
24-month regression on Monthly data	3.6%
24-month regression on rolling 12 data	6.7%

The biosimilar utilization as a percentage of total services for injections that have a biosimilar option has been increasing logarithmically over the past few years but slowed down in the past year:

Percentage of Biosimilar Services	
CY 2019	6.2%
CY 2020	28.9%
CY 2021	41.2%
CY 2022	39.3%

We do not expect the percentage to remain at this rate through calendar year 2024. We expect that the percentage of biosimilars will grow by about 5 percent per year. At this rate, we calculate that the percentage of biosimilars will be about 50 percent for calendar year 2024.

Combining all the categories yields a 2.0 percent utilization trend for pharmaceuticals, including the impact of change in mix, which is lower than the assumption in the prior filing (3.6 percent).

Overall Medical Utilization Trend

Using the 2022 allowed charges PMPM, adjusted for the index rate projection factors described earlier in this section, we calculate the following overall medical utilization trend:

Calculation of the overall medical utilization trend - Individual		
Category	**Uncapped Allowed Charge PMPM, adjusted for projection factors (Line D of Exhibit 3J-IND)**	**Selected Utilization Trend**
Inpatient	$129.07	0.5%
Outpatient	$292.97	0.5%
Pharmaceuticals	$80.87	2.0%
Professional	$184.80	1.0%
COVID-19	$7.74	0.0%
Total	**$695.45**	**0.8%**

Calculation of the overall medical utilization trend – Small Group		
Category	**Uncapped Allowed Charge PMPM, adjusted for projection factors (Line D of Exhibit 3J-SMG)**	**Selected Utilization Trend**
Inpatient	$116.86	0.5%
Outpatient	$239.86	0.5%
Pharmaceuticals	$77.05	2.0%
Professional	$159.48	1.0%
COVID-19	$9.71	0.0%
Total	**$602.97**	**0.8%**

Projected Payment Integrity Impacts

As described above, the FWA programs yielded savings and recoveries of about 2.5 percent of total allowed charges in 2022. We do not expect this percentage to change in 2024.

3.4.7.3. Pharmacy Trend Development

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

Non-Specialty Drug Utilization

As described above, we use a matched population as the basis for our trend analysis and adjust for pharmacy working days, which are different from medical working days. Using the array of monthly PMPM claims after adjustments, we performed 24-month and 36-month regressions as well as time series.

Exhibit 3F provides the monthly, quarterly, and the 12-month rolling data, along with the corresponding year-over-year and exponential regression trends and time series for non-specialty drug utilization. We use the number of days supply, rather than the number of scripts, to normalize for changes in the days supply per script (e.g. increased use of 90-day fills). Because there are several popular brand drugs that have become generic during the experience period, or will become generic during the projection period, we combine the data for generic and brand drugs for the purpose of analyzing utilization patterns. Vaccines and devices have been moving from the medical benefit to the pharmacy benefits. These two categories are excluded from the non-specialty trend calculations as they would skew the results. COVID-19 vaccines are completely excluded from this analysis, as their inclusion would skew the results.

Due to the relaxation of clinical edits in response to COVID-19, many members refilled their prescription early in March 2020. This changed the pattern of monthly days supply per member. To adjust for this one-time event, we smooth monthly days supply per member for the periods from March 2020 to May 2020 and June 2020 to August 2020 by using the monthly spread from the same months in 2019. Blue Cross VT introduced Vermont Blue Rx in July 2021, which included a change in pharmacy benefit manager. Prior to the transition, members were offered the option to refill their prescriptions early to avoid potential disruptions. We smooth the monthly days supply for the period from June 2021 to August 2021 by using the monthly spread from the same months in 2019.

Similar to the prior filing, we performed regressions and time series on quarterly data, which decreases the variance of the statistics. As shown in the table below, the regressions, year-over-year, and the two-year trend converge around 2.0 percent. Accordingly, we select a 2.0 percent non-specialty trend.

Trend for Non-Specialty Drug Utilization	
8 Quarter Regression	2.7%
12 Quarter Regression	2.0%
16 Quarter Regression	2.9%
Year Over Year	1.3%
Two-Year	1.4%

Instead of projecting a generic dispensing rate, we separate the drugs into nine categories:

- Generics: Drugs that have been generic since at least January 2020
- New Generics: Generic drugs that have been in the market for less than 36 months (introduced January 2020 to December 2022)
- Brands going Generic: brands that are expected to become available in generic form in the projection period, based on a list from our pharmacy benefit manager
- Vaccines
- Over the Counter (OTC) drugs
- Compounds
- Devices, such as continuous glucose monitoring and insulin pens
- All other Brands
- COVID Vaccines

As shown on Exhibit 3I, all days supply are trended forward at the same rate of 2.0 percent.

Generic Cost Trend

Exhibit 3H, page 1, shows monthly Average Wholesale Price (AWP) cost per days supply and the 24-month regressions. We select 3.8 percent for the generic cost trend, which is the roughly the average of the 24-month regressions and the year over year result. The rolling annual trends have been between 3.6 and 4.0 percent for the last eleven 12-month periods. We consider 3.8 percent to be a reasonable long-term outlook for generic cost trend. This is consistent with our prior filing.

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

Brand Cost Trend

To ensure that the brand cost trend is not skewed by brands going generic, vaccines, over the counter drugs, devices, and compounds, we performed a 24-month regression on monthly AWP cost per days supply on the “brands with at least four years of claims” category only. The monthly AWP cost per day supply for brand drugs is impacted by the mix of new and older brands. Brands that have been in the market for one to two years have been, on average, less expensive than older brands. To account for this change in mix, we perform a 24-month regression on monthly AWP cost per day supply for brand drugs that have been in the experience for at least four years and have had no drastic change in their market share.

Exhibit 3H, page 2, shows monthly cost per days supply and the 24-month regression. We select 10.5 percent for the brand cost trend, which is the average of the 24-month regression on monthly data and the most recent year over year result. This selection is consistent with recent filings, and we consider it to be a reasonable outlook of future trend. We apply the selected trend to all brand drugs, including devices and vaccines.

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

We also do not expect over-the-counter drugs and COVID-19 drugs to follow the overall brand cost trend, and we select a 0.0 percent cost trend for these drugs.

Specialty Drugs

In July 2021, we introduced Vermont Blue Rx, which improved our discount off AWP for specialty drugs. We adjust months prior to July 2021 to reflect the current contract.

We did not adjust the experience to reflect aging or benefits because we used the matched population. We did not adjust for working days, as nearly all retail specialty medications are provided through mail service and the vast majority of prescriptions are refills.

As described above, Blue Cross VT introduced Vermont Blue Rx in July 2021, which included a change in pharmacy benefit manager (PBM). Prior to the transition, members were offered the option to refill their prescriptions early to avoid potential disruptions. We smooth the monthly days supply for the period from April 2021 to August 2021 by using the monthly spread from the same months in 2019 and 2022. This smoothing period for specialty drugs is longer than for non-specialty drugs due to the nature of the prescriptions and observed refill patterns.

Exhibit 3G contains the monthly and the 12-month rolling data, the smoothing adjustment, and the results of the regressions. We select 19.5 percent as the contracted adjusted trend.[26] This is informed by the average trend produced by a 24-month regression on monthly cost, a 24-month regression on rolling 12-month cost, the most recent year over year increase, and an expected reduction in costs due to the introduction of biosimilars. For our regressions, we chose 24 points of monthly data to best capture the most recent history of drug costs.

Changes in Pharmacy Contracts

Vermont Blue Rx has established contracted rates with its new PBM that continue to provide substantial savings to consumers. Furthermore, the contract includes annual discount improvements that will impact the projected pharmacy allowed charges. To calculate a contract improvement factor, we applied the contracted discounts and dispensing fees for each type of drug (Generic, Brand and Specialty) to calendar year 2022 claims for contract provisions applicable to both the experience period and the projection period. We apply the contract improvement factor to the projected pharmacy claims for each type of drug, calculated by taking the ratio of the projected pharmacy claims under each contract (see Exhibit 3I for details).

[redacted]

[26] [redacted]

Overall Pharmacy Trend

Exhibit 3I summarizes the trends and calculates our total allowed pharmacy trend as 14.9 percent. Note that changes in pharmacy contracts are included in the cost trend component on Exhibits 3J.

3.4.7.4. Vision and Dental Trend Development

Dental Trend

The pediatric dental benefit is available to all members age 21 and under. Dental services were greatly impacted by the COVID-19 pandemic, with some dentist offices closing during the spring of 2020. In prior filings, we expected dental services to return to 2019 levels. The 2022 experience is still slightly below the 2019 experience and we believe that dental services have reached their new steady state levels. We therefore apply no trend for dental services. The table below shows the historical dental allowed charges per child member per month (PCMPM) and PMPM.

Historical for Dental Claims – Using matched population		
Calendar Year	**PCMPM**	**PMPM**
2019	$11.68	$1.76
2020	$9.16	$1.38
2021	$10.86	$1.62
2022	$10.81	$1.60

Vision Trend

While the slowdown in the spring of 2020 due to the COVID-19 pandemic impacted vision services, the deferred care returned in the second half of the year and the annual PCMPM and PMPM are aligned with the other years in the experience The table below shows the historical vision allowed charges PCMPM and PMPM.

Historical for Dental Claims – Using matched population		
Calendar Year	**PCMPM**	**PMPM**
2019	$0.52	$0.08
2020	$0.56	$0.08
2021	$0.48	$0.07
2022	$0.52	$0.08

We expect 2023 and 2024 to remain at the level experienced in 2022; we therefore select a 0.0 percent overall vision trend.

3.4.7.5. Overall Total Trend

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

	Row on Exhibits 5	Individual Factor	Small Group Factor
Cost Trend Factor	$1+d_1$	1.1507	1.1504
Utilization Trend Factor	$1+d_2$	1.0522	1.0513

3.5. Credibility of Experience

In the experience period, Blue Cross VT had 194,869 member months in the individual market and 235,406 in the small group market for a total for 430,275 member months in the combined market. The experience is fully credible in all markets.

3.6. Credibility manual rate development

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

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

3.6.2. Adjustments Made to the Data: Not Applicable

3.6.3. Inclusion of Capitation Payments: Not Applicable

3.7. Market Adjusted Index Rate

The Market Adjusted Index Rate (line H of Exhibits 5) is $911.24 for the individual market and $821.25 for the small group market. We calculate these quantities by adjusting the Projected Index Rate (line F of Exhibits 5) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustment Transfer PMPM:

On March 17, 2023, CMS published an Interim Summary Report on Risk Adjustment for the 2022 benefit year[27]. The Blue Cross VT data included in the report represents claims incurred in 2022 and paid through December 31, 2022. We assume that MVP's 2022 interim submission includes the same incurred and paid data as Blue Cross VT, consistent with previous years' interim submissions. The final 2022 report will include the impact of supplemental diagnosis files and claims runout. We estimate the impact of claims runout and supplemental diagnoses for Blue Cross VT and MVP by considering

[27] https://www.cms.gov/cciio/programs-and-initiatives/premium-stabilization-programs/downloads/interim-ra-report-by2022.pdf

historical relationships of the plan liability risk score (PLRS) in the 2018 to 2021 Final Summary Reports relative to the 2018 to 2021 Interim Summary Reports.

The 2024 risk adjustment calculation starts with the estimated final 2022 risk adjustment and projects to 2024 based on projected membership changes, market-wide premium increases, PLRS adjustments due to model changes, and other factors impacting the transfer.

Market-Wide Premium Increases

We calculate the 2024 market-wide premium by applying statewide increases from the 2022 Interim Summary Report to 2023 and from 2023 to 2024. The statewide premium in 2023 represents the weighted average increase between Blue Cross VT and MVP. The weights and increase for Blue Cross VT are observed from our data by comparing actual February 2023 premium PMPM compared to calendar year 2022 premium PMPM. MVP's weight was pulled from the January 2023 DVHA enrollment report[28] and their rate increase was pulled from their approved 2023 ACA rate filing adjusted for the observed 2023 plan mix change in each market. We project the 2024 market-wide premium by applying Blue Cross VT rate increases by market as an approximation for the statewide increase.

The calculation of 2024 average premium by market is shown in Exhibit 4, Table 1.

Model Adjustments

On April 17, 2023, HHS released the final notice of benefit and payment parameters (NBPP)[29] which included finalized 2024 risk adjustment model coefficients.

Blue Cross VT performed an analysis using production Edge Server data for benefit year 2021, the most recent fully complete experience year. The analysis consisted of mapping each 2021 unique member, metal level and market combination to the 2022 model and the 2024 model. This mapping allowed us to observe the impact of model changes between 2022 and 2024 using the same base experience. We observed that the model changes impacted various member groupings in different ways. Most notably, metal levels are impacted by varying degrees and members that had a claims-based HCC component had a smaller relative model change compared to a member whose risk score consisted only of a demographic component.

The Blue Cross VT impact was summarized from the analysis by metal level and market. The overall impact represents the weighted average by metal and market using the projected 2024 plan mix as the weights. The MVP impact was measured by taking a subset of the Blue Cross VT data such that the average risk score for each metal and carrier category matched with MVP's 2021 experience risk score by metal and carrier. MVP's 2021 risk scores were imputed from the experience section of their URRT within each respective 2023 ACA rate filing. The overall MVP impact used their metal distribution from the DVHA enrollment report as the weight applied to the MVP estimated model impact by metal and market. The result of this analysis was that relative risk scores between the carriers changed by a factor of 1.0014 and 0.9998 for the individual and small group markets, respectively. Since the modeled relative results were so close to 1.00, we concluded that MVP's model impact was not materially

[28] Report provided by DVHA to carriers on February 27, 2023.
[29] https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf

different than Blue Cross VT's and thus assumed the same model impact factor for both carriers. The table below summarizes the model impact analysis.

	Model Impact CY 2024 compared to CY2022		Selected model impact for both carriers
Market	**Blue Cross VT**	**MVP**	
Individual	0.9620	0.9603	0.9620
Small Group	0.9709	0.9711	0.9709

Population Adjustments

We adjust the PLRS for both Blue Cross VT and MVP for the impact of members migrating between carriers, the impact of new members, members leaving the ACA market altogether, and the impact of members changing their metallic plan design.

Comparing membership as of February 2023 to experience membership, we categorize members into "renew", "cancel" or "new" buckets. We adjust the Blue Cross VT projected 2024 risk score by removing members who canceled for reasons other than retirement, death, expiration of 90-day newborn coverage, or transition to another Blue Cross VT line of business. [redacted]

We estimate the impact of new members to Blue Cross VT by first imputing a demographic risk score from in force enrollment data using observed age, gender and plan selection. We calculate the remaining risk score components—medical diagnosis, severity, duration, prescription drug, medical-pharmacy interaction and cost-share reduction (silver only)— based on historical relationships between new members and renewing members. [redacted]

We estimate the impact of plan changes within the renewing population by mapping each member and their experience risk score to a hypothetical 2022 risk score in their new metal level. The individual and small group markets both saw a benefit buy-down on average. [redacted]

As described in section 3.4.1, we project that the Medicaid redetermination will add new members in both the individual and small group ACA markets. Our assumption is that the new members formerly in Medicaid will select a Blue Cross VT plan comparable to the current market share, about 60 percent, resulting in the Blue Cross VT individual market growing by 1,609 members and the Blue Cross VT small group market growing by 1,711 members. We further project that the new Medicaid members will have the same risk score relationship between the carriers as the existing market; therefore, the risk score impact is 1.000 for both carriers. However, increasing the size of the markets has an impact on the

projected transfer even if the risk scores are not impacted. Adding new Medicaid members to the individual market increases the billable member months by 8.8 percent, increasing the projected transfer increases by $1.8 million. The small group market is projected to grow by 7.8 percent, increasing the transfer by $1.1 million.

MVP's risk scores are impacted by members leaving and joining as well as observed changes in plan design. A member that is considered "new" to Blue Cross VT is assumed to be a member who left MVP, while Blue Cross VT members who left voluntarily are assumed to have the same risk profile as those who joined MVP. [redacted]

MVP, like Blue Cross VT, observed a benefit buy-down from its 2022 experience plan designs. Using data from the DVHA January 2023 statewide enrollment by plan report we can estimate the change in plan mix for MVP. [redacted]

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

Other Factors

Adjustments were made to the 2022 Interim Summary Report for the Catastrophic plan to reflect the projected 2024 catastrophic statewide premium. Blue Cross VT had approximately 98 percent of the catastrophic market in 2022, and we project a similar market share in 2024. Since Blue Cross VT has an identical market share in both the experience and projection periods, we did not make any population adjustments to the 2022 experience. The 2024 projected statewide premium was calculated by applying a weighted average 2023 increase based on approved rate increases and the Blue Cross VT projected 2024 increase as an approximation for the statewide increase to the 2022 interim statewide premium.

Other factors impacting the risk adjustment transfer include the actuarial value (AV), induced demand factor (IDF) and allowed rating factor (ARF). The AV and IDF factors change from the estimated final 2022 calculation as a result of the metallic distribution changing in 2024. We assume the ARF is unchanged from 2022 within the individual and small group markets. These results are shown in Exhibit 4, Table 3.

The 2022 Interim Summary Report has a total transfer amount $22,888,645. Due to claims runout and the expected impact of the supplemental diagnosis file, we estimate the final 2022 transfer will be $26,092,375 for the individual, small group, and catastrophic markets combined. Adjusting the final 2022 transfer for model, population, and plan changes, we estimate the final 2024 transfer will be $19,940,915 for the individual market, $14,667,461 for the small group market, and ($13,786) for the catastrophic plan. Each of these transfer amounts is prior to the charges for the HCRP program.

The 2024 transfer amount PMPM is partially offset by the projected charges and payments for the HCRP program. The plan year 2021 HCRP charge for the individual market was 0.31 percent of premium[30]. The plan year 2021 HCRP charge for the small group market was 0.49 percent of premium. Due to trend leverage for a constant attachment point, the charge will increase over time as a percentage of total

[30] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2021.pdf

premium. To estimate the 2024 charge, we trend the charge using a 28.0 percent trend for three years for claims above $1 million[31]. We then divide by an estimated average nationwide premium increase of 10 percent annually for three years. This calculation yields the following estimates of the 2024 charge:

Market	Percent of Premium	PMPM
Individual	0.459%	$4.01
Small Group	0.723%	$5.60

In the buildup of the projected index rate, we exclude all claims above the detrended pooling point of $1 million. By including the total cost of reinsurance and the total HCRP charge, we effectively assume that claims above the pooling point would be offset by reinsurance and HCRP recoveries of an equal amount. The exception is for the high claimant discussed in section 3.4.6, whose claims net of HCRP recoveries we include separately, as described in that section.

Since the Market Adjusted Index Rate is on an allowed claims basis, we adjust the net projected risk adjustment payment by the average paid-to-allowed ratio (from Exhibit 6C).

Details of the risk adjustment transfer calculation are on Exhibits 4.

The overall market-wide adjustment (line g_1 of Exhibits 5) for the risk adjustment program is ($120.19) PMPM for the individual market and ($61.19) PMPM for the small group market.

3.7.2. Exchange User Fees

Blue Cross VT does not expect Vermont Health Connect to charge a user fee for 2024.

3.8. Plan Adjusted Index Rates

3.8.1. Plan Adjustment – Actuarial Value and Cost Sharing adjustment

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

- Benefit Richness Adjustment
- Paid-to-Allowed Ratio

The paid-to-allowed ratio comes from the federal actuarial value calculator (AVC) and is adjusted for benefit items that are not supported by the calculator as well the impact of aggregate and stacked deductibles. The adjustments to the federal AVC come from the Blue Cross VT internal re-adjudication model. The experience used to calculate the adjustments to the-paid-to allowed ratio is our calendar year 2018 data trended to calendar year 2024 using the trend factors described in section 3.4.7. The model re-adjudicates claims by starting with the allowed charges and applying appropriate cost sharing for each service. The model generates the projected average paid claims for each benefit based on what the AVC can support as well as what the model cannot support. The relationship between these outputs

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

from the Blue Cross VT based model is applied to the federal AVC paid-to-allowed ratio. The Blue Cross VT re-adjudication model is calibrated to 2018 experience and reproduces the experience paid-to-allowed ratio to within 0.1 percent.

The benefit richness adjustment reflects the expected changes in utilization due to different levels of cost sharing. This adjustment is based on the 2020 adjusted federal AVC. The 2024 federal AVC was not used as the basis because the updates made to the AVC in 2021 and carried forward to 2024 produced counterintuitive results across metal levels. The AVC, while not developed as a pricing tool, is used here to set the relativities between the plans because it represents the best approximation of a total market distribution free from selection bias. The adjustment described in section 3.8.6 ensures that the total premium collected is appropriately based on the Blue Cross VT re-adjudication model and experience, and not the federal AV calculator.

3.8.1.1. Benefit Richness Adjustment

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

These factors are normalized using the projected membership to ensure that the total adjustment is 1.000. The plan-level adjustment for benefit richness is calculated by applying the benefit richness adjustment by base benefit and applying a factor of 1.000 for non-system claims and market-wide adjustments. See Exhibit 6B for details.

3.8.1.2. Paid-to-Allowed Ratio

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

3.8.2. Silver Loading

On March 15, 2023 the Green Mountain Care Board provided prescriptive guidance on Silver Loading to ensure compliance with 45 CFR 156.80(d)(2) as follows;

- Based on the combined experience of all the issuer's individual market plans, consistent with the other metal tiers, and
- calculated using weighted average benefit richness of Silver members, inclusive of the issuer's CSR-adjusted benefits.

Blue Cross VT developed the 2024 Silver Load by first calculating a paid-to-allowed ratio similar to all other plans as described in section 3.8.1.2 for each federal CSR variant, 73%, 87%, 94% and 100%, on each of the four silver plan designs. Then, an average paid-to-allowed ratio was calculated for the on-exchange silver plans using the projected 2024 membership which accounts for the mix of federal CSR variants within each silver plan. The Silver Load shown in Exhibit 6C represents the ratio of the weighted average paid-to-allowed ratio described above relative to paid-to-allowed ratio of the base silver plan.

This factor does not apply to the small group market.

3.8.3. Provider Network, Delivery System and Utilization Management adjustment

Not applicable.

3.8.4. Adjustment for benefits in addition to the EHBs

We trend our 2022 experience period non-EHB claims using the medical trends described in section 3.4.7, which produces an average allowed charge of $0.05 PMPM for the individual market and $0.11 PMPM for the small group market. Applying the same paid-to-allowed ratio to this benefit as to the EHB benefit, we calculate plan level factor adjustments that range from 1.0000 to 1.0002 for the individual market and 1.0001 to 1.0002 for the small group market, as shown on Exhibits 6A.

3.8.5. Impact of specific eligibility categories for the catastrophic plan

This plan adjustment includes two components of the impact of the specific eligibility categories for the catastrophic plan. Both adjustments are based on the eligible population. Since the expanded subsidies are continuing through 2025, we continue to project that 100 percent of the population eligible for this product in 2024 will be under age 30.

To adjust for the eligible population, we first calculate the adjustment for the impact on the pricing actuarial value of the expected lower allowed charges of the group eligible to enroll in the catastrophic plan. We calculate that the overall expected allowed charges are 0.4706 of the total allowed charges. We then adjust the paid–to-allowed ratio based on the average total allowed charges. This factor is 0.9673.

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

The total adjustment for the specific eligibility categories for the catastrophic plan is 0.3649 for the individual market. This factor does not apply to the small group market. See Exhibits 6D for details.

3.8.6. Impact of Selection

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

The total impact of selection is 1.1355 for the individual market and 1.1152 for the small group market.

3.8.6. Adjustment for distribution of the administrative costs

3.8.6.1. Administrative Expense Load:

The table below shows the total of all administrative charges outlined in this section as a percent of premium. The details of the administrative charges are on Exhibits 7A.

Total Administrative Charges as a Percent of Premium	
Individual Market	7.0%
Small Group Market	6.3%

Blue Cross VT did not initially calculate the administrative expense load as a percent of premium adjustment. This adjustment is the sum of the following fees divided by the average premium PMPM from Exhibits 6A.

<u>Blue Cross VT Base Administrative Charges</u>

We use calendar year 2022 data for both individual and small group members to develop the base administrative expenses PMPM.

The table below shows the reconciliation from GAAP accounting data to base administrative charges, including the removal of federal fees, GMCB billback, debit and credit card fees, and fees paid to vendors for the administration of Health Savings Accounts and Health Reimbursement Accounts linked to our insurance products. Each of these items that have been removed are added to premiums elsewhere. We also remove any expenses incurred due to one-time, non-recurring events, as these costs are not expected to continue to occur in the projection period.

Reconciliation of Experience Base Administrative Expense to Reported GAAP Expenses				
	Individual Market		Small Group Market	
	Total Dollars	PMPM	Total Dollars	PMPM
Reported Expenses (GAAP)	$12,245,531	$62.84	$11,758,858	$49.95
Federal and State fees	($857,219)	($4.40)	($874,211)	($3.71)
Fees for outside vendors	($47,889)	($0.25)	($111,267)	($0.47)
Exclusions	($912,032)	($4.68)	($720,735)	($3.06)
Base Administrative Expenses	$10,428,391	$53.51	$10,052,644	$42.70

The base administrative charges are projected to 2024 using a 4.0 percent annual trend. This projection factor is intended to make reasonable but modest provision for increases in overall operating costs PMPM. In light of continued inflationary pressures, Blue Cross VT believes than an overall administrative expenses annual trend of 4.0 percent better reflects the expected growth in costs.

We calculate PMPM admin charges with experience period enrollment and projected enterprise-wide 2024 enrollment. When projecting the 2024 enrollment, we include the observed membership changes, and expected growth due to the anticipated Medicaid redetermination initiative and its expected impact on ACA membership (see section 3.4.1 for details). Blue Cross VT variable costs represent approximately 30 percent of total administrative expenses. Blue Cross VT is committed to providing insurance coverage for our members at the most affordable rates possible; as a result, even though it is impractical to react to enrollment shifts by immediately right-sizing staff, we nonetheless remove from our projection the entirety of variable costs associated with the changes in enrollment. We therefore apply a net decrease of 3.4 percent to the base PMPM charges to account for the growth in membership on core operating platform. The table below shows the calculation.

Development of Enterprise Membership Adjustment	
	Members Months
Experience Period	1,965,527
Projected 2024 Enrollment	2,065,332
Adjustment for Enterprise Membership	= 1+0.7 x (1,965,527/ 2,065,332-1) = -3.4%

To calculate the projected base administrative charges, we increase the base experience PMPM by 4.0 percent for two years of trend and by negative 3.4 percent for the impact of membership.

Projected Administrative Charges Calculation			
		Individual Market	Small Group Market
Experience Base Administrative Charges PMPM	A	$56.38	$45.26
Trend Projection	B	1.0816	1.0816
Impact of Membership changes	C	0.9662	0.9662
Projected Base Administrative Charges (Exhibits 7A)	D = A x B x C	$58.92	$47.29
Projected Base Administrative Charges as a percent of premium		6.7%	6.1%

Debit and Credit Card Fees

Starting in plan year 2021, Blue Cross VT offers members the opportunity to pay their premiums via debit and credit cards. Debit and credit card fees are a percentage of the amount paid. We therefore excluded the fees in the experience administrative charges and applied the percentage of premium to the 2024 projected premiums.

To project the average fee, we use premium payment and fee data from calendar year 2022. The average fees as a percentage of premium were 0.1 percent for the small group market and 0.25 percent for the individual market. The table below shows the calculation of the percentage.

Calculation of Debit and Credit Card Fees as a Percent of Premium		
	Individual Market	Small Group Market
Billed Premium PMPM – CY 2022	$684.41	$610.25
Card Fees PMPM	$1.69	$0.40
Card Fees as a percent of Billed Premium	0.25%	0.1%

Charges for Outside Vendors

- Dental and Vision

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

- HRA/HSA Integration Services

All Vermont ACA market members are eligible for HRA and/or HSA integration services. For plans with an HSA-compatible benefit design, we offer a service to integrate with the mechanics of depositing monies into and paying claims out of Health Savings Accounts (HSAs). All plans are also eligible for this service in connection with Health Reimbursement Accounts (HRAs). To calculate these fees, we use the experience of members that are already enrolled in this program and compare it to all members enrolled in the Vermont ACA market in the first two months of 2023.

Reconciliation to the Supplemental Health Care Exhibit

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

In the SHCE, administrative expenses are included in lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4. Line 1.5 also includes an allocation of federal income taxes that are not part of administrative expenses. Those must be excluded to reconcile to statutory basis administrative expenses. Statutory and GAAP accounting treat some expenses differently, mainly related to certain network fees and pension costs. The following chart demonstrates a reconciliation of the SCHE to GAAP base period administrative charges:

Reconciliation of SCHE and GAAP accounting		
		Individual and Small Group
SCHE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	$23,890,405
Less taxes in SCHE 1.5 that are not admin	B	($1,695,934)
Total administrative charges - STAT basis	C = A – B	$25,586,339
Differences in STAT and GAAP treatment	D	($1,581,950)
Total administrative charges - GAAP basis	**E = C + D**	**$24,004,389**

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

Contribution to Member Reserves

As directed by Blue Cross VT management, the filed rates include a nominal 3.0 percent contribution to reserves (CTR). A contribution to member reserves is required in order to maintain an adequate level of surplus. Surplus, or member reserves, is a critical consumer protection that is required by the Vermont Department of Financial Regulation. In the event of unforeseen adverse events that may otherwise impact Blue Cross VT's ability to pay claims, surplus allows subscribers to receive needed care and providers to continue to receive payments.

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

The recommendations provided in Attachment C have been reviewed and were found to yield a reasonable contingency margin.

Other Risk Margin

Under the ACA, enrollees who are receiving Advance Premium Tax Credits (APTC) have a three-month grace period to pay premiums, while enrollees who are not receiving APTC have a one-month grace period. For both these populations, the State requires the insurer to pay for claims incurred in the first month of the grace period even if premium is never collected. This uncollected premium is considered bad debt. To ensure that Blue Cross VT collects enough premium from the total pool to cover the grace periods, it is necessary to include a risk margin for bad debt. This only applies to the individual market.

For the individual market, we have added a margin of 0.20 percent, which equals the observed amount of uncollected premium due to the grace periods in each of the previous four years.

Calculation of the Unpaid 30-day Grace Period as a Percent of Premium - Individual			
	Unpaid 30-day Grace Period Premium	**Total Billed Premium**	**Percent of Billed Premium**
2019	$232,289	$131,158,860	0.2%
2020	$269,037	$129,532,299	0.2%
2021	$231,511	$123,499,348	0.2%
2022	$109,955	$133,369,892	0.1%
Total	**$842,792**	**$517,576,640**	**0.2%**

This provision is not applicable to the Small Group market.

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

3.8.6.3. Taxes and Fees:

The table below shows the total of all taxes and fees outlined in this section as a percent of premium. The details of the taxes and fees are on Exhibits 7C.

Total Taxes and Fee as a Percent of Premium	
Individual Market	1.3%
Small Group Market	1.4%

These taxes and fees are imposed by both the state and federal government.

Green Mountain Care Board Billbacks

Blue Cross VT is assessed a billback from the Green Mountain Care Board. We include the experience period PMPM of $2.32 PMPM in the rates.

Health Care Claims Tax

The Health Care Claims Tax (HCCT) levied by the State of Vermont totals 0.999 percent of claims. This consists of 0.8 percent of claims for the HCCA tax and 0.199 percent of claims for the VITL assessment. Act 73 of 2021 sunset the 0.199 percent assessment for the Health IT-Fund on July 1, 2023. Given that this fee has routinely been extended close to its sunset date, we continue to include it in the calculation for the full calendar year.

Patient-Centered Outcomes Research Institute Fee

This fee is part of the Affordable Care Act and applies to all plan years through October 1, 2029. We estimate that the fee will be $0.29 PMPM for the plan year ending December 2024.

Federal Insurer Fee

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

Risk Adjustment User Fees

Per the 2024 Final Notice of Benefits and Payment Parameters[32], the risk adjustment user fee is $0.21 per member per month.

3.8.7. Calibration

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

3.8.8. Projected Loss Ratio

The Medical Loss Ratio (MLR) calculation at individual market and small group market levels has a minimum requirement of 80 percent. We project that the overall loss ratio, using the federally prescribed MLR methodology, will be as follows:

Projected overall Medical Loss Ratio Using Federally Prescribed Methodology	
Individual Market	88.9%
Small Group Market	90.3%

The details of the MLR calculation are on Exhibits 8.

[32] https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf

3.9. Consumer Adjusted Premium Rate Development

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

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

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

Please see Exhibits 9A for details calculations of the contract conversion factor.

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

3.10. Small Group Plan Premium Rates

All Small Groups must renew on January 1, 2024 according to market rules. Blue Cross VT will not file small group rates for Q2-Q4 2024.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

Blue Cross VT will not be terminating any products prior to January 1, 2024.

4.2. Plan Type

The plan type is EPO.

4.3. Act 193 Information

This information is included templates filed in SERFF with this filing:

- *VT Rx Data Template – Blue Cross VT 2024 ACA Market – Individual.xlsx*
- *VT Rx Data Template – Blue Cross VT 2024 ACA Market – Small Group.xlsx*

4.4. Report on Outreach to Directly Enrolled Individuals

In the GMCB's Decision[33] of August 4, 2022 at page 20, the Board stated: "…we feel compelled to express our opinion that BCBSVT can and should do more to encourage direct enrollees to purchase a plan through VHC so that they can take advantage of federal and state subsidies that may be available to them." The GMCB required Blue Cross to: "include in next year's individual rate filing detailed information on the efforts it has taken to encourage enrollment through VHC and the effectiveness of these efforts." Please see attachment E for the report.

5. RELIANCE AND ACTUARIAL CERTIFICATION

5.1. Reliance

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

[33] https://ratereview.vermont.gov/sites/dfr/files/PDF/08.04.2022%20%20REDACTED%20Decision%20and%20Order%20GMCB-003-22rr%20%20GMCB-004-22rr_redacted_.pdf

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the plans that Blue Cross and Blue Shield of Vermont (Blue Cross VT) is proposing to offer to the Vermont individual and small group markets in 2024. These calculations are not intended to be used for any other purpose. This memorandum documents the methodology used to calculate the AV Metal Value for each Qualified Health Plan and reflective plan offered by Blue Cross VT in 2024, the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, that the Index Rate is developed in accordance with federal regulations, and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

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

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

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

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

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Exchanges, and for certification that the Index Rate is developed in accordance with federal regulation, is used consistently, and is only adjusted by the allowable modifiers.

Martine B. Lemieux, F.S.A., M.A.A.A.
Actuarial Director, Financial Integrity
Blue Cross and Blue Shield of Vermont
May 9, 2023

5.3. Disclosures

Information Date: The analysis provided in the report is based on information as known on May 3, 2023.

Scope: The purpose of this filing is to establish the premium rates for products offered by Blue Cross and Blue Shield of Vermont in the ACA market for the 2024 plan year. This filing is not intended to be used for other purposes.

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

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

Per GMCB guidance published on March 29, 2023[34], Vermont hospital budgets submissions are due June 30, 2023. The hospital budget submissions will be different from the assumptions included in this filing and may call into question the adequacy or excessiveness of the premium rates discussed herein.

Reliance on Other Sources for Data and Other Information: This analysis relies upon data from the Blue Cross VT data warehouse. I have reviewed the data for reasonableness, but no audit was performed. This analysis relies upon several sources of information that are cited as footnotes at their respective references. If any of the sources we have relied upon are incorrect or inaccurate, it may affect the accuracy of the results presented in the report.

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

On May 1, 2023, Blue Cross VT announced that it intends to affiliate with Blue Cross and Blue Shield of Michigan. The regulatory approval process, which will begin once both entities file with their respective state regulators, does not have a specific timeline. The effect of this proposed affiliation on the projections included in the filing is currently expected to be immaterial.

As of May 3, 2023, the Internal Revenue Service (IRS) has not released the 2024 limits on deductibles for high deductible health plans. This limit is the threshold used in Vermont for the maximum pharmacy out-of-pocket. In the event that the 2024 limit is higher than the limits included in Attachments A and B, the plan designs would need to be updated following this filing to reflect the changes in pharmacy out-of-pocket maximum. This plan design change should have a minimal impact on premiums.

[34] https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Hospital%20Budget%20Guidance%20FINAL.pdf