BLUE CROSS BLUE SHIELD OF VERMONT
2025 VERMONT QHP 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, 2025

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 Qualified Health plans (QHP) for the Vermont individual and small group markets that Blue Cross and Blue Shield of Vermont (Blue Cross VT) proposes to offer for the 2025 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 8, 2024)
- 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 16.3 percent. Changes for specific plans range from 8.5 percent to 21.5 percent for non-loaded plans and from 39.9 percent to 44.9 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, which increases the loaded silver plans by 20.8 percent and reduces the non-loaded plans by 2.1 percent.

1.4.2. Small Group Market

The average rate change is 19.1 percent. Changes for specific plans range from 14.4 percent to 22.2 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 2023 experience. For the individual market, the claims experience for 2023 was under the expectation embedded within the 2024 filing. This was offset by much lower than expected risk adjustment transfer and other small population changes to produce an overall change to 2023 rates due to the experience and population changes of 1.9 percent. For the small group market, calendar year 2023 claims were higher than expected in the prior filing, due to both a higher level of claims across the whole segment and very high claimants. While not as profound as for individual, the lower expected risk adjustment transfer is also increasing rates. Combined, the experience and population changes increase the 2025 rates by 4.0 percent.

Similar to the last few years, trend is the most significant driver of the change in rates (see section 3.4.7). The 2024 approved rates included assumptions for projecting 2023 to 2024 which must be re-examined because the 2025 filing is based on updated actuarial assumptions that reflect current data. Also, an additional year of projected trend applies from 2024 to 2025. The overall anticipated increase in rates due to trend is 9.8 percent for individual and small groups:

2025 Rate Impacts of Trend		
Trend Component	**Individual**	**Small Group**
Restatement of 2023 to 2024 Trend	0.7%	0.7%
Additional Year of Medical Utilization Trend	2.4%	2.3%
Additional Year of Medical Unit Cost Trend	3.4%	3.3%
Additional Year of Retail Pharmacy Trend	3.0%	3.2%
Additional Year of Dental Trend	0.0%	0.0%
Additional Year of Vision Trend	0.0%	0.0%
Leap Year	0.0%	0.0%
Total	**9.8%**	**9.8%**

As noted in Attachments A and B, the claims underlying the federal Actuarial Value Calculator (AVC) were trended forward to 2025 and the underlying claims distributions were updated. The federal out-of-pocket maximum also decreased from $9,450 to $9,200. 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. Along with the impact of benefit leverage and changes to the model used to calculate the actuarial value, these factors increase rates by 1.2 percent for individuals and 1.2 percent for small groups.

The Vermont House Bill H.766 limits Blue Cross VT's ability to contain health care costs by removing programs such as claims edits, step therapy, and prior authorizations in certain circumstances. This increases the projected claims costs, and therefore the premiums include the impact of this legislation. Altogether, the provisions in this legislation increase rates by 1.8 percent for individuals and 1.9 percent for small groups.

Blue Cross VT base administrative charges are increasing as compared to the 2024 approved rates, mostly due to inflationary pressures (see section 3.8.7), increasing premiums by 0.3 percent for individuals and 0.5 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 2023 was well below the mandated range. Therefore, Blue Cross VT is filing a contribution to member reserve (CTR) of 3.0 percent as part of the plan to move towards the mandated RBC range. Due to CTR of 2.0 percent approved in the 2024 rates, the total increase to premiums is 1.0 percent. Other federal and state taxes and fees will remain stable from 2024 to 2025.

Following the Department of Financial Regulation's approval, Blue Cross VT and Blue Cross Blue Shield of Michigan formally affiliated with one and other on October 10, 2024. While it is still very early in the affiliation process with Blue Cross Blue Shield of Michigan, there is already some value from integration of contracts that are slowing the increase in premiums by 0.2 percent for the individual and small group markets.

1.6. <u>Historical Financial Performance</u>

Blue Cross VT has offered QHP products since the start of the program in 2014. Prior to offering QHP 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 QHP 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 QHP 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 table below shows 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

[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.

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%	-2.2%	-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%	6.6%	7.2%
2021	411,961	1.5%	0.5%	0.4%	-0.2%
2022	430,399	1.5%	1.0%	-5.2%	-5.2%
2023	498,644	1.5%	-0.3%	-8.8%	-8.8%
Cumulative	6,008,567	1.6%	0.1%	-1.4%	-1.7%

The table below shows the premium, claims, and administrative costs used to calculate the "Actual Contribution to Reserve (Financial)" information above.

Year	Incurred Claims	Administrative Charges	Earned Premium	Gain/(Loss)
2014	$225,552,535	$24,876,874	$252,999,782	$2,570,373
2015	$299,694,497	$33,343,065	$329,390,859	($3,646,703)
2016	$356,939,763	$37,020,681	$385,409,679	($8,550,764)
2017	$374,482,083	$30,769,754	$409,489,115	$4,237,279
2018	$319,269,837	$37,924,041	$351,033,856	($6,160,022)
2019	$293,513,224	$25,882,078	$317,274,454	($2,120,848)
2020	$252,424,584	$35,962,084	$308,892,896	$20,506,228
2021	$257,470,409	$31,831,304	$290,401,034	$1,099,320
2022	$288,308,963	$24,004,389	$296,933,566	($15,379,786)
2023	$381,172,623	$27,868,522	$376,046,311	($32,994,834)

The cumulative operating margin on QHP business since inception is a loss of $40.4 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. In addition, the significant losses sustained in 2022 and 2023 driven by accelerated health care costs underscore the importance of ensuring 2025 premiums are adequate to cover estimated costs in 2025.

[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 received approval in the fall of 2023 to formally affiliate with Blue Cross Blue Shield of Michigan (BCBSM). The partnership allows our organizations to begin sharing expertise and technology and broaden health plan services and offerings. We are pioneering a new way for Blues plans to work together.

The 2025 premiums are minimally impacted by early progress with the affiliation. Many of the integration initiatives we are undertaking are in the planning stages, with careful and purposeful prioritization to ensure that we get the most value for our members with the least level of risk of disruption. As we work toward more integration, Vermont members will continue to see benefits for the next several years.

This strategic partnership 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.

Blue Cross VT continues as 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.

Vermont Legislature

The Vermont Legislature adjournment coincides with the rate filing deadline. Blue Cross VT advocates in the Statehouse 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. This year is particularly challenging due to the possible legislative changes to our internal processes and significant programs including prior authorization. In prior years, the legislature focused on adding new covered services or removing cost shares. Both of these types of legislation increase premiums yet are more straightforward to estimate. It will take months to fully understand the impact of the 2025 legislative session as we begin to evaluate and implement the changes to on our day-to-day operations. This filing includes our best estimate at this time of these complex changes.

Silver Loading

For plan year 2025, the Green Mountain Care Board requires that QHP issuers use a silver load of41.87 percent, which is dramatically higher than in prior years. Blue Cross VT supports this effort to increase the federal Advance Premium Tax credits for Vermonters who qualify for these benefits. At the same time, this new guidance introduces complexity for members during the open enrollment season. First, On-Exchange Silver plans will have higher premiums than Gold plans. This dynamic will be confusing and members will be encouraged to carefully evaluate their options when choosing the best health plan. Blue Cross VT plans to work with other stakeholders to ensure that the messaging is consistent and that members are supported through this change.

Rising Health Care Costs

In Vermont, and nationally, health care costs continue to grow year after year at a faster pace than many other economic indexes. Increases in the volume of services along with the costs of these services have put pressure on our member and group customers' finances. Blue Cross VT is committed to working with stakeholder groups and regulators in their analyses of our healthcare system and understanding the impact of policy decisions. We understand the concerns individuals and small businesses have with these rising costs and will continue work closely with stakeholders to bring solutions that will support all Vermonters.

1.8. Vermont Statutory Rate Review Criteria

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

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

8 V.S.A. § 4062(a)(3). Affordability and the other non-actuarial "standards by which the Board reviews rate filings are 'general and open-ended,' the result of 'the fluidity inherent in concepts of quality care, access, and affordability.'" *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 16. As the Board has noted, it must assess affordability "without specific statutory guidance or a standardized definition." *In re Blue Cross 2021 Filing*, GMCB-005-20rr, at 17 (Aug. 14, 2020). But any approach to affordability cannot overlook the reality that rates "are driven by claims costs." *In re MVP Health*, 2016 VT 111, ¶ 23. The Board's own Rate Review Rule recognizes that reality, expressly incorporating actuarial review standards[3] into the process. *See* GMCB Rule 2.000 § 2.401 (Board must "determine whether the requested rate is . . . not excessive, inadequate, or unfairly discriminatory").

Further, the non-actuarial criteria selected by the Legislature form an interdependent feedback loop among promoting "access to health care," promoting "quality care," and determining whether a rate is "affordable." For example, lowering rates to align them with economic indicators might make them more "affordable," but reducing rates does not decrease the costs those rates are designed to finance. Ordering rates that are lower than what is actuarially justified means the rates will be insufficient to cover members' claims, jeopardizing access to and quality of care for the relevant insured population.

Backstopping the entire rate review process, the Legislature required the Board to 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). DFR considers insurer solvency to be the most fundamental aspect of consumer protection.[4] 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. The full funding of adequate rates is thereby critical to both insurer solvency and affordability.

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[3] *See* Actuarial Standard of Practice No. 8 (defining "adequate" and "excessive" rates), *available at* https://www.actuarialstandardsboard.org/asops/regulatory-filings-health-benefits-health-insurance-andentities-providing-health-benefits/

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

Read holistically, the rate review criteria mean that a Vermont insurer must develop actuarially sound rates and simultaneously implement measures aimed at reducing the underlying health care costs being financed by the proposed premiums. That is the only way an insurer can develop rates that will enhance affordability, promote quality of and access to necessary care, and maintain its solvency. Blue Cross VT is fully committed to that mission; Attachment D describes the numerous programs we have implemented in order to control costs without compromising quality, access, or solvency. These efforts flow naturally from our mission as a not-for-profit organization, and advance our vision that together we can build a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care.

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 2025. 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, durable medical equipment vendors, 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-134033385 for deductible plans and BCVT-134033498 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-134033528.

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-134033427 for Vermont Preferred and BCVT-134033485 for Vermont Select.

Reflective Silver Plans
Pursuant to Act 88, Blue Cross VT will offer certain silver plans only off-exchange for the 2025 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 2024.

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* 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*[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 2023 experience of Blue Cross VT individual and small group QHP markets.

We analyzed claims incurred January 1, 2023 through December 31, 2023 and paid through March 31, 2024. 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 2, 2024, the IRS has yet to release the HSA deductible limits for 2025. 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, 2023 through December 31, 2023 and paid through March 31, 2024	$186,269,617	$219,406,079
Estimate of IBNR for claims incurred January 1, 2023 through December 31, 2023 as of March 31, 2024	$995,150	$887,374
Estimate of IBNR pharmacy rebates incurred January 1, 2023 through December 31, 2023 as of March 31, 2024	($5,447,857)	($5,447,857)
Total completed experience period claims	$181,816,910	$214,845,596
Member months	234,963	234,963
Total claims per member per month (PMPM)	$773.81	$914.38

Calculation of Experience Period Claims Per Member Per Month (PMPM) – Small Group Market		
	Incurred Claims	**Allowed Claims**
Claims incurred January 1, 2023 through December 31, 2023 and paid through March 31, 2024	$182,682,933	$216,801,980
Estimate of IBNR for claims incurred January 1, 2023 through December 31, 2023 as of March 31, 2024	$1,043,778	$1,094,456
Estimate of IBNR pharmacy rebates incurred January 1, 2023 through December 31, 2023 as of March 31, 2024	($6,712,188)	($6,712,188)
Total completed experience period claims	$177,014,523	$211,184,248
Member months	263,429	263,429
Total claims per member per month (PMPM)	$671.96	$801.67

In the experience period, the earned premium was $177,404,739 for the individual market and $178,205,275 for the small group market. Blue Cross VT will not be required to pay minimum loss ratio (MLR) rebates for the 2023 calendar year. Vermont does not currently have a 1332 waiver for a Reinsurance program. The estimated 2023 risk adjustment receivable, according to the information from the Interim Report, is $8,391,074 for the individual market (including Catastrophic) and $5,043,571 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 3.8.4 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	$933.79
Allowed Claims for Non-EHB	$0.07
Experience Index Rate in section 2 of worksheet 1 of URRT	**$933.72**

The experience index rate for 2023 for the individual market is $933.72.

Calculation of the Experience Index Rate PMPM – Small Group market	
Allowed Claims in section 1 of worksheet 1 of URRT	$823.00
Allowed Claims for Non-EHB	$0.13
Experience Index Rate in section 2 of worksheet 1 of URRT	**$822.87**

The experience index rate for 2023 for the small group market is $822.87.

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	$219,406,079	$933.79
Remove BlueCard Fees	($459,495)	($1.96)
Remove Pharmacy Rebates	$11,405,103	$48.54
Remove Payments to Blueprint Program	($594,035)	($2.53)
Replace Capitation with FFS equivalent	$18,968	$0.08
Line a1 of Exhibit 5 – IND	$229,776,620	$977.93

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	$216,801,980	$823.00
Remove BlueCard Fees	($863,529)	($3.28)
Remove Pharmacy Rebates	$12,906,267	$48.99
Remove Payments to Blueprint Program	($996,568)	($3.78)
Replace Capitation with FFS equivalent	$42,031	$0.16
Line a1 of Exhibit 5 – SMG	$227,890,180	$865.09

3.3.1. Pooling experience claims

Blue Cross VT purchases reinsurance coverage for the QHP 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.

Three QHP members, one in the individual market and two in the small group market, are excluded from the reinsurance agreement in 2024 due to the expected ongoing high cost drugs they are receiving. We excluded the total allowed charges from the experience period, as none of the projection factors described below apply to these specific members. The net expected projected 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 2023 total allowed claims	A1	$229,776,596
Allowed charges for drugs not included in the Blue Cross VT reinsurance agreement	A2	$1,598,269
Net allowed charges	A = A1 – A2	$228,178,328
Claims above $853,498	B	$1,830,386
Capped Claims	C = A - B	$226,347,941
Impact of capping claims (a_5 on Exhibit 5 - IND)	D = C / A	0.9920

Calculation of the Impact of Capping Claims – Small Group Market		
CY 2023 total allowed claims	A1	$227,890,140
Allowed charges for drugs not included in the BCBSVT reinsurance agreement	A2	$1,926,302
Net allowed charges	A = A1 – A2	$225,963,838
Claims above $853,735	B	$349,951
Capped Claims	C = A - B	$225,613,887
Impact of capping claims (a_5 on Exhibit 5 - SMG)	D = C / A	0.9985

3.4. Projection Factors

3.4.1. Membership Projections

As of March 2024, Blue Cross VT had 45,182 members enrolled in the Vermont QHP markets, with 23,164 enrolled individually through Vermont Health Connect or directly through Blue Cross VT and 22,018 small group employees and their dependents.

We used this information as the starting point to project the 2025 enrollment and the distribution by plan.

With the new guidance from the Green Mountain Care Board (GMCB) on Silver Loading[6], On-Exchange Silver plans have higher increases than all other plans and have higher premiums than Gold 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 2025.

The table below shows the March 2024 enrollment in On-Exchange Silver plans by CSR level, the assumed percentage of member moving to another metal and metal level we assume they will move to.

On-Exchange Silver Plans Membership				
Plan	March 2024 Membership	Percentage of Members Moving to Another Metal	Total Members Moving to Another Metal	Expected New Metal Level
70% plan	1,727	100%	1,727	Gold
73% plan	885	100%	885	Gold
77% plan	1,669	100%	1,669	Gold
87% plan	2,621	50%	1,310	Platinum
94% plan	1,014	0%	0	NA
100% plan	9	0%	0	NA

For members changing metal level, we assume they would remain in the same product suite when possible. We assumed that members currently in the Standard Silver CDHP would move to the Standard Gold as there is no Standard Gold CDHP option.

[6] See section 3.8.2 for details

Exhibits 2A shows the 2025 Blue Cross VT individual and small group projected population by plan and market.

Blue Cross VT expects to cover 542,184 member months in the Vermont QHP combined market in 2025, with 277,968 member months in the individual market and 264,216 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.

3.4.2. Changes in the Morbidity of the Population Insured

Impact of Medicaid Redetermination ($1+b_7$)

In April 2023, Medicaid started their "unwind" plan to redetermine eligibility for all Vermonters on Medicaid. From June to September 2023, we experienced sizeable growth in our Individual Subsidized population that can be directly attributed to this redetermination. Due to these members joining mid-year, their claim experience is not a direct representation of a full calendar year. To adjust for this, we apply seasonality factors to medical outpatient, medical professional, and pharmacy non-specialty, as those are the claims categories where benefit design impacts the timing of utilization of services. To determine this seasonality factor, we compared individual subsidized population's first seven months of claims in 2023 to their full calendar year 2023 claims. We apply those ratios to the PMPMs of subsidized members who were newly enrolled starting June 2023 to adjust their partial year, and then include the adjusted experience into our individual projected index rate calculation. As shown on Exhibit 2B, the impact of this adjustment for partial year enrollment (line $1+b_7$ on Exhibit 5-IND) is 1.0009 This factor does not impact the small group market.

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 QHP market coverage. The impact is measured by observing experience period claims costs for groups and members known to be no longer enrolled as of March 2024.

The base for our experience period is calendar year 2023. Using March 2024 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 QHP market. If all members in a group are no longer enrolled in the Blue Cross VT QHP 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 QHP 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 QHP market.

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 March 2024, 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 0.9942 for the individual market and 1.0077 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 1.0119 for the individual market and 0.9971 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. Using the same methodology as in last year’s QHP filing, we add the estimated allowed PMPM of $1.26 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	$220.01	$208.88
Projected Hearing Aids PMPM	B	$1.26	$1.26
Trended Professional PMPM, including Hearing Aids	C = A + B	$221.27	$210.14
Factor $1+c_6$ on Exhibits 5 for Professional Claims	D = C / A	1.0057	1.0060

Details of the assumptions and calculations supporting the $1.26 PMPM are in Attachment E.

3.4.4. Changes in Demographics

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

For both market segments, we use the age-gender factors from the SOA’s report Health Care Cost – From Birth to Death[7] to calculate the age-gender factors for the experience membership and compare to those of the projected 2025 membership.

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

For small groups, we first observe the actual change in average age-gender factors from the experience period to March 2024. We observed a consistent seasonal pattern in the age-gender factors for small groups. We therefore adjust the year-to-date March observation to reflect a full calendar year age-gender factor. We divide the full year 2024 age-gender factor by the experience age-gender factor to calculate a projection factor from 2023 to 2024. We then use a three-year average impact of the demographic changes for renewing groups to project from 2024 to 2025.

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 March 2024 age and calculate the average duration by age. We assign the age one duration to members aged zero in 2024. We assessed historical persistency by age for members who are eligible for Medicare. Based on historical patterns, we assume that 27.0 percent of members aged 64 in 2024 will remain enrolled through 2025, and that 57.7 percent of members aged 65 and over in 2024 will remained enrolled through 2025. Finally, in order to complete the age distribution, we add new members aged zero in 2025. Again, we examined historical patterns to develop newborn assumptions. For the VHC enrolled population, we expect newborns to comprise 0.75 percent of the total population with an average duration of 4.02 months. For direct enrolled members, we expect the newborns to comprise 0.63 percent with an average duration of 4.57 months. We apply these percentages to the in-force 2024 enrollment to estimate the newborns in 2025. 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 0.9900 for the individual market and 1.0072 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[8] 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. In September 2023, we experienced a 100 percent shift of abiraterone scripts to the CivicaRx version. We expect to continue to have only CivicaRx scripts for this drug in 2025. We therefore adjusted the experience period by recalculating the allowed charges if all scripts from January 2023 to August 2023 had been at the new much lower cost drug provided through CivicaRx. The impact of this adjustment on pharmacy specialty is 0.9956 for the individual market and 0.9958 for the small group market.

The passage of the American Rescue Plan Act removed the cap which limited Medicaid rebates to 100 percent of the Average Manufacturer Price (AMP). In response to this, many manufacturers announced significant pricing changes. Based on modeling provided by our pharmacy benefit manager, we adjust the pharmacy non-specialty allowed charges to reflect the anticipated reductions in the ingredient cost in drugs affected by the

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

cap. We calculate the impact on non-specialty drugs to be 0.9161 for the individual market and 0.9309 for the small group market.

Adjustment to Experience Period of One-Time Events ($1+c_5$)
H.766, which is currently being considered by the Vermont legislature, is expected to materially change allowable payment integrity programs, prior authorizations, and step therapy. We identified key components of the legislation that would likely affect medical and pharmacy claims. On a program-by-program basis, we identified the expected impact of the legislation, either via an internal analysis or information provided by an external vendor. To estimate the impact of the legislation, we increase medical and pharmacy claims by the expected loss in savings.

Calculation of impact of reduction in payment integrity, step therapy and prior authorizations – Individual Market			
		Medical	**Pharmacy**
Experience Period Allowed Charges	A	$179,125,981	$50,098,450
Estimated Reduction in Savings	B	$2,600,994	$1,367,538
Adjusted Experience Period	C = A + B	$181,726,975	$51,465,988
Factor $1+c_5$ on Exhibits 5-IND	D = C / A	1.0145	1.0273

Calculation of impact of reduction in payment integrity, step therapy and prior authorizations – Small Group Market			
		Medical	**Pharmacy**
Experience Period Allowed Charges	A	$176,287,713	$50,955,760
Estimated Reduction in Savings	B	$2,699,644	$1,543,093
Adjusted Experience Period	C = A + B	$178,987,356	$52,498,853
Factor $1+c_5$ on Exhibits 5-SMG	D = C / A	1.0153	1.0303

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 2025 rebates, we start with actual calendar year 2023 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])^(12/24)-1 = 11.2%	

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 $53.14 for the individual market and $54.47 for the small group market.

- Blueprint Payments (e_2):
Blue Cross VT participates in the Vermont Blueprint for Health[9] 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 2025. and instead assume that the experience period PMPM would continue to 2025.

Calculation of Projected Blueprint Payments PMPM		
	Individual	Small Group
Experience Member Months	234,963	263,429
Experience Blueprint Payments	$594,035	$996,568
Blueprint Payments PMPM	$2.53	$3.78

- 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).

[9] http://blueprintforhealth.vermont.gov/

Calculation of Projected ITS Fees PMPM		
	Individual	Small Group
Experience Member Months	234,963	263,439
Experience ITS fees	$459,208	$862,617
ITS fees PMPM	$1.95	$3.27
Trend (for 2 years)	1.029	1.029
Projected ITS fees PMPM	$2.07	$3.47

- Vermont Vaccine Purchasing Program Payments (e_4):

The Vermont Vaccine Purchasing Program[10] (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 5, 2023, the Vermont Vaccine Purchasing Program released a memo that included the rates for April 1, 2023 – March 31, 2024. The memo did not include an estimate of charges beyond March 31, 2024, so we use the approved state fiscal year 2024 rates throughout the projection period.

Calculation of the VVPP PMPM - Individual			
Market	**Age Category**	**Weighted Rate for CY 2025**	**Projected Membership**
Individual	Child	$13.54	1,911
Individual	Adult	$2.74	20,905
Individual	Over 65	$0.00	348
Total		**$3.59**	**23,164**

Calculation of the VVPP PMPM – Small Group			
Market	**Age Category**	**Weighted Rate for CY 2025**	**Projected Membership**
Small Group	Child	$13.54	3,437
Small Group	Adult	$2.74	17,702
Small Group	Over 65	$0.00	879
Total		**$4.32**	**22,018**

- Cost of Reinsurance (e_5):
  Blue Cross VT uses reinsurance to protect itself against very high claims. For plan year 2024, 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 2025 is $[redacted] PMPM, which is the 2024 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 and two members in the small group market with ongoing high-cost claims that are not covered by Blue Cross VT reinsurance. We include these claims, net of HCRP recoveries, in this component.

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[10] http://www.vtvaccine.org/

- 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. In 2024, Blue Cross VT introduced the Enhanced Community Primary Care (ECPC) program to independent primary care practices. With this program, practices can earn performance incentive payments by meeting target thresholds for specific quality, total cost of care, and utilization metrics. We estimate the monthly PMPM needed for our payment reform efforts as $2.50 PMPM.

  The table below shows the estimated and actuals payments for payment reform initiatives QHP members from January 2023 to March 2024.

Actual Payment Reform Initiative Payments			
		Individual	**Small Group**
CY 2023	Expected PMPM	$1.88	$2.10
	Actual PMPM	$1.62	$1.91
	Actual Total Dollars	$379,917	$502,596
YTD March 2024	Expected PMPM	$2.25	$2.25
	Actual PMPM	$1.65	$1.91
	Actual Total Dollars	$113,011	$126,695

  The payments to date are smaller than expected mainly due to the lack of uptake on installing an Electronic Health Record (EHR) overlay to support care coordination and chart review. We also are working closely with the practices who participate in VBIC to close their gaps with the metric thresholds in that program and increase the payments.

- 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. The total PMPM in the experience period under Vermont Blue Rx was $ PMPM for individuals and $ PMPM for small groups. We project this cost to be the same in 2025.

- 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 $ PMPM for these services. We project the PMPM to be the same in 2025.

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, 2020 and December 31, 2023, paid through March 31, 2024. 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.

We exclude claims for over-the-counter COVID tests, as those are no longer covered under the QHP benefits.

The data includes claims from the QHP small group and individual markets. 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. We also exclude members with annual claims above $500,000 from all analyses.

Some components of trend can be skewed by changes in the health status of the underlying population. We create a matched population specific to each benefit year to address this concern for medical utilization trend, except for pharmaceuticals, and for the pharmacy trend, except for specialty drugs. We use the full population for the medical cost trend calculation, pharmaceutical utilization, and specialty drug trends. We use the matched population for all other trend analyses.

The matching methodology ensures that the mix of age, gender, metal level, market, duration, and health conditions is the same over the four years of data used in this analysis. 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. Starting with calendar year 2023, we match backward to the 2022, 2021 and 2020 populations. Page 1 of Exhibit 3B shows the summary statistics of the full Blue Cross VT QHP small group and individual markets, as well as the matched population.

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

We use the full population for the cost trend base to ensure that the weights among facilities and other providers reflect the most accurate weights for the individual and small group markets.

Observations of recent contracting and provider budgetary changes are the main source of unit cost trend. We use calendar year 2023 as the base for mix of site of care and project costs two years to 2025.

During calendar year 2023, about 54 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 GMCB review, we start with the assumption that the GMCB will approve hospital budgets for October 1, 2024, and October 1, 2025 at the GMCB guidance maximum for commercial rate growth of 3.4 percent[3] .

The provider contracting and actuarial departments worked together to assess the impact these increases would have on contract negotiations specific to the network used for the QHP markets.

For other providers within the Blue Cross VT service area, we work with the Blue Cross VT contracting team to include expected contract changes.

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 2023 Blue Trend Survey, which is a proprietary and confidential dissemination of the BlueCross BlueShield 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 2023	Cost Trend from 2023 to 2024	Cost Trend from 2024 to 2025	Total Annual Cost Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	54.1%	4.3%	3.5%	3.9%
Other facilities and providers[11]	45.9%	5.2%	4.9%	5.0%
Total	100.0%	4.7%	4.1%	4.4%

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

[11] Vermont facilities with professional reimbursement on the Blue Cross VT Community fee schedule are included in this category.

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 2023 Blue Trend Survey, which is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

We normalize claims to the December 2023 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 2023. 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 2023[12] in accordance with the following chart:

Incurred Period	Percent of claims recovered as part of FWA programs[13]
Q1-Q3 2020	0.67%
Q4 2020	1.21%
CY 2021	2.49%
CY 2022	2.50%
CY 2023	3.69%

We further normalize the claim costs such that each month reflects the average number of working days per month in 2023, as defined by our reserving models.

When using the full population, we also apply normalization factors for changes in demographics and changes in paid-to-allowed ratio. The demographics factors are from the SOA's report *Health Care Costs – From Birth to Death*[14] and the induced utilization factors are derived using the same formula as used in the calculation of the changes in benefit factors (see section 3.4.3).

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

[12] The impact of projected changes to the FWA programs is described in the projected payment integrity impacts section on page 32.
[13] 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.
[14] https://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx

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.

Facility Claims

For facility claims, we select a 3.0 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**
2020	$278.25	
2021	$342.46	+23.1%
2022	$328.78	-4.0%
2023	$341.74	+3.9%

Using the array of PMPM claim costs net of high claimants and adjusted for contract, aging, induced utilization, number of working days, and FWA, we performed 24-month regressions, 36-month regressions, 48-month regressions, and time series calculations.

The deferral and return of care attributable to the COVID-19 pandemic unduly affected the 48-month regressions and time series, so we do not consider their results to be reliable projections of trend. In the fall of 2020, a cyberattack on the University of Vermont Health Network (UVMHN) impacted medical claims as some services needed to be rescheduled in the first quarter of 2021 amplifying 2021 claims. This results in lower-than-expected trends from 2021 to 2022.

Claims in the year-ended December 2023, after the adjustments described above, are 3.9 percent higher than the year-ended December 2022. This data point is elevated due to a high number of acute inpatient visits in 2023. We do not expect this high trend level to continue through 2025. FY 2024 hospital budget submissions noted some facilities had undertaken work to clear their backlogs and reduce wait times in 2022 and 2023[15], which likely increased trend in 2023. However, the University of Vermont Health Network noted it was undertaking an initiative to improve their case mix index[16], which will result in higher commercial payments through the projection period. Any increases in the average severity will affect the intensity trend, which lends support to a continuing positive trend.

We therefore consider a 3.0 percent trend rate to be a reasonable selection through CY 2025 for these claims. This is aligned with expected facility utilization trends in other lines of business.

Details on facility trends are shown on Exhibit 3C.

[15]https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY_2024_UVMHN_budget_narrative_6.30.23_final_1.pdf, pages 4-7
[16]https://gmcboard.vermont.gov/sites/gmcb/files/documents/UVMHN%20additional%20follow-up%20questions%209.8.23.pdf, question 1

Professional and Ancillary

We select a 2.1 percent utilization trend for non-mental health and substance use disorder (MHSUD) professional claims and 1.1 percent for MHSUD services.

Similar to facility claims, we use the array of PMPM claim costs net of high claimants and adjusted for contract, aging, induced utilization, number of working days, and FWA, to perform 24-month regressions, 36-month regressions, 48-month regressions, and time series calculations.

Consistent with the previous filings, we select separate utilization trends for mental health and substance use disorder (MHSUD) professional services and other professional services. After the adjustments described above, professional MHSUD claims increased by 0.3 percent from year-ending December 2022 to year-ending December 2023, while all other professional claims increased by 2.2 percent over the same period.

MHSUD claims saw a significant increase in visits in the initial year of the COVID-19 pandemic but have since seen its trend rate dampen. We expect trend through CY 2025 will be aligned with the observed trend in recent years, and therefore select a utilization trend of 1.1 percent, which is about the average of the 24-month and 36-month measures.

For all other professional services, an increase in evaluation and management visits and facility services underlie the high year-over-year trend. As with facility services, we consider the recent trends to be partially influenced by the work of providers to lessen their backlog and the higher acute inpatient admissions. Considering this, we believe a selection of 2.1 percent, which is slightly lower the most recently observed of trend of 2.2 percent and about the average of the 24-month and 36-month measures, best projects trend through CY 2025. This selection is slightly aligned with projected trends in other lines of business.

We provide the historical professional utilization trends through December 2023 in the table below.

Professional Claims PMPM						
	Non-MHSUD		MHSUD		Total Professional	
	PMPM	Trend	PMPM	Trend	PMPM	Trend
2020	$111.02		$16.54		$127.56	
2021	$140.87	26.9%	$18.10	9.4%	$158.96	24.6%
2022	$138.16	-1.9%	$18.72	3.5%	$156.89	-1.3%
2023	$141.25	2.2%	$18.78	0.3%	$160.03	2.0%

The Index Rate projection combines all professional services. The table shows the calculation of the combined professional trend.

Blend of Professional Trend Selections			
	Non-MHSUD	MHSUD	Total
Unadjusted CY 2023 for the full population	$159.84	$20.28	$180.12
Selected Trend	2.1%	1.1%	
Months of Trend	24	24	
Projected Period PMPM	$166.62	$20.73	$187.35
Blended Trend	= ($187.35/$180.12) ^(12/24)-1 = 2.0%		

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

Pharmaceuticals

We select a 5.0 percent utilization trend for pharmaceuticals processed through the medical benefit.

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 specialty medication this analysis and retained other medications in the respective facility or professional analysis. Due to the small list of included medications and their low number of services compared to other medical services, using the matched population results in a dataset that is too small for this type of analysis. With the additional adjustment for aging and induced utilization, and with the relative stability of the Blue Cross VT individual and small group markets since 2020, using the full population for this portion of the trend analysis is more appropriate.

The year ending December 2023 over year ending December 2022 annualized trend, after the adjustments described above, is 8.8 percent. We consider a 5.0 percent trend rate, which is aligned with 36-months regressions but much lower than the most recent year-over-year to be a reasonable selection for these claims.

We provide the historical pharmaceutical utilization trends through December 2023 in the table below.

Pharmaceuticals		
Year	**PMPM**	**Annualized Trend**
2020	$52.66	
2021	$46.64	-11.4%
2022	$44.68	-4.2%
2023	$48.58	+8.8%

Exhibit 3E shows the normalized professional PMPM for pharmaceuticals in the medical benefit, along with the regressions and time series.

Overall Medical Utilization Trend

Using the 2023 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	$154.26	3.0%
Outpatient	$346.04	3.0%
Pharmaceuticals	$74.33	5.0%
Professional	$195.57	2.0%
Total	**$770.21**	**2.9%**

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	$127.16	3.0%
Outpatient	$310.12	3.0%
Pharmaceuticals	$50.65	5.0%
Professional	$181.87	2.0%
Total	**$669.79**	**2.9%**

To ensure that the trends selections are reasonable individually and in aggregate, we compared the weighted average trends in the tables above to the year-over-year and two-year trends for the full QHP population. The weighted average of the selected trends is slightly lower than the average of the year-over-year and two-year trends, which is reasonable and appropriate.

Projected Payment Integrity Impacts

As described above, the payment integrity programs yielded savings and recoveries of about 3.7 percent of total allowed charges in 2023. Since most of the payment integrity programs are impacted by H.766, the impact to experience has been reflected in section 3.4.5. We do not expect the remaining payment integrity impact as a percent of allowed changes to change in 2025.

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, except for specialty drugs, 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. We exclude vaccines, compound drugs, over the counter, glucagon-like peptide 1 (GLP-1), and devices from the non-specialty trend calculations as they would skew the results.

We separate GLP-1 receptor agonists from non-specialty utilization trend. This class of drugs experienced substantial growth in the year ending December 2023, and its inclusion in non-specialty utilization would not reliably project future trends.

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 average monthly spread from the same months in 2020, 2022, and 2023.

We performed regressions and time series on quarterly data, which decreases the variance of the statistics. We select a 1.1 percent non-specialty utilization trend, which approximately corresponds to the average of the regressions on monthly, rolling costs, year-over-year and two-year trends.

Trend for Non-Specialty Drug Utilization	
8 Quarter Regression	2.4%
12 Quarter Regression	1.4%
16 Quarter Regression	1.1%
Year Over Year	0.2%
Two-Year	0.7%

The utilization of GLP-1 drugs in December 2023 is almost double the observed amount in December 2022 for the full QHP population. Considering this increase in days supply in the experience period for this class, we rebase our experience to be the annualized amount from May – December 2023 before trending at the same trend rate as all other non-specialty drugs.

Calculation of Utilization Adjustment for GLP-1 Drugs		
Total GLP-1 days supply for May 2023 to December 2023	A	180,642
Member Months for May 2023 to December 2023	B	337,597
Total GLP-1 days supply for January 2023 to December 2023	C	243,222
Member Months for January 2023 to December 2023	D	498,392
Additional Projected GLP-1 days supply	E = A / B x D - C	23,458

As shown on Exhibit 3I, all days supply are trended forward at the same rate of 1.1 percent.

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

- Generics: Drugs that have been generic since at least January 2021
- New Generics: Generic drugs that have been in the market for less than 36 months (introduced January 2021 to December 2023)
- 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
- Glucagon-like peptide 1 (GLP-1)
- All other Brands

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. We consider this to be a reasonable long-term outlook for generic cost trend and 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, GLP-1s, 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 7.3 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 lower than 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, except for GLP-1 drugs.

New GLP-1 drugs, such as Wegovy and Mounjaro, became available through the experience and their costs are higher than other GLP-1 drugs. This is increasing the average cost per day for GLP-1 drugs. We expect this increase in average cost to continue through 2025 and therefore use the most recent year-over-year cost trend of 14.8 percent to project GLP-1 costs.

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 to follow the overall brand cost trend, and we select a 0.0 percent cost trend for these drugs.

Specialty Drugs

We adjusted the experience to reflect aging and benefits due to using the full population for specialty drugs. Due to the low utilization of specialty drugs, the matched population does not capture enough of the underlying data to have a credible base to set a reliable expected trend. With the relative stability of the Blue Cross VT individual and small group markets since 2020 and the adjustments above, using the full population for this portion of the trend analysis is more appropriate. We did not adjust for working days, as nearly all specialty medications for one-month supply.

As described above, Blue Cross VT introduced Vermont Blue Rx in July 2021, which included a change in pharmacy benefit manager (PBM). First, this change improved our discount off AWP for specialty drugs. We adjust months prior to July 2021 to reflect the current contract. Second, prior to the transition, members were offered the option to refill their monthly 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 2020, 2022, and 2023. This smoothing period for specialty drugs is longer than for non-specialty drugs due to the nature of the prescriptions and observed refill patterns.

We exclude the one drug with a CivicaRx alternative (see section 3.4.5) from the base experience to ensure that the trend did not include this one-time shift to a lower cost option.

We provide the historical specialty drug trends through December 2023 in the table below.

Specialty Drugs (after contract adjustment)		
Year	**PMPM**	**Annualized Trend**
2020	$84.74	
2021	$94.94	12.0%
2022	$107.18	12.9%
2023	$119.56	11.6%

Exhibit 3G contains the monthly and the 12-month rolling data, the smoothing adjustment, and the results of the regressions. We select 12.5 percent as the contract adjusted trend[17].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. 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 PBM that continue to provide 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 2023 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).

Overall Pharmacy Trend

Exhibit 3I summarizes the trends and calculates our total allowed pharmacy trend as 11.1 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. While 2021 and 2022 experience remained at the same level, the 2023 experience increased drastically. This increase is due to the increase in the cost of 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**
2020	$9.05	$1.37
2021	$10.76	$1.61
2022	$10.79	$1.60
2023	$12.51	$1.87

[17]

We do not expect the high trends to continue through 2025 but expect the cost trend to continue to pressure the dental trends and therefore select a 6.0 percent trend, which is about a third of the trend experienced in from 2022 to 2023.

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 Vision Claims – Using matched population		
Calendar Year	**PCMPM**	**PMPM**
2020	$0.52	$0.08
2021	$0.46	$0.07
2022	$0.51	$0.08
2023	$0.46	$0.07

We expect 2024 and 2025 to remain at the level experienced in 2023; 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	$1+d_1$	1.0952	1.0956
Utilization Trend Factor	$1+d_2$	1.0698	1.0693

3.5. Credibility of Experience

In the experience period, Blue Cross VT had 234,963 member months in the individual market and 263,429 in the small group market for a total for 498,392 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 $1,063.16 for the individual market and $962.80 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 14, 2024, CMS published an Interim Summary Report on Risk Adjustment for the 2023 benefit year[18]. The Blue Cross VT data included in the report represents claims incurred in 2023 and paid through December 31, 2023. We assume that MVP's 2023 interim submission includes the same incurred and paid data as Blue Cross VT, consistent with previous years' interim submissions. The final 2023 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 historical relationships of the plan liability risk score (PLRS) in the 2018 to 2022 Final Summary Reports relative to the 2018 to 2022 Interim Summary Reports.

The 2025 risk adjustment calculation starts with the estimated final 2023 risk adjustment and projects to 2025 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 2025 market-wide premium by applying statewide increases from the 2023 Interim Summary Report to 2024 and from 2024 to 2025. The statewide premium in 2024 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 March 2024 premium PMPM compared to calendar year 2023 premium PMPM. MVP's weight was imputed from the January 2024 DVHA enrollment report[19] and their rate increase was pulled from their approved 2024 QHP rate filing adjusted for the observed 2024 plan mix change in each market. We project the 2025 market-wide premium by applying rate increases by market that are similar but slightly lower than Blue Cross VT's increases as an approximation for the statewide increase.

The calculation of 2025 average premium by market is shown in Exhibit 4, Table 1.

Model Adjustments

On April 2, 2024, HHS released the final notice of benefit and payment parameters (NBPP)[20] which included finalized 2025 risk adjustment model coefficients.

[18] https://www.cms.gov/files/document/by23-interim-ra-report-final.pdf
[19] https://dvha.vermont.gov/sites/dvha/files/documents/202401-VT-HealthCoverage-Map.pdf
[20] https://www.cms.gov/files/document/cms-9895-p-patient-protection-final.pdf

Blue Cross VT performed an analysis using data from benefit years 2021, 2022 and 2023. Production Edge Server data was used for benefit years 2021 and 2022, and data from our internal DIY software was used for benefit year 2023. The analysis consisted of mapping each unique member, metal level and market combination to the 2023 model and the 2025 model. This mapping allowed us to observe the impact of model changes between 2023 and 2025 using the same base experience. Similar to the analysis we performed last year, 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.

We summarized the Blue Cross VT impact from the analysis by metal level and market. The overall impact represents the weighted average by metal and market using the projected 2025 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 2022 experience risk score by metal and carrier. MVP's 2022 risk scores were imputed from the experience section of their URRT within each respective 2024 QHP 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 0.9983 and 0.9999 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 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 2025 compared to CY2023		Selected model impact for both carriers
Market	**Blue Cross VT**	**MVP**	
Individual	0.9215	0.9231	0.9215
Small Group	0.9298	0.9300	0.9298

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 QHP market altogether, and the impact of members changing their metallic plan design.

Comparing membership as of March 2024 to experience membership, we categorize members into "renew", "cancel" or "new" buckets. We adjust the Blue Cross VT projected 2025 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.

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, and the changes in demographics described in section 3.4.4.

We estimate the impact of plan changes within the renewing population by mapping each member and their experience plan risk score to their projected 2025 plan risk score in their new metal level.

MVP's risk scores are impacted by members leaving and joining, as well as observed changes in plan design and population attributes. 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.

MVP had modest benefit changes from its 2023 experience plan designs in their small group market. We are projecting MVP's individual market will have similar plan changes as Blue Cross VT's individual market in 2025. Using data from the DVHA January 2024 statewide enrollment by plan report we can estimate the change in plan mix for MVP.

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

<u>Other Factors</u>

Adjustments were made to the 2023 Interim Summary Report for the Catastrophic plan to reflect the projected 2025 catastrophic statewide premium. Blue Cross VT had approximately 98 percent of the catastrophic market in 2023, and we project a similar market share in 2025. 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 2023 experience. The 2025 projected statewide premium was calculated by applying a weighted average 2024 increase based on approved rate increases and the Blue Cross VT projected 2025 increase as an approximation for the statewide increase to the 2023 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 2023 calculation as a result of the metallic distribution changing in 2025. We assume the ARF is unchanged from 2023 within the individual and small group markets. These results are shown in Exhibit 4, Table 3.

The 2023 Interim Summary Report has a total transfer amount $13,434,645. Due to claims runout and the expected impact of the supplemental diagnosis file, we estimate the final 2023 transfer will be $12,416,494 for the individual, small group, and catastrophic markets combined. Adjusting the final 2023 transfer for model, population, and plan changes, we estimate the final 2025 transfer will be $8,937,789 for the individual market, $8,406,450 for the small group market, and $16,410 for the catastrophic plan. Each of these transfer amounts is prior to the charges for the HCRP program.

The 2025 transfer amount PMPM is partially offset by the projected charges and payments for the HCRP program. The plan year 2022 HCRP charge for the individual market was 0.36 percent of premium[21]. The plan year 2022 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 premium. To estimate the 2025 charge, we trend the charge using a 19.6 percent trend for three years for claims above $1 million[22]. 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 2025 charge:

Market	Percent of Premium	PMPM
Individual	0.462%	$4.76
Small Group	0.629%	$5.73

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 claimants 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 ($38.23) PMPM for the individual market and ($37.42) 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 2025.

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

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[21] https://www.cms.gov/files/document/summary-report-permanent-risk-adjustment-transfers-2022-benefit-year.pdf

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

used to calculate the adjustments to the-paid-to allowed ratio is our calendar year 2022[23] data trended to calendar year 2025 using the trend factors described in section 3.4.7. The model re-adjudicates claims by starting with the allowed charges and applying appropriate cost sharing for each service. The model generates the projected average paid claims for each benefit based on what the AVC can support as well as what the model cannot support. The relationship between these outputs from the 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 2022 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 2025 adjusted federal AVC. 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 2025 AVC is the first calculator to use QHP specific data from EDGE and thus we decided to update our baseline from the 2020 AVC that we used in previous filings. 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.

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.

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 February 14, 2024, the Green Mountain Care Board approved the "Revised Proposed Guidance" approach to the Silver Loaded plans. Enrollment figures were provided to Lewis and Ellis by each carrier and a statewide silver load factor was calculated to be 1.4187. The factors are shown in Exhibit 6C.

This factor does not apply to the small group market.

[23] Due to the complexity and intensity of updating the AV model, we started working on this model in Q4 2023 and therefore used CY 2022, the most recent completed year, as the base for the model.

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 2023 experience period non-EHB claims using the medical trends described in section 3.4.7, which produces an average allowed charge of $0.08 PMPM for the individual market and $0.14 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 1.0001 to 1.0003 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 2025 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 0.4737 of the total allowed charges. We then adjust the paid–to-allowed ratio based on the average total allowed charges. This factor is 0.9479.

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 0.4254 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 plan selections 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 anti-selection 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 QHP 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 1.1095 for the individual market and 1.0935 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	6.2%
Small Group Market	5.7%

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.

Blue Cross VT Base Administrative Charges

We use calendar year 2023 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. We are also reflecting the known value from our affiliation with BCBSM from processes and contracts already integrated. While there is still much to be done to fully integrate some functions with BCBSM, Blue Cross VT already started to experience lower costs of processing claims through NASCO (our claims processor) by accessing the lower fee schedule for BCBSM affiliates.

Reconciliation of Experience Base Administrative Expense to Reported GAAP Expenses				
	Individual Market		Small Group Market	
	Total Dollars	PMPM	Total Dollars	PMPM
Reported Expenses (GAAP)	$14,463,197	$61.56	$13,405,325	$50.89
Federal and State fees	($1,002,428)	($4.27)	($972,715)	($3.69)
Fees for outside vendors	($57,109)	($0.24)	($124,570)	($0.47)
Exclusions and Reallocations	($504,279)	($2.15)	($111,727)	($0.42)
Affiliation Value	($129,044)	($0.55)	($136,760)	($0.52)
Base Administrative Expenses	$12,770,338	$54.35	$12,059,553	$45.78

The base administrative charges are projected to 2025 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 reflects the expected growth in costs.

We calculate PMPM admin charges with experience period enrollment and projected enterprise-wide 2025 enrollment. When projecting the 2025 enrollment, we include membership projections from all lines of business. 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 increase of 2.6 percent to the base PMPM charges to account for the decline in membership on core operating platform. The table below shows the calculation.

Development of Enterprise Membership Adjustment	
	Members Months
Experience Period	2,050,050
Projected 2025 Enrollment	1,976,657
Adjustment for Enterprise Membership	= 1+0.7 x (2,050,050/ 1,976,657 -1) = 2.6%

To calculate the projected base administrative charges, we increase the base experience PMPM by 4.0 percent for two years of trend and by 2.6 percent for the impact of membership.

Projected Administrative Charges Calculation			
		Individual Market	Small Group Market
Experience Base Administrative Charges PMPM	A	$54.35	$45.78
Trend Projection	B	1.0816	1.0816
Impact of Membership changes	C	1.0260	1.0260
Projected Base Administrative Charges (Exhibits 7A)	D = A x B x C	$60.31	$50.80
Projected Base Administrative Charges as a percent of premium		5.9%	5.6%

Debit and Credit Card Fees

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 2025 projected premiums.

To project the average fee, we use premium payment and fee data from calendar year 2023. The average fees as a percentage of premium were 0.1 percent for the small group market and 0.3 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 2023	$755.03	$676.48
Card Fees PMPM – CY 2023	$2.23	$0.68
Card Fees as a percent of Billed Premium	0.3%	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 QHP 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 QHP market in the first three months of 2024.

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 SHCE to GAAP base period administrative charges:

Reconciliation of SHCE and GAAP accounting		
		Individual and Small Group
SHCE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	$27,160,329
Less taxes in SHCE 1.5 that are not admin	B	($2,346,607)
Total administrative charges - STAT basis	C = A – B	$29,506,936
Differences in STAT and GAAP treatment	D	($1,638,413)
Total administrative charges - GAAP basis	**E = C + D**	**$27,868,522**

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 0.10 percent, which equals the observed amount of uncollected premium due to the grace periods in each of the previous four years.

Calculation of the Unpaid 30-day Grace Period as a Percent of Premium - Individual			
	Unpaid 30-day Grace Period Premium	**Total Billed Premium**	**Percent of Billed Premium**
2020	$269,037	$129,532,299	0.2%
2021	$231,511	$123,499,348	0.2%
2022	$109,955	$133,369,892	0.1%
2023	$116,854	$177,404,736	0.1%
Total	**$727,357**	**$563,822,519**	**0.1%**

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	1.2%
Small Group Market	1.3%

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 $2.26 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.

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 $0.31 PMPM for the plan year ending December 2025.

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 2025 Final Notice of Benefits and Payment Parameters, the risk adjustment user fee is $0.18 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	90.1%
Small Group Market	89.8%

The details of the MLR calculation are on Exhibits 8.

3.9. <u>Consumer Adjusted Premium Rate Development</u>

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. <u>Small Group Plan Premium Rates</u>

All Small Groups must renew on January 1, 2025 according to market rules. Blue Cross VT will not file small group rates for Q2-Q4 2025.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

Blue Cross VT will not be terminating any products prior to January 1, 2025.

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 2025 QHP Market – Individual.xlsx*
- *VT Rx Data Template – Blue Cross VT 2025 QHP Market – Small Group.xlsx*

The formulary list included in the template is the formulary in place for 2024.

4.4. Unified Rate Review Template Reconciliation

Exhibits 10-IND and 10-SMG provides a reconciliation of the projection factors from worksheet 1 of the URR templates.

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)

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 2025. 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 2025, 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.

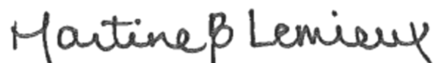
I, Martine B. Lemieux, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience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



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Martine B. Lemieux, F.S.A., M.A.A.A.
Chief Actuary
Blue Cross and Blue Shield of Vermont
May 13, 2024

5.3. Disclosures

Information Date: The analysis provided in the report is based on information as known on May 3, 2024.

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 QHP market for the 2025 plan year. This filing is not intended to be used for other purposes.

Intended Users: This material has been prepared for the Green Mountain Care Board. 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 Green Mountain Care Board guidance published on March 29, 2024[24] Vermont hospital budgets submissions are due July 1, 2024. 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.

H.766 is still being considered by the Vermont legislature. If the final bill varies from the current version, or if the bill ultimately does not become law, it may affect the adequacy or excessiveness of the premium rates discussed herein. Blue Cross VT continues to evaluate the potential impacts of the bill. As such, the estimates included herein are likely to change based on further understanding of the impact of the bill.

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 I have relied upon are incorrect or inaccurate, it may affect the accuracy of the results presented in the report.

The H.766 impact estimates rely on clinical and legal internal analyses, internal reporting, vendor reporting, and vendor analyses. If any of the sources I have relied upon are incorrect or inaccurate, it may affect the accuracy of the results presented in the report.

Subsequent Events: 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.

As of May 3, 2024, the Internal Revenue Service (IRS) has not released the 2025 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 2025 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.

[24] https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY25%20HBR%20Guidance%20FINAL%2003292024.pdf