Cycle IV Rate Review Grant Evaluation
Submitted to the Green Mountain Care Board

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Executive Summary

State health insurance regulators are charged with finding, through the premium rate review process, the right balance between ensuring carrier solvency and affordable prices for consumers. The Affordable Care Act (ACA)[1] provides Health Insurance Premium Review Grants to help states improve their rate review processes and enhance health insurance pricing transparency.[2] In September 2014, the Centers for Medicare & Medicaid Services (CMS) awarded Vermont a grant in the fourth round of Health Insurance Premium Review Grants funding, known as the Cycle IV Grant.[3]

Effective January 2014, the Green Mountain Care Board (GMCB) became the primary reviewer of comprehensive major medical rate filings. Under Vermont law, the GMCB must determine whether proposed rates are "excessive, inadequate or unfairly discriminatory,"[4] ensure that they "are affordable, promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading, or contrary to [State] law."[5]

The GMCB engaged BerryDunn Health Analytics, Inc. (BerryDunn), an actuarial and health analytics consulting firm, to provide an evaluation of Vermont's rate review process as required by the Cycle IV Grant, including identifying appropriate measures to evaluate, developing a determination on the adequacy of the review process, and providing feedback for the continuous quality improvement of the process, including the consumer experience. The findings of this study are summarized below.

Rate savings averaged 2.8%. This study found that for rates effective January 2013 through calendar year 2019 (filed through July 2018), the total premium rate adjustments made in the rate review process have saved Vermonters approximately $108 million, or about 2.8%. In the absence of the rate review process and state regulators' power under statute to disapprove or modify requested rate increases, it is likely the unadjusted rates would have been implemented, increasing consumer premium cost and carrier premium revenue.

Improved administrative efficiency. Administrative efficiency of the review process has been improved, owing primarily to two factors. First, the GMCB has effectively directed carriers to improve how they populate the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF) and requires carriers to populate the standardized actuarial memo data set. These steps allow more efficient review of the rates by consulting actuaries and staff. Second, the number of rate filings and reviews has declined over time. Fewer filings are a result of implementation of the ACA, which standardized the filing format and allowed Vermont to consolidate the individual and small group market into a combined, or "merged," market, and direction from the GMCB for carriers to include the development of rate factors in their rate filings, thus eliminating the separate rate factor filings. The GMCB has also encouraged carriers to move to annual large group filings. In addition,

carrier administrative costs as a percentage of premium have on average decreased significantly and become more consistent.

Medical loss ratios (MLRs) are near carrier targets, though margins are thin. For 2014 through 2017, while the average reductions in rates resulting from the review process for ACA plans were 3.9% for MVP[6] and 2.2% for Blue Cross Blue Shield of Vermont (BCBSVT), carrier actual loss ratio results were comparable to their projected levels.

For 2014 through 2017, the period studied since ACA implementation for which realized carrier loss ratios are available, both carriers experienced reasonable results. The actual MLRs for exchange plans from 2014 to 2017 averaged 1.4% lower than projected for MVP, and 0.5% higher than projected for BCBSVT. This evidence suggests that the GMCB's rate review process created a fair and equitable result in this case, reducing unnecessarily high proposed consumer rate increases while preserving rate adequacy for the carriers.

However, the GMCB's reductions of carrier rate proposals for exchange products have allowed contribution to reserve (CTR) of only 0.5% to 1.0% annually. BerryDunn recommends the GMCB continue to closely monitor reserve levels to ensure adequate carrier reserves for exchange products.

Process supports thorough, fair rate review. Throughout the period of the Cycle IV Rate Review Grant, the GMCB has continued to enhance the premium rate review process to help ensure fair, reasonable, and equitable results. Vermont regulators ensure that carriers provide appropriate documentation to support the rate review process, including an actuarial justification for the rates developed in each filing, the standardized actuarial memo data, and improved population of the NAIC's SERFF. These data support GMCB's consulting actuaries in determining if the filings are reasonable. Both the in-depth actuarial reviews and the enhanced documentation provide the GMCB with a sound empirical basis to make fair and informed decisions to approve, modify, or disapprove proposed rates, and strike an appropriate balance between carrier solvency and affordable prices for consumers. Additionally, the Health Care Advocate, a project of Vermont Legal Aid, participates as a party to filings and requests carrier data to further justify proposed rates.

Benefit plans available are fewer but richer. This study also reviewed the benefit plan options available in the market over the grant period in order to assess changes in the number, type, and variety of benefit plans available to consumers. The number of benefit plans available in small group markets decreased significantly over the grant period. For the individual market there were minimal changes in the number of benefit plans; however, there was a noticeable increase in the richness of benefit plan options available to individuals. The combination of metal actuarial value requirements for qualified health plans[7] (QHPs) limiting the number of potential benefit plans coupled with the potential for selection risk[8] in the merged small group and individual markets is likely driving the decrease in benefit plan options available to small group employers.

Plans became slightly less affordable each year since the growth rate for the Standard Silver plan has been outpacing the growth rate in income. In response to the federal defunding of cost-sharing reductions (CSRs), the Vermont General Assembly enacted Act 88 (2018) to permit "Silver loading" for the 2019 plan year. Silver loading leverages federal premium tax credits, allowing subsidized consumers the ability to purchase richer plan designs through higher subsidies. As a percent of median Vermont income, the annualized premium for a single subscriber for the second most popular Silver plan increased from 12.0% in 2014, to 14.3% in 2018, and up to 15.9% in 2019. The increase in 2019 was driven by the introduction to "Silver loading," removing the impact of Silver loading results in 14.0% percent of median income.

Access to insurance coverage is improving as the uninsured rate falls. There was a slight decrease in the uninsured rate from 2014 to 2018 (3.7% to 3.2%). The uninsured rate for Vermont residents in 2018 is more than 50% lower than the uninsured rate prior to the implementation of the ACA.

BerryDunn will provide enhanced data collection tools for GMCB to maintain. BerryDunn created data collection tools for use in the analysis of the GMCB rate-review process, including for rate review measures and consumer access data. BerryDunn recommends that the GMCB maintain these data collection tools going forward in order to continue to analyze and enhance the rate review process.

Consumer experience and transparency is very good but improvable. BerryDunn reviewed the GMCB's rate review consumer resources and the rate review websites of other states to evaluate transparency and consumer experience in Vermont. The review found that the GMCB's website offers an above-average opportunity for consumer education and participation. While GMCB's website is more than adequate to meet the needs of Vermont consumers, based on this review, BerryDunn recommends refinements to the website functionality to improve the ability to search for filings and provide a summarized report of key statistics.

Executive Summary Endnotes

[1] The comprehensive health care reform law was enacted in March 2010 in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act," (ACA), is used to refer to the final, amended version of the law. Centers for Medicare & Medicaid Services (CMS): Health care.gov glossary. Accessed 10 October 2018: https://www.healthcare.gov/glossary/affordable-care-act/.

[2] Centers for Medicare & Medicaid Services. The Center for Consumer Information & Insurance Oversight: New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes and to Enhance Health Pricing Transparency. Accessed 25 October 2018: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/rates.html

[3] *Ibid.*

[4] Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(2); GMCB Rule 2.000 (Rate Review) § 2.301(b).

[5] *Ibid.*

[6] The Vermont market includes both MVP Health Plan, Inc. and MVP Health Insurance Company. Both entities share the same parent company and will be referred to jointly as MVP throughout this report.

[7] "Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements." Healthcare.gov. Accessed 25 October, 2018: https://www.healthcare.gov/glossary/qualified-health-plan/

[8] Individual choice among a large number of health insurance policies may result in "risk-based sorting" across plans. Individuals who expect high health care costs tend to prefer richer benefit plans while those who expect low costs choose leaner benefit plans. This individual selection process increases the average cost to the insurer for each separate benefit plan. Insurers are not allowed to adjust their pricing to account for selection. This is generally less impactful in the small group market where an employer chooses a plan or metal level on behalf of its employees.

1 Introduction and Process Overview

1.1 Introduction

State health insurance regulators are charged with finding, through the premium rate review process, the right balance between ensuring carrier solvency and affordable prices for consumers. The ACA[1] provides Health Insurance Premium Review Grants to help states improve their rate review processes and enhance health insurance pricing transparency.[2] In September 2014, CMS awarded Vermont a grant in the fourth round of Health Insurance Premium Review Grants funding, known as the Cycle IV Grant.[3]

Prior to 2014, the Department of Financial Regulation (DFR) reviewed health insurance rate filings and provided recommendations to the GMCB to approve, modify, or disapprove the proposed rates. Effective January 2014, the GMCB became the primary reviewer of comprehensive major medical rate filings. The GMCB receives assistance from consulting actuaries contracted by the GMCB, and advice from DFR related to the impact of the proposed rates on insurer solvency.

Under Vermont law, the GMCB must determine whether proposed rates are "excessive, inadequate or unfairly discriminatory,"[4] ensure that they "are affordable, promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading, or contrary to [State] law.[5] In addition, the GMCB takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion.[6] The GMCB has promulgated a regulation that comports with the standard of review set forth in the statute.[7]

This study, a requirement of the Cycle IV Rate Review Grant, evaluates the effectiveness of the rate review process and its impact on consumers, including the review of rates, consumer experience, transparency to the public, and access to quality health insurance. The GMCB engaged BerryDunn's Health Analytics Practice Area (formerly Compass Health Analytics), to conduct the study and provide this report, which summarizes the evaluation of these components.

The following sub-sections of this introduction summarize the current health insurance rate review process in Vermont, describe the main data sources supporting this analysis, and address limitations affecting the analysis. Section 2 of the report presents summary statistics regarding the rate review process, develops measures for evaluation of the process, and reports on the results of the process during the Cycle IV Rate Review Grant period. Section 3 discusses consumer access to affordable products, the price range, and the relative benefit value (i.e., actuarial value) available to Vermonters during the period. Section 4 describes the consumer experience and transparency.

The GMCB reviews rates for all commercial major medical health insurance plans regulated by the State of Vermont.[i] However, in consultation with the GMCB, BerryDunn has focused this report on the individual and small group markets, which became a single "merged" market in 2014 under the ACA.[ii] Also in consultation with the GMCB, BerryDunn has focused this analysis with more emphasis on the period since ACA implementation (2014 to present).

1.2 Vermont Rate Review Process Overview

As described by the GMCB, "[t]he State of Vermont regulates health insurance rates to ensure that Vermonters pay a fair price for quality coverage. The process also examines whether insurance companies have sufficient assets to run their business and to pay for the medical claims of their policyholders."[8]

Vermont is a "file and approve" state for health insurance rate filings, meaning all rate filings must have prior approval from the GMCB before rates can be implemented. Some states are considered "file and use[iii]," meaning a carrier must notify the state of changes to health insurance rates through rate filings, but as long as the proposed rates comply with the relevant state laws they may be implemented. Therefore, any consumer savings resulting from the Vermont rate review process are directly related to the approval requirement. In fact, a national study comparing premium outcomes for 2010 through 2013 between states with approval authority and loss ratio requirements,[iv] versus states with no approval authority found that states with approval authority and loss ratio requirements had, on average, 3.5% lower premiums in the individual market than states without such authority.[9] The 3.5% difference across states in this research finding is not a directly comparable measure to the 3% savings in actual rates relative to submitted rates in Vermont; however, both suggest that rate review is effective and with comparable effect.

In Vermont, commercial health insurance carriers must submit the consumer premiums they plan to charge for products in advance of every contract period.[v] Within five days of receiving

[i] This refers to the commercial fully insured market; self-insured plans are regulated by federal law (ERISA), and their premiums are therefore not subject to the Vermont rate review process.
[ii] BerryDunn analyzed the rate review process for the entire fully insured market, but emphasized the Vermont Health Connect filings, as large employer groups have the ability to negotiate their rates and generally have a greater sophistication around insurance benefits, whereas in the individual and merged market, consumers face the prices offered by carriers (as approved by the regulators). Therefore, the rate review process has significantly greater practical impact on the individual and small group markets.
[iii] File and use states do not approve rates before use, but the ACA requires that any increase greater than 10% be reviewed by the department of Health and Human Services (HHS).
[iv] The ACA implemented loss ratio requirements nationwide in 2011.
[v] Carriers may also submit separate "rate factor filings," requests for approval of changes to various components of the pricing process such as claims trend, insurance carrier administrative expenses, contribution to reserve, taxes, etc. Insurance carriers update rating factors on an ongoing basis and often

the filing, the GMCB makes new rate requests publicly available through its website. A 75-day public comment period begins once the rate filing is posted, and the Vermont Office of the Health Care Advocate (HCA) may intervene in the proceeding to represent the interests of Vermonters. The GMCB's contract actuaries review each filing for completeness, accuracy, and the validity of assumptions and rating factors, and provide the GMCB its analysis in an actuarial memorandum. In addition, DFR must submit an opinion of the impact that each rate filing has on insurer solvency. Both of these documents must be posted to the GMCB website within 60 days of GMCB receiving the rate filing, and the public comment period ends 15 days thereafter.[10]

Within 30 days of posting the actuarial and solvency opinions, the GMCB must hold a public hearing on the filing[11] unless the GMCB renders a decision without a hearing pursuant to Rule 2.309, "Adjudication on the Record."[12] The GMCB is responsible for issuing a decision (approval, approval with modifications, or disapprove) within 90 days of receiving the filing.[13] The GMCB adjusts proposed rates (and rate factors) when they fail to meet statutory review standards. Rate changes, as approved, may be implemented only after the GMCB's decision. The GMCB's decisions may be appealed to the Vermont Supreme Court within 30 days of the decision.[14]

The following subsections address the primary data sources used in this analysis, the limitations of those sources, how those limitations were addressed, and their effects on the report conclusions.

1.3 Data Sources

The primary data sources used in the analysis were:

- Vermont insurance carrier rate filing (and rate factor filing) data,[vi] including proposed rates and rate factors, projected membership, approved rates and rate factors, realized MLRs, and membership
- Documents related to the rate filings such as the GMCB Decision and Order, the DFR Recommendation, and the Memorandum from the reviewing actuary
- Qualitative interviews with the HCA and GMCB actuarial consultant Lewis & Ellis
- The Cycle II Rate Review Grant Evaluation report and supporting data[vii]

do so when developing a rate filing. Rate factor filings do not directly request changes to premiums charged to consumers, but as inputs to premium rates, rate factor changes affect future rate filings.

[vi] Rate filings were accessed directly from GMCB's instance of the NAIC SERFF, with any corresponding filing exhibits in Excel format provided by GMCB, and indirectly from DFR SERFF instance through the GMCB staff.

[vii] State of Vermont GMCB, Cycle II Rate Review Grant Evaluation, accessed October 15, 2018, https://gmcboard.vermont.gov/content/gmcb-cycle-ii-rate-review-grant-evaluation

- GMCB and DFR public websites, as well as Vermont statutes and regulations
- U.S. Census Bureau[viii]
- Congressional Budget Office[ix] (CBO)
- Bureau of Labor Statistics[x]
- Draft 2018 Vermont Household Health Insurance Survey

1.4 Limitations

In 2014, the ACA ushered in changes to the rating rules and additional standardized rate filing exhibits. For example, prior to the ACA's 2014 provisions, individual and small group were separate markets. The new policies sold in 2014 and beyond are part of a merged small group and individual market. These changes created challenges in capturing consistent metrics between non-ACA filings and ACA filings.

[viii] U.S. Census Bureau, accessed November 1, 2018, Median earnings in the past 12 months Full-Time Year Round Workers, 2017 American Community Survey 1-Year Estimates https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_B20018&prodType=table

[ix] Congressional Budget Office, An Update to the Budget and Economic Outlook: 2017 to 2027, accessed November 1, 2018, https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/52801-june2017outlook.pdf

[x] Bureau of Labor Statistics, accessed November 1, 2018, Employment Cost Index (NAICS), https://data.bls.gov/timeseries/CIU2020000000000A

2 Evaluation of the Rate-Review Process and Results

As a starting point for evaluating the rate review process, BerryDunn measured rate filing summary statistics including counts of filings, hearings, covered lives impacted, proposed and final premium dollars, premium dollars saved, per member per month (PMPM) dollars saved, and the percent reduction in rates and premiums.

While the summary statistics are helpful in measuring the effectiveness of rate review in reducing premiums, measuring the regulator's premium reductions alone does not address whether the resulting rates are fair, reasonable, and equitable. To evaluate the process on these more difficult-to-assess dimensions, BerryDunn used measures of the major pricing components, or "rating factors," of premium rates and studied them over the period of the Cycle IV Grant. These measures included:

- MLR
- Pricing trends
- Administrative expense
- Taxes and fees
- CTR

The latter three non-medical components are known collectively as "retention." Analyzing these components provides information about how much of premium and premium increases are associated with medical spending, carrier administrative expenses, government levies, and carrier CTR. BerryDunn analyzed these measures alongside the rate reductions resulting from rate review to shed light on the issues of fairness, reasonableness, and equity from both carrier and consumer perspectives.

2.1 Cycle IV Grant Rate Reviews Summary Statistics and Results

Evaluating Vermont's rate review process under the Cycle IV Grant first requires understanding the overall rate review process, its results, and how they have changed over time. BerryDunn researched, compiled, and analyzed this information, including counts of filings, number of hearings, covered lives impacted, proposed and final premium dollars, premium dollars saved, and the percent reduction in rates and premiums. These findings follow.

BerryDunn reviewed rate filings starting with 2013 effective dates. This is prior to the start of Vermont's Cycle IV, which began in 2014, and prior the implementation of the ACA. The DFR and the GMCB have reviewed 110 health insurance filings. Of these, 76 were rate filings and 34

were rate factor filings[xi], and 54 of the 76 rate filings (71%) resulted in an adjustment to the proposed rates.

Nineteen rate filings and two rate factor filings, or about 19% of total filings, resulted in hearings. The number of rate filings, the number of hearings, and the number of members impacted are presented in Table 1; the number of rate factor filings and hearings are presented in Table 2.

Table 1: Rate Filings

Year	Filings	Hearings	Members
2013	23	7	132,912
2014	14	2	120,436
2015	11	2	80,452
2016	8	2	90,897
2017	10	2	88,454
2018	8	2	85,731
2019	2	2	93,542
Total	76	19	

Table 2: Rate Factor Filings

Year	Filings	Hearings	Members
2013	11	2	245,182
2014	15	0	276,523
2015	2	0	34,570
2016	2	0	31,000
2017	2	0	31,800
2018	2	0	28,432
2019	0	0	-
Total	34	2	

Members included in the rate factor filings could be included in more than one rate factor filing each year, and in the rate filings. For example, some filing types were submitted as frequently as quarterly, and in this case members would be counted multiple times in one year. The initial year of the evaluation (2013) was the last year of rate filings submitted prior to the ACA

[xi] Rate factor filings include requests for approval of changes to various components of the pricing process such as claims trend, insurance carrier administrative expenses, contribution to reserve, taxes, etc. Rate factor filings do not directly request changes to premiums charged to consumers, but as inputs to premium rates, rate factor changes affect future rate filings.

implementation. As of the completion of data collection for this study, a number of filings with 2019 effective dates had not been filed or approved. This study includes all filings approved as of August 9, 2018.

The number of members affected decreases in the first three years of the study (2013 to 2015). The reduction in members in 2014 is attributable to the removal of a large inter-municipal group from the study, as it remained under the auspices of DFR and is no longer reviewed by GMCB. This was partially offset by increased large group membership. In 2015, the membership was lower than the prior year because there were fewer large group filings and the number of members projected in the carrier's rate filings in the merged market was lower in 2015. Starting in 2016, membership affected in the filings became more stable. The smaller fluctuations were a result of changes in carrier projections of their membership that will be impacted by each filling. Membership projections are made approximately 9 to 10 months in advance of the rate filing effective date, and actual membership can vary from projected membership due to a number of factors such as competitive rate position and changes in products.

Even after adjusting for the incomplete years, the number of filings has decreased over time. The primary drivers of this result are implementation of the ACA, which standardized the filing format, consolidation of the individual and small group market into a combined, or "merged," market, and direction from GMCB for carriers to include the development of rate factors in their rate filings, thus eliminating the separate rate factor filings. The GMCB also provided direction to the carriers to file large group rates annually, which provides for additional efficiencies.

These changes have increased administrative efficiency. A merged individual and small group market generates fewer rate filings, as does including the development of rating factors within a rate filing, and an annual large group filing. Fewer filings reduce the administrative burden on both carriers and regulators. In addition, the more standardized ACA filings have increased efficiency of the rate filing process.

Vermont regulators have created additional efficiencies in the rate review process by effectively directing the carriers to improve how they populate information in the NAIC SERFF platform and by requiring carriers to populate the standardized actuarial memo data set. This data set reports historical rate increases, disruption analysis, five years of historic premium and claims experience plus interim period and projected premium and claims, a granular breakdown of carrier administrative expense and other carrier retention expenses, historical claims trend data, and projected pricing trend assumptions in a standardized spreadsheet format. Access to these data in standardized formats is extremely valuable to actuaries performing rate reviews.

For rates effective January 1, 2013, to calendar year 2019 (approved as of August 9, 2018), the total adjustments made in the rate review process have saved Vermonters approximately $108 million, or about 2.8% of total premiums proposed.

Total premiums, PMPM savings, premium dollars saved, and the percentage savings are presented in Table 3.

Table 3: Premium Dollars and Rate Review Savings

		In Millions				
Year	Members	Proposed Premium	Final Premium	Savings	% Savings	PMPM Savings
2013	132,912	$725.2	$702.0	$23.2	3.2%	$14.55
2014	120,436	$541.3	$519.2	$22.1	4.1%	$15.29
2015	80,452	$426.9	$416.8	$10.1	2.4%	$10.47
2016	90,896	$497.8	$487.2	$10.5	2.1%	$9.64
2017	88,452	$554.3	$548.4	$5.9	1.1%	$5.60
2018	85,730	$573.2	$556.5	$16.7	2.9%	$16.26
2019	93,542	$541.5	$522.0	$19.5	3.6%	$17.35
Total		$3,860.2	$3,752.2	$108.1	2.8%	

Note: 2019 includes filings approved on or before August 9,2018.

By necessity, rate filings are based on projected covered lives during the rating period. Premium dollars and any rate review savings are measured based upon that projected membership. Actual premium and dollars saved depend upon the number of members that ultimately enroll during the rating period, or "realized" members, and on the benefit plans that they select. Where realized membership was available, the premium and savings dollars displayed above for 2013 to 2017 filings were adjusted for realized membership.[xii] Separate data for projected and realized membership (where realized figures are available) are presented in Appendix A.

The passing of Act 88 (2018), which allowed "Silver loading" in Vermont, impacted proposed and final premiums in 2019. Silver loading allows carriers to increase the premium for Silver plans offered through the exchange to offset the loss of federal funding for CSR payments. However, the resulting higher premiums for these Silver plans increases the advance premium tax credits (APTCs) for those consumers subsidized in the marketplace, allowing subsidized consumers to enroll in Bronze or Gold at a much lower cost than in previous years. The BCBSVT- and MVP-approved rate increases included in Table 3 were 5.8% and 6.6%, respectively; however, after accounting for the larger premium subsidies due to Silver loading federal funding, the average effective rate increase to the consumer is estimated to be 3.2% for BCBSVT and 1.9% for MVP. Silver loading and its impact on 2019 plan designs is discussed further in Section 3.1 of this report.

[xii] Please note that movement into new benefit plans was not measured as a part of this analysis.

While the summary statistics are helpful in measuring the rate review process's effects on consumer premiums and carrier and regulator administrative burden, these measures alone do not answer the questions of fairness, reasonableness, and equity. To evaluate the process at this more complex level, BerryDunn developed measures for each carrier of the major pricing components, or "rating factors," in premium rates and studied them over the period of the Cycle IV Grant.

2.2 Rating Factors

As discussed previously, rate factors are the data elements and series underlying the development of premium rates, including pricing trend, insurance carrier administrative expenses, CTR, and taxes and fees. To support the Cycle IV Grant evaluation, BerryDunn compiled and measured these key rating factors and studied them over time.

2.2.1 Pricing Trend

The pricing trend is a measure of how claims cost changes over time and is typically expressed as an annual trend number. In developing a proposed pricing trend, a carrier will consider historical allowed claim trends as a starting point and adjust for factors such as anticipated unit cost and utilization changes during the rating period and the impact of fixed cost sharing on paid trends ("leveraging").

For the individual, small group, and merged market filings with 2013 to 2019 effective dates, summarized in Table 4, total annual approved pricing trends ranged from 3.9% to 7.9% and averaged 5.5%. Combined pricing trends include both medical and pharmacy trend.

Table 4: Combined Medical and Pharmacy Approved Pricing Trends

Carrier	Market Segment	Filing Description	Effective Date	Combined Trend
BCBSVT	SG	Q1 Q2 2013 TVHP	1/1/2013	7.0%
BCBSVT	SG	Q1 -Q3 2013 BCBSVT	1/1/2013	6.6%
BCBSVT	SG	Assoc. of Chamber Execs	1/1/2013	5.2%
BCBSVT	SG	VT Health Services Gp	1/1/2013	5.0%
MVP	SG	PPO/EPO Q1 Q2 13	1/1/2013	5.2%
MVP	SG	HMO Q1 Q2 13	1/1/2013	5.0%
MVP	IND	Indemnity Q1 Q2 2013	1/1/2013	7.8%
BCBSVT	IND	Q3 13 Catamount	7/1/2013	3.9%
MVP	IND	Indemnity Q3 Q4 13	7/1/2013	5.9%
BCBSVT	Merged	Health Exchange 2014	1/1/2014	3.9%
MVP	Merged	Health Exchange 2014	1/1/2014	4.7%
MVP	SG	GF PPO/EPO Q1 Q2	1/1/2014	5.5%
MVP	IND	GF Q1 Q2 14	1/1/2014	5.4%
BCBSVT	Merged	Health Exchange 2015	1/1/2015	5.1%
MVP	Merged	Health Exchange 2015	1/1/2015	7.8%
MVP	SG	GF PPO Q1 Q2 2015	1/1/2015	7.9%
BCBSVT	Merged	Health Exchange 2016	1/1/2016	7.0%
MVP	Merged	Health Exchange 2016	1/1/2016	5.7%
BCBSVT	Merged	Health Exchange 2017	1/1/2017	4.9%
MVP	Merged	Health Exchange 2017	1/1/2017	3.9%
BCBSVT	Merged	Health Exchange 2018	1/1/2018	4.4%
MVP	Merged	Health Exchange 2018	1/1/2018	4.7%
BCBSVT	Merged	Health Exchange 2019	1/1/2019	5.2%
MVP	Merged	Health Exchange 2019	1/1/2019	5.2%

For the market prior to, and outside of, Vermont Health Connect (Vermont's health insurance exchange) pricing trends are relatively stable over time; most of the rate filings were developed with pricing trends between 5% and 7%. The lowest approved pricing trend in this period was the BCBSVT July 2013 Catamount[xiii,15] pricing trend of 3.9%, a rate review reduction by GMCB from the proposed trend of 7.9%. The 7.8% pricing trend for the MVP individual indemnity product in 2013 was the highest approved pricing trend. Indemnity trends tend to run higher than Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO)

[xiii] Catamount Health was an individual health plan administered by MVP and BCBSVT, available to eligible Vermonters from October 2007 to December 2013. State subsidies were available to members on a sliding scale for individuals or families with incomes less than or equal to 300% of the federal poverty level.

products due to their lack of care management and provider contracting efforts. In addition, this product has a small membership pool, which tends to increase trend volatility.

Vermont Health Connect pricing trends have ranged between 3.9% and 7.8%, with the lowest trends used in the 2014 and 2017 filings. Aggressive carrier pricing, in an attempt to gain market share with the launch of the exchange, is a likely factor in this result in 2014. The requested and approved pricing trends for both carriers increased in 2015. MVP's low trend in 2017 was due to lower projected medical unit cost increases. Both pharmacy and utilization trends were similar to other years.

The GMCB approved a higher trend for BCBSVT in 2016, while MVP lowered its pricing trend for the same period. BCBSVT's trend in 2016 represents a shift upward, due to both a unit cost increase forecasted at 5.6% versus 5% in the previous rating period and a utilization trend increase from near zero to 2%. MVP projects similar unit cost increases but has flat or negative utilization projections. From 2017 through 2019, trends were very stable ranging from 3.9% to 5.3%, and averaged 4.5%. Pricing trends in this most recent period are very close to the long-term average and very stable.

All pricing trends in these markets ranged from 3.9% to 7.9% during 2013 to 2019. Excluding outliers, the range tightens to 3.9% to 5.7%. Based on the experience of BerryDunn staff, with over 30 years of pricing experience in the New England market, these ranges are narrow considering the ongoing transformation of the health insurance market in this period. A narrow pricing trend range over a long historical period suggests that the rate review process effectively limited any possible carrier reactions to random claim fluctuations, keeping trends more stable. Pricing to the long-term expected claims trend results in more predictable premiums, which are, other things being equal, better for consumers and carriers.

BerryDunn compared the 2019 pricing trends to New England states[xiv] where trend information was available from public rate filings. Pricing trends in other New England states ranged from 5.7% to 11.4%. While many factors could contribute to differences in pricing trends in other states, GMCB rate review and Hospital Budget review have helped keep the Vermont pricing trend rates at the low end of the range in New England. These actions help keep health care coverage affordable in Vermont.

Trend stability has improved over time and as discussed, the most recent pricing trends are close to the long-term average. Contributring to medical trend stablity is the GMCB Hospital Budget approval process. This process limits hospital spending budgets for Vermont hospitals to annual increases that are approved by the GMCB. The hospital increases have dampened and stabilized over time in an effort to control medical costs in Vermont. Hospital "net patient revenue" is defined as the monies that hospitals receive in total charges less deductions

[xiv] Pricing trends from Maine and Connecticut were included in the comparison. Other New England states were either not available or not yet available at the time of the writing of this report.

including contractual discounts, bad debt, and uncompensated care. While improvements have been made to increase transparency in pharmacy prices, Vermont does not have regulatory authority over pharmacy pricing.

Each Vermont Health Connect rate filing used trended claims experience to compute rates. Claims experience is trended for two years to project the rating period claims expense. Rating trends are then expressed as an annual rate of change over that time period. Similarly, BerryDunn computed net patient revenue increases on an annual basis for Vermont hospitals over time periods that correspond closly to each rate filing projection. It is important to note that a direct comparison of carrier filed rating trends to the annualized Vermont Hospital Budget increases cannot be made. For example, the Hospital Budget trends include other payers such as Medicaid and Medicare and non-resident patients, exclude certain pharmacy costs, do not account for provider claims costs outside of Vermont, and do not account for differences by carrier in provider contracting. In addition, carriers must account for the impact of cost share leveraging in their trend development and for providers outside of the Vermont hospital system.

A comparison between hospital net patient revenues and the carrier allowed (before member cost share) rating trends for hospital and professional services (medical) can provide a proxy for a directional comparison between the trends. When comparing carrier allowed medical trends to net patient revenue increases over time, directional alignment is observed. Hospital Budget net patient revenue increases have declined and stabilized over time. Carrier medical trends have been more stable and lower in the three most recent rate filing periods. Vermont Health Connect carrier allowed medical trends are presented in Table 5. Hospital Budget net patient revenue increases are presented by fiscal year in Table 6. The hospital Budget fiscal year runs from October to September. Fiscal years 2017 and prior are based upon actual net patient revenue increases. The fiscal year 2018 increase is based upon 2018 projected net patient revenue compared to 2017 actual net patient revenue. Fiscal year 2019 is based on approved 2018 to 2019 budget net patient revenue increases. Average annual net patient revenue increases over two-year periods are also presented in Table 6. The Health Connect rate filings include medical claims trend over a two-year period. Therefore, average annual two-year net patient revenue increases are somewhat comparable to Vermont Health Connect rate filing trends.

Table 5: Carrier Medical Trends

Carrier	Effective Date	Medical Trend Components		
		Cost	Utilization	Total
BCBSVT	1/1/2014	3.8%	0.0%	3.8%
MVP	1/1/2014	4.7%	0.0%	4.7%
BCBSVT	1/1/2015	4.4%	0.0%	4.4%
MVP	1/1/2015	6.8%	0.0%	6.8%
BCBSVT	1/1/2016	5.0%	2.0%	7.1%
MVP	1/1/2016	3.9%	0.0%	3.9%
BCBSVT	1/1/2017	3.2%	0.5%	3.7%
MVP	1/1/2017	2.5%	0.0%	2.5%
BCBSVT	1/1/2018	2.6%	1.0%	3.6%
MVP	1/1/2018	2.4%	0.7%	3.1%
BCBSVT	1/1/2019	2.7%	1.4%	4.1%
MVP	1/1/2019	3.4%	0.0%	3.4%

Table 6: Hospital Budget Net Patient Revenue Increases

Fiscal Year End	Revenue Increases
2013	7.1%
2014	1.5%
Two Year	4.3%
2014	1.5%
2015	5.0%
Two Year	3.2%
2015	5.0%
2016	4.4%
Two Year	4.7%
2016	4.4%
2017	2.8%
Two Year	3.6%
2017	2.8%
2018	4.5%
Two Year	3.6%
2018	4.5%
2019	2.1%
Two Year	3.3%

2.2.2 Retention

Retention is the portion of the rate that carriers collect to pay expenses and consists of three main components: administrative expense, taxes and fees, and CTR. GMCB approved total carrier retention expenses PMPM; percentage breakouts by major component are presented by product and effective date in Table 7. Carriers typically price administrative expense as a fixed PMPM, a fixed percent of premium, or a combination of the two. BCBSVT prices administrative expense as a fixed PMPM. MVP priced administrative expense as a percentage of premiums until 2016, when it moved to a fixed PMPM approach. Carriers typically price CTR and taxes as a fixed percentage of premiums. Table 7 displays administrative expense as both a PMPM and percent of premium for clarity.

Table 7: Carrier Retention

Carrier	Market Segment	Filing Description	Effective Date	Admin Expense PMPM	Admin Expense	CTR	Taxes	Total
BCBSVT	SG	Q1 Q2 2013 TVHP	1/1/2013	$52.83	12.5%	0.0%	1.3%	13.7%
BCBSVT	SG	Q1 -Q3 2013 BCBSVT	1/1/2013	$82.54	14.2%	0.0%	0.9%	15.1%
BCBSVT	SG	Assoc. of Chamber Execs	1/1/2013	$33.83	9.8%	0.0%	1.2%	11.0%
BCBSVT	SG	VT Health Services Gp	1/1/2013	$83.74	13.7%	0.0%	0.9%	14.6%
BCBSVT	IND	Q3 13 Catamount	7/1/2013	$26.92	5.9%	0.0%	1.7%	7.7%
MVP	SG	PPO/EPO Q1 Q2 13	1/1/2013	$57.44	14.3%	3.0%	3.1%	20.3%
MVP	SG	HMO Q1 Q2 13	1/1/2013	$80.30	10.8%	3.0%	1.2%	14.9%
MVP	IND	Indemnity Q1 Q2 2013	1/1/2013	$30.20	13.5%	3.0%	3.3%	19.8%
MVP	IND	Indemnity Q3 Q4 13	7/1/2013	$53.22	13.5%	3.0%	4.3%	20.8%
BCBSVT	Merged	Health Exchange 2014	1/1/2014	$30.25	8.3%	0.5%	3.2%	12.0%
MVP	Merged	Health Exchange 2014	1/1/2014	$35.88	9.8%	0.5%	4.0%	14.3%
MVP	SG	GF PPO/EPO Q1 Q2	1/1/2014	$38.13	9.8%	1.0%	5.5%	16.2%
MVP	IND	GF Q1 Q2 14	1/1/2014	$21.42	11.0%	1.0%	5.3%	17.3%
BCBSVT	Merged	Health Exchange 2015	1/1/2015	$27.31	6.3%	1.0%	3.7%	11.0%
MVP	Merged	Health Exchange 2015	1/1/2015	$41.83	10.1%	1.0%	3.7%	14.8%
MVP	SG	GF PPO Q1 Q2 2015	1/1/2015	$43.12	9.8%	1.0%	5.7%	16.4%
BCBSVT	Merged	Health Exchange 2016	1/1/2016	$29.78	6.4%	1.0%	3.6%	11.0%
MVP	Merged	Health Exchange 2016	1/1/2016	$38.26	9.2%	-0.2%	3.8%	12.8%
BCBSVT	Merged	Health Exchange 2017	1/1/2017	$34.22	7.0%	2.3%	0.9%	10.1%
MVP	Merged	Health Exchange 2017	1/1/2017	$38.38	8.6%	1.0%	1.8%	11.4%
BCBSVT	Merged	Health Exchange 2018	1/1/2018	$36.06	6.7%	0.7%	3.8%	11.2%
MVP	Merged	Health Exchange 2018	1/1/2018	$39.96	8.6%	2.0%	2.9%	13.6%
BCBSVT	Merged	Health Exchange 2019	1/1/2019	$40.29	7.1%	0.6%	1.3%	8.9%
MVP	Merged	Health Exchange 2019	1/1/2019	$41.40	8.1%	0.5%	1.1%	9.8%

2.2.2.1 Administrative Expense

Administrative expense is the largest component of retention. It refers to carriers' overhead costs such as salaries, building expenses, claim processing, systems expense, customer

mailings, etc. Administrative expenses may also include broker commissions. However, beginning with the 2014 rate period and implementation of the Vermont health benefit exchange, carriers were prohibited from paying and including broker commissions for small group and individual plans.[16]

After accounting for changes in measurement occurring prior to the implementation of the ACA, administrative expenses have been relatively stable. In 2013, both MVP and BCBSVT included broker commissions in their administrative expense. As shown in Table 7, the level of administrative expense varied widely for 2013 filings, from $26.92 PMPM to $83.74 PMPM (from 5.9% to 14.3% of premium), a wider and higher range than seen in the succeeding years.[xv] Starting in 2014, when commissions were prohibited and excluded from small group and individual plans, administrative expense was more stable.

As seen above, in 2015 BCBSVT reduced its administrative expense by $2.94 PMPM, from $30.25 (8.3% of premium) to $27.31 (6.3% of premium), a 9.7% decrease in the PMPM. From 2015 to 2016, BCBSVT's administrative expense remained nearly flat as a percent of premium, edging up to 6.4%. Over a five-year period, BCBSVT increased its PMPM administrative expense by 5.9% per year, on average. BCBSVT typically increases administrative expenses by 2.5% to 3.0% each year for increase in wages and other overhead expenses. Contributing to the higher rate of increase is the cost of BCBSVT's Blue Reward program, which pays rewards to members for healthy behaviors such as completing health assessments, getting a physical exam, and other wellness activities. The membership eligible for this program has increased over time, and thus increased this component of administrative expense. Most recently, BCBSVT has experienced membership loss in its Vermont Health Connect rating pool, and attributes 3.4% of its 2019 PMPM increase to declining membership (fewer members to cover fixed administrative costs).

MVP's administrative expense rose between 2014 and 2015 from 9.8% to 10.1% of premium, and the PMPM increased by $5.95, or by 16.6%. MVP priced administrative expenses as a percentage of premium in 2015. MVP's administrative expense then fell to 9.2% of premium in 2016, a $3.58 (8.6%) reduction in the PMPM. In 2016, MVP changed from a percent of premium to a PMPM administrative expense. At the same time, MVP worked to improve administrative efficiencies and reflected anticipated improvement in its pricing. Since 2016, MVP's administrative expense has increased by 2.7% per year on average. Over a five-year period, MVP's PMPM administrative expense increased by 2.9% per year on average.

After accounting for additional factors, the carriers' underlying changes in administrative expense compare closely to general Consumer Price Index (CPI) changes in the Northeast region, which increased between 1.3% and 2.6% for 12-month periods ending in 2017.[17] Given

[xv] The $82.54 PMPM administrative fee was so high because it included broker commission of 6.25% of premium.

the added expense of implementing the ACA, the administrative expense has remained relatively stable for both carriers.

2.2.2.2 Taxes and Fees

Retention also includes taxes, fees, and assessments. Examples include premium tax, the Vermont vaccine program assessment, and the ACA insurer fee. Taxes and fees have fluctuated over time. State premium taxes are levied on PPO and indemnity products, so taxes and fees were higher on those products due to a 2% premium tax requirement. The carriers filed their 2014 merged market filings on HMO products. However, as shown in the "Taxes" column of Table 7, taxes and fees have increased for both MVP and BCBSVT due to the ACA insurer fee and other ACA-related fees. In 2017, carriers began to include an explicit component in their retention for the Vermont Billback, which is levied under 18 V.S.A. 9374(h).[18] The tax was applicable prior to 2017 but was much smaller. The increase in the Billback in 2017 was due to a reduction of federal funding that year. In 2017, this explicit component of retention added between 0.1% and 0.3% to premium. Carriers did not begin to break this tax out explicitly in their rate filings until 2017. Until its 2019 filings, MVP had miscategorized Billback as a medical expense. In 2017, the ACA tax was suspended, and taxes and fees decreased between 2% to 2.7% of premium. In 2018, the ACA tax fee was reinstated and then suspended again in 2019, causing additional fluctuation in the expense component. At any premium level, higher taxes and fees result in a lower target loss ratio for the carriers.

2.2.2.3 CTR

The CTR component of retention is the amount included in premium rates in a given contract period to increase reserves, the funds held by not-for-profit insurers,[xvi] to ensure they hold adequate funds to pay unexpected future claims costs. The DFR examines the carriers' reserve levels and the GMCB monitors and considers reserve levels in any decisions on CTR. The goal of GMCB has been to keep this premium component as low as possible while still maintaining adequate carrier reserve levels.

As shown in the CTR column of Table 7, since 2014 and the implementation of the ACA, CTR has been between 0.5% and 2.3%. The exception was the 2016 MVP filing in which the carrier filed a 0.0% CTR to help improve its competitive position in the market in 2016. A slight reduction made by the GMCB resulted in a -0.2% CTR in that year for MVP. In most years, the ACA rate filings include CTR between 0.5% and 1.0%. Given the uncertainty in the market in the early years of the ACA implementation, and a period of continued changes in the market, these percentages are low. However, as part of the review process, DFR performs a solvency analysis to ensure that the approved rates do not adversely affect the solvency of the insurer.

[xvi] MVP Health Plan and BCBSVT are not-for-profit companies; BCBSVT is licensed in Vermont under Chapter 123 of Title 8 as a nonprofit hospital service corporation. MVP Health Insurance Company is a for-profit insurance company and this component of retention is considered profit.

Changes to retention components in the rate review process impact the carriers' target loss ratio and the resulting comparison of approved to realized MLRs have strong implications for evaluating whether the rate review process is fair, reasonable, and equitable. BerryDunn explores this topic in the next section.

2.3 Process Evaluation: Fair, Reasonable, and Equitable

As noted above, the GMCB is charged by statute with ensuring that Vermont health insurance premiums are not "excessive, inadequate or unfairly discriminatory," and that they promote access to quality health care and protect insurer solvency.[19] That is, the GMCB must ensure that Vermont health insurance premiums and the rate review process are fair, reasonable, and equitable to both carriers and consumers.

This evaluation focuses on the period since ACA implementation in 2014. The market and regulatory discontinuities created by health insurance reform make before-and-after comparisons difficult and limit their value.

One measure to evaluate if the rate review process is fair reasonable and equitable is the MLR[xvii], which is the ratio of total claims expense to premium. Insurance carriers set premiums to obtain a "proposed target loss ratio" based on projected claims expense. The proposed target loss ratio is set at the benefit plan level and then aggregated using the projected distribution of membership across the benefit plans included in a filing. The proposed target loss ratio can be altered in the rate review process by direct regulator adjustments or indirectly through changes to other rating factors or the premiums themselves. An "approved target loss ratio" results when these changes are finalized, applied to the benefit plans in the filing, and averaged across plans using the membership distribution.

After the rating period is complete and actual claims expense is known, the realized loss ratio can be computed. The realized loss ratio is the ratio of claims expense incurred over the rating period to the premium collected. For any given benefit plan, if actual claims are higher than expected, the realized loss ratio will be higher than the target; this may be an indication that the rates were set too low. It is important to note, since target loss ratios are set at the benefit plan level, if the realized membership distribution among benefit plans differs from the projection, the realized loss ratio could differ from the target loss ratio, even if the actual experience for the plans is realized at the level anticipated in the rate development. It is, therefore, important to be cautious when using this measure.

Realized loss ratios are available through calendar year 2017. Rating periods have been standardized to the calendar year for rating periods 2015 and beyond; actual loss ratios for 2018 and 2019 are therefore unknown as of the time this report was written.

[xvii] This definition of MLR differs from the federal MLR. The federal medical loss ratio allows carriers to include administrative expenses geared toward claims cost reduction to be included in claims expense.

Table 8 presents the GMCB approved premium reduction, the proposed loss ratio, approved loss ratio, and realized loss ratio for Vermont Health Connect filings since inception.

Table 8: Health Exchange Rate Review
Premium Reduction and MLRs

Carrier	Effective Date	Premium Reduction	Proposed Loss Ratio	Approved Loss Ratio	Realized Loss Ratio
BCBSVT	1/1/2014	4.3%	87.8%	88.0%	86.0%
MVP	1/1/2014	4.7%	84.8%	85.7%	86.7%
BCBSVT	1/1/2015	1.9%	89.1%	89.0%	87.9%
MVP	1/1/2015	4.1%	84.7%	85.2%	89.3%
BCBSVT	1/1/2016	2.3%	88.0%	89.0%	92.8%
MVP	1/1/2016	0.6%	87.1%	87.2%	88.5%
BCBSVT	1/1/2017	0.9%	89.9%	89.9%	91.2%
MVP	1/1/2017	4.6%	89.1%	88.6%	76.7%
BCBSVT	1/1/2018	3.1%	87.5%	88.8%	N/A
MVP	1/1/2018	3.1%	87.0%	86.4%	N/A
BCBSVT	1/1/2019	3.5%	90.2%	91.1%	N/A
MVP	1/1/2019	3.9%	88.7%	90.2%	N/A

Many factors can affect the realized loss ratios, including, but not limited to, changes in the demographic make-up of the membership, differences in the anticipated benefit plan distribution, changes in government regulations, new unexpected drugs and technology expenses, and random claims fluctuations. It is important to measure the realized versus the approved loss ratio over time rather than drawing conclusions from just one rating period.

From the 2014 rating period through 2019, total premium adjustments made by the GMCB on the merged market health exchange plans have saved Vermonters approximately $74.2 million, or 2.7% of premium. Savings through 2017 are approximately $38.5 million or 2.4% of premium.

For 2014 through 2017, the period for which actual carrier loss ratios are available for the merged market, both carriers experienced varied results. The actual loss ratios for BCBSVT Health Exchange plans ranged from 3.9% unfavorable (above the approved target) to 2.0% favorable (below the approved target). The average actual loss ratio over the four-year period is 0.5% unfavorable. BCBSVT achieved these results despite rate review reductions of 2.2%. The actual loss ratios for MVP Health Exchange plans ranged from 4.1% unfavorable (above the approved target) to 11.9% favorable (below the approved target). The average actual loss ratio over the four-year period is 1.4% favorable. The wider variance for MVP is likely due to the smaller size of their rating pool making results more volatile. MVP achieved these results despite rate review reductions of 3.9%. This evidence suggests the GMCB's rate review process created a fair and equitable result in this case, reducing unnecessarily high proposed consumer rate increases while preserving rate adequacy for the carriers. However, the actual

loss ratios exclude federal risk adjustments, any adjustments for transitional reinsurance recoveries and other financial adjustments.

An additional measure that accounts for these adjustments is the underwriting gain from the annual financial statements. The underwriting gain can be used as a rough proxy for the realized CTR[xviii]. BerryDunn calculated the underwriting gain using Supplemental Health Care Exhibit (SHCE) data that the carriers submit with their annual NAIC financial statements. The realized CTR in the table below is based upon the underwriting gains included on the SHCE. Table 9 includes the realized CTR, the carrier-filed CTR, the GMCB-approved CTR, and the approved CTR adjusted for any unspecified rate cuts. Unspecified rate cuts, in effect, lower the approved CTR. An unspecified rate cut would include reductions to premium that go beyond recommendations by the GMCB's rate review actuary and are not based on actuarial factors. An example of an unspecified rate cut would be a reduction to increase affordability. The underwriting gain adjusted to the filed CTR is the gain that would have occurred if the GMCB had approved the filed CTR.

Table 9: Carrier Health Exchange Filed CTR vs. Underwriting Gain

Blue Cross Blue Shield of Vermont	CY 2014	CY 2015	CY 2016	CY 2017	Cumulative
Member Months	735,603	766,083	835,621	819,824	3,157,131
Filed CTR	1.00%	1.00%	2.00%	2.25%	1.62%
Approved CTR	0.50%	1.00%	1.00%	2.25%	1.25%
Approved CTR with Unspecified Rate Cut	-0.10%	1.00%	0.80%	1.00%	0.72%
Underwriting Gain (Realized CTR)	0.63%	1.14%	-4.03%	0.53%	-1.20%
Underwriting Gain Adjusted to filed CTR	1.72%	1.14%	-2.77%	1.78%	0.40%

MVP Health Plan Inc.	CY 2014	CY 2015	CY 2016	CY 2017	Cumulative
Member Months	60,497	64,921	82,377	135,424	343,219
Filed CTR	1.50%	1.50%	0.00%	1.00%	1.01%
Approved CTR	0.50%	1.00%	0.00%	1.00%	0.66%
Approved CTR with Unspecified Rate Cut	0.50%	1.00%	-0.20%	1.00%	0.62%
Underwriting Gain (Realized CTR)	5.35%	0.38%	-9.49%	15.00%	5.34%
Underwriting Gain Adjusted to filed CTR	6.30%	0.89%	-9.28%	15.00%	5.63%

The GMCB-approved target loss ratios and administrative expenses for exchange products have indicated CTR of 0.00% to 1.00% annually. As noted in Section 2.2, these projected margins are low given the uncertainty in the reformed market. Actual results show that over time the Health Exchange for BCBSVT experienced a -1.20% realized CTR, and MVP experienced a 5.34% realized CTR. For BCBSVT, the four-year Health Exchange financial loss reduced its solvency, which is not sustainable over time. For MVP, results are more volatile due to the smaller size of its pool. The four-year cumulative gain of 5.34% compares favorably to MVP's

[xviii] SHCE underwriting gain may include timing differences and other accounting entries not considered in rate development.

approved CTR of 0.62%; however, the range over the four-year period is from -9.49% to 15.00% in any given year. Over this period, the GMCB reduced MVP-filed premiums by 3.9% and, given their cumulative underwriting results, these reductions appear to be appropriate. However, given the size of the MVP risk pool, underwriting results are volatile, and both annual and cumulative underwriting gains should be used with caution. The DFR performs solvency reviews and, given these mixed results, BerryDunn recommends DFR and GMCB continue to closely monitor reserves levels and consider those levels in their decision-making on CTR rating factors to ensure adequate carrier reserves for exchange products.

Throughout the period of the Cycle IV Grant, the GMCB has continued to enhance the rate review process to help ensure fair, reasonable, and equitable results. GMCB ensures that carriers provide appropriate documentation to support the rate review process, including an actuarial justification for the rates developed in each filing, the standardized actuarial memo data (a robust data set to support the rate review process), and improved population of SERFF. These data support the consulting actuaries contracted by GMCB to perform in-depth rate reviews on each filing in determining if the filings are reasonable. Both the in-depth actuarial reviews and the enhanced documentation provide the GMCB with a sound empirical basis to make fair and informed decisions to approve, modify, or disapprove proposed rates, and strike an appropriate balance between carrier solvency and affordable prices for consumers.

2.4 Lewis & Ellis, Inc. (L&E) Interview

BerryDunn conducted an interview with L&E, the actuarial consulting firm retained by the GMCB to assist in conducing Vermont rate reviews. BerryDunn conducted the interview to help further evaluate the adequacy and efficiency of the rate review process. L&E indicated that, in addition to Vermont, it has worked in 10 other states since the ACA filings started in 2013. L&E stated that in general Vermont has one of the most efficient rate review processes, as compared to the other states they review, for three reasons:

1) GMCB is a dedicated agency with significant commitment and dedication to the integrity of the process
2) GMCB level of engagement ensures L&E and GMCB are well coordinated and aligned
3) The 60-day review period forces efficiency

L&E indicated that BCBSVT's ACA filings rank high in terms of preparation and diligence out of over 500 ACA filings it has reviewed. MVP also has robust filings that have improved significantly over time from its 2014 filing. Through GMCB direction, and collaboration among all parties, the carriers have learned what L&E will ask for and will proactively prepare their flings based on historical requests. The actuarial data set provides great information, and L&E updates the actuarial data set yearly. The carriers include this data with the rate filings, and it provides considerably more information than L&E receives in other states. When L&E started the rate review process, it had a face-to-face meeting with the carriers' actuaries and developed communication protocols, which facilitate getting any needed additional information. L&E

indicated that its objection letters typically seek further clarification. The carriers consistently respond with the required information according to deadlines. The carriers understand the GMCB, and they know in any year the GMCB might focus on a new issue. For example, GMCB may be interested in a breakdown of tax items. L&E attempts to think of new information that could be added to the actuarial data set. L&E also tries to flush out new items in advance through discussions with GMCB.

BerryDunn asked L&E about recent issues and potential improvements, and L&E indicated that most recently there were two issues under consideration:

1) Risk adjustment timing – Final federal risk adjustment numbers are not published until close to the rate filing date. L&E receives federal data up-front, estimates the adjustment, and communicates that to the carriers. This process has addressed the issue and streamlined the process.
2) A transparent connection between rate filings and the Hospital Budget process – The GMCB finalizes the rate filings in August, prior to finalizing Hospital Budgets in September. GMCB and the Vermont hospitals discussed changing the Hospital Budget schedule, but the hospitals could not accommodate a change. L&E indicated that the difference between submitted and final budgets are not material to the filings. BCBSVT provides transparency in its filing by submitting a trend exhibit that provides a breakdown of the impact of Hospital Budgets. L&E indicated it could work with the GMCB to require MVP to provide an exhibit similar to what BCBSVT submits. A similar MVP exhibit would provide additional information of the impact of budgets Hospital Budgets on rate filings.

L&E spoke highly of the GMCB rate review process and indicated it is efficient and provides a transparent and robust process.

The next section assesses the effects of this rate review process on consumer access to quality health insurance at affordable prices in Vermont's merged individual and small group market.

3 Access to Affordable Products

Consumer access to quality health insurance is dependent upon carriers offering, at an affordable price, a variety of quality benefit plans to meet the varying needs of consumers. An effective rate review program helps to ensure that health insurance rates are adequate to encourage carriers to participate in the market with products that represent a fair value (i.e., plans offered at reasonable prices given the benefits offered) to a diverse group of consumers.

To assess consumer access to affordable products of fair value in the Vermont individual and small group market, BerryDunn reviewed carrier offerings for 2013 through 2019 rating periods. This approach showed the market's evolution from year to year from before implementation of the ACA (2013) through the sixth year of Vermont Health Connect (2019).

This review has three main components: (i) an assessment of product variety, as measured over time by the quantity of distinct benefit plans offered and the distribution of members across benefit levels, (ii) an analysis of benefit richness and benefit value, as measured by the range of actuarial value and price relativity, and (iii) an analysis of affordability, as measured by the annual cost of a Standard Silver QHP[xix] as a proportion of median income for a full-time year-round worker in Vermont.

BerryDunn reviewed rate filings for the first quarter of the years 2013 to 2019 for the two carriers offering individual and small group health insurance coverage in Vermont and the Catamount filing for third quarter 2013 to compile and analyze the following measures of access and affordability. BerryDunn reviewed the following:

- Number of benefit plans filed: The simple count of benefit plans available to individuals and employees of small employer groups (by metal level[xx] for ACA filings), and its evolution over time, provides a starting point for assessing access to a sufficient variety of products. BerryDunn met with GMCB and agreed that for this evaluation, the count of benefit plans was limited to medical plan options and did not include variations due to various combinations of riders and pharmacy benefit options.
- Anticipated member months and distribution of anticipated member months: This measure, by ACA metal level[xxi] and year, illuminates where the membership is

[xix] "Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements." HealthCare.gov. Accessed 29 November, 2015: https://www.healthcare.gov/glossary/qualified-health-plan/.
[xx] The qualified health plan standard benefit levels: Platinum (on average, 90% of member health care costs paid by the carrier), Gold (80% paid by carrier), Silver (70%), and Bronze (60%).
[xxi] Pre-ACA filings were not standardized and did not all include member months.

clustered, thereby identifying the more popular plan types and how those are changing over time, which may provide insight into consumer value and affordability.

- Major product attributes: Product attributes for the high-cost plan (highest premium) and low-cost non-catastrophic[xxii] plan for each market, carrier, and year provide a sense of the breadth of benefit options available and how that has changed over time. Under this definition, higher costs will not necessarily denote richer benefits because of differences in pricing for separate risk pools; however, this definition allows for comparisons within market segments across time.
- Premium PMPM: Capturing the highest, lowest, and average premium PMPM for each market, carrier, and year combination, including a metric for the range from lowest to highest (spread), illustrates the cost differential of benefits in the marketplace, how much the average person would pay for coverage, and how that has changed over time.
- Metal actuarial value: Actuarial value is the theoretical projected range of the total average amount a plan will pay for covered essential benefits for a standard population. Tracking the highest and lowest metal actuarial value over time provides an indication of where the QHP products are falling in the de minimis range over time.[xxiii]
- Average cost sharing PMPM and average total cost of health care PMPM: These metrics allow comparisons over time of the average cost sharing borne by a member as well as the average total cost of health care (cost share plus premium). Individual plan members pay 100% of health care premium (exclusive of subsidies), whereas small group plan members likely receive premium contributions from their employers and pay all of the cost sharing.
- Affordability comparison: Affordability is critical to consumer access. BerryDunn developed a measure to compare the median income for a full-time year-round worker in Vermont to the annualized cost of Standard Silver insurance coverage for a single rate tier. Additionally, the expected rate of growth in income is compared to the rate of growth in health insurance premiums over time.

[xxii] As part of the health insurance marketplace, the ACA introduced a catastrophic plan, designed to have the leanest benefits and lowest premium in the marketplace. Those under 30 or who have obtained a "hardship exemption" qualify for a high deductible, low premium, catastrophic plan. Since this plan is not available to the entire market it was not included in setting the low-cost plan in the analysis that follows.

[xxiii] The final rule established that a de minimis variation of +/- 2 percentage points of actuarial value is allowed for each metallic tier. The federal government increased the de minimis variation in 2017 for plan year 2018, to -4/+2 for all metal levels except for "expanded" bronze. https://www.gpo.gov/fdsys/pkg/FR-2017-04-18/pdf/2017-07712.pdf

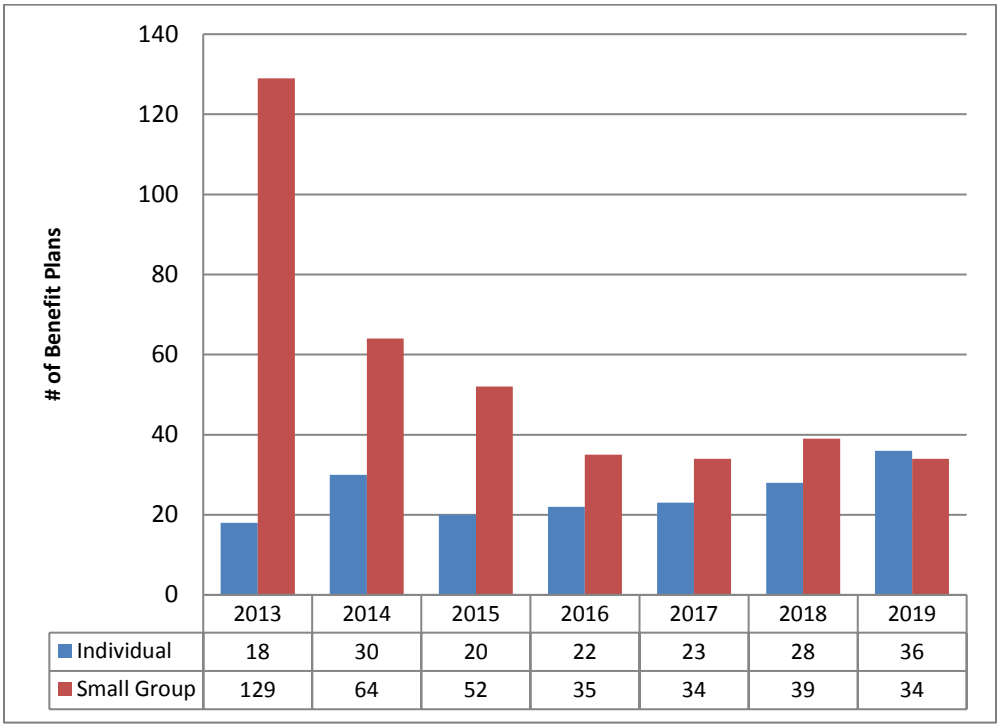
3.1 Products

The introduction of state health insurance marketplaces by the ACA in 2014 had a material impact on the number and range of benefit options available in the small group and individual markets owing to the introduction of four standardized actuarial value metal levels and one individual catastrophic plan, with which all benefit plans must comply. Effective January 1, 2014, all newly purchased individual and small group policies are required to be ACA-compliant, regardless of whether they are sold on- or off-exchange. In addition, Vermont opted to take a merged market approach, combining the individual and small group markets. Although new policies are required to be ACA-compliant and their products consistent between the individual and small group markets, plans that were in-force prior to 2014 may be exempted from the ACA rules as "grandfathered plans."[xxiv] Grandfathered plans may remain in force indefinitely as long as they are still offered by the carrier and the carrier does not make any substantial changes to the plan. Beginning with 2019 effective dates, no carriers participating in the merged small group and individual market will offer grandfathered products in Vermont.

Prior to 2014, there were considerably more benefit options available in Vermont's small group market than in the individual market. The number of options for the individual market increased with the implementation of the ACA's 2014 provisions, followed by a decline in benefit options in 2015. Since 2015, the number of benefit designs available to those in the individual market has increased each year. In 2019, MVP eliminated its grandfathered plans, and the number of plan designs available to the individual segment surpassed the number of small group plan designs. The individual market has two catastrophic plan designs that are not available to small groups. Figure 1 shows the number of benefit plans filed in the individual and small group markets by year, from 2013 to 2019.

[xxiv] Grandfathered plans are health plans that were in existence on March 23, 2010, and have not been changed in ways that substantially cut benefits or increase costs for plan holders.

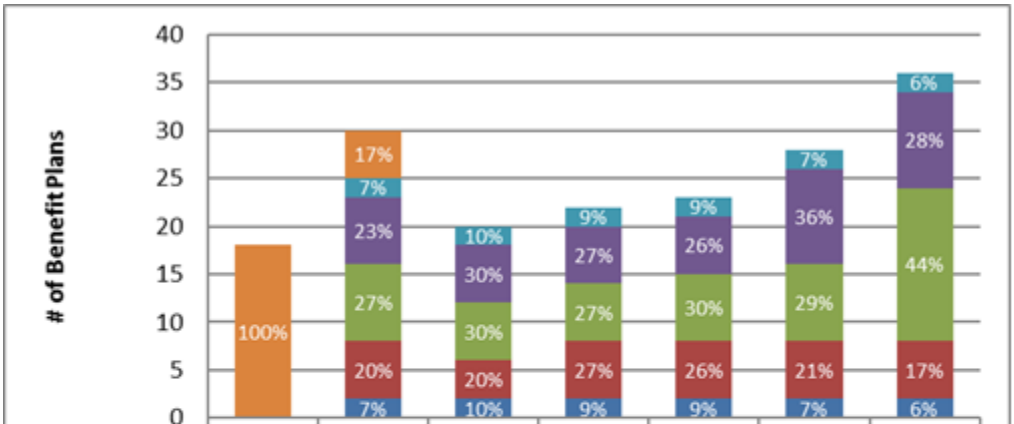
Figure 1: Individual vs Small Group
Number of Benefit Plans Filed by Year



	2013	2014	2015	2016	2017	2018	2019
Individual	18	30	20	22	23	28	36
Small Group	129	64	52	35	34	39	34

The total number of benefit options currently available in the individual market is double the number of benefit options before ACA implementation. Initially, the number of benefit options increased in 2014, due to newly available ACA-compliant benefit options, then decreased back to near pre-ACA levels driven by the elimination of non-ACA (grandfathered) benefit options in 2015 and a decrease in the ACA Bronze and Silver benefit options between 2014 and 2017. The passage of Act 210 (2018) brought on the introduction of Bronze plan designs without a pharmacy maximum out-of-pocket limit, increasing the number of Bronze plans in the merged market. In 2019, the number of Silver plans will double due to the introduction of "Reflective" Silver plan designs into the merged market brought on by the passing of Act 88 (2018). Reflective Silver plans are plans offered outside of the exchange that mirror the exchange Silver plan benefits, but do not have the additional premium cost due to Silver loading (related to the elimination of federal CSR funding), allowing access to Silver plans for consumers not eligible for APTC subsidies. Figure 2 shows the number of benefit plans filed in the individual market by year and type (ACA-compliant by metal level or non-ACA compliant).

Figure 2: Individual Market
Number of Benefit Plans Filed by Year



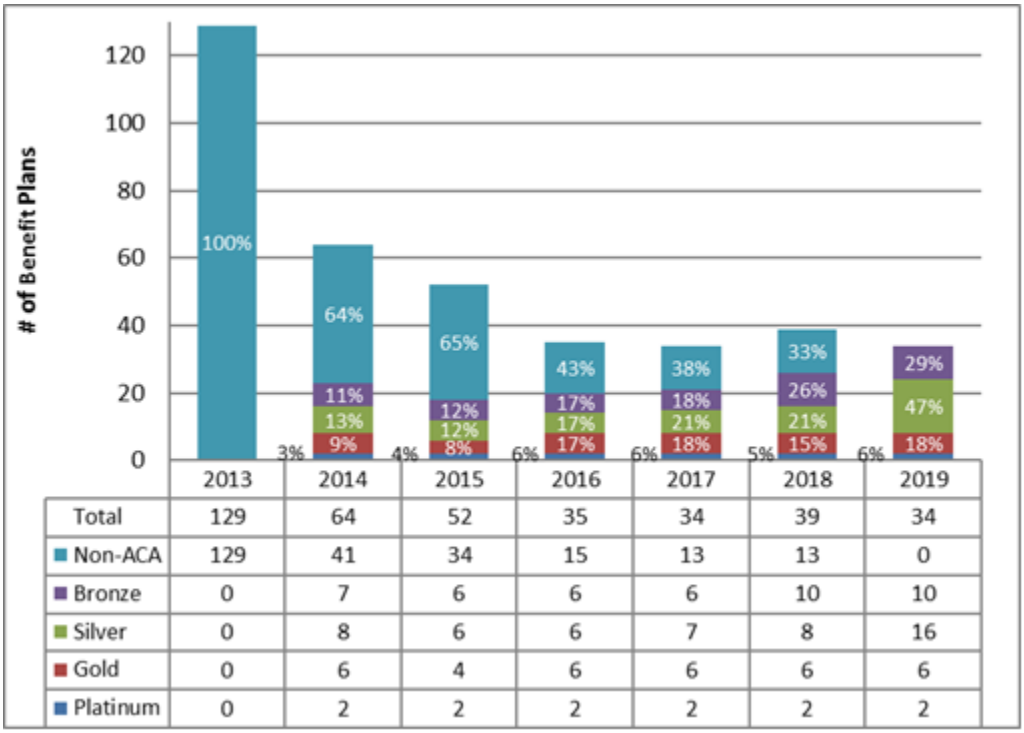
	2013	2014	2015	2016	2017	2018	2019
Total	18	30	20	22	23	28	36
Non-ACA	18	5	0	0	0	0	0
Catastrophic	0	2	2	2	2	2	2
Bronze	0	7	6	6	6	10	10
Silver	0	8	6	6	7	8	16
Gold	0	6	4	6	6	6	6
Platinum	0	2	2	2	2	2	2

The number of benefit options available to small groups on Vermont Health Connect is roughly one-fourth of the available small group benefit plans prior to the ACA (2013). The combination of metal actuarial value requirements for QHPs limiting the number of potential benefit plans, coupled with the potential for selection risk[xxv] in the merged small group and individual market, is likely driving the decrease in plans available to small group employers. In addition, the non-ACA benefit options (grandfathered plans) have been decreasing over the period 2014 to 2018. The remaining small group grandfathered plans in Vermont were offered by MVP and were discontinued in 2018.The number of ACA benefit plans remained relatively stable through 2017. In 2018, there was an increase in Bronze plan designs, and in 2019, there was an increase in Silver plan designs as outlined in the previous section. Figure 3 shows the number of benefit plans filed in the small group market by year and type (ACA-compliant by metal level or non-ACA compliant). Since Vermont Health Connect is a merged marketplace, the number of QHP

[xxv] Individual choice among a large number of health insurance policies may result in "risk-based sorting" across plans. Individuals who expect high health care costs tend to prefer richer benefit plans while those who expect low costs choose leaner benefit plans. This individual selection process increases the average cost to the insurer for each separate benefit plan. Insurers are not allowed to adjust their pricing to account for selection. This is generally less impactful in the small group market where an employer chooses a plan or metal level on behalf of its employees.

offerings by metal level for 2014 to 2019 is the same for small groups and individuals, with the exception of catastrophic coverage, which is only available to certain individuals.

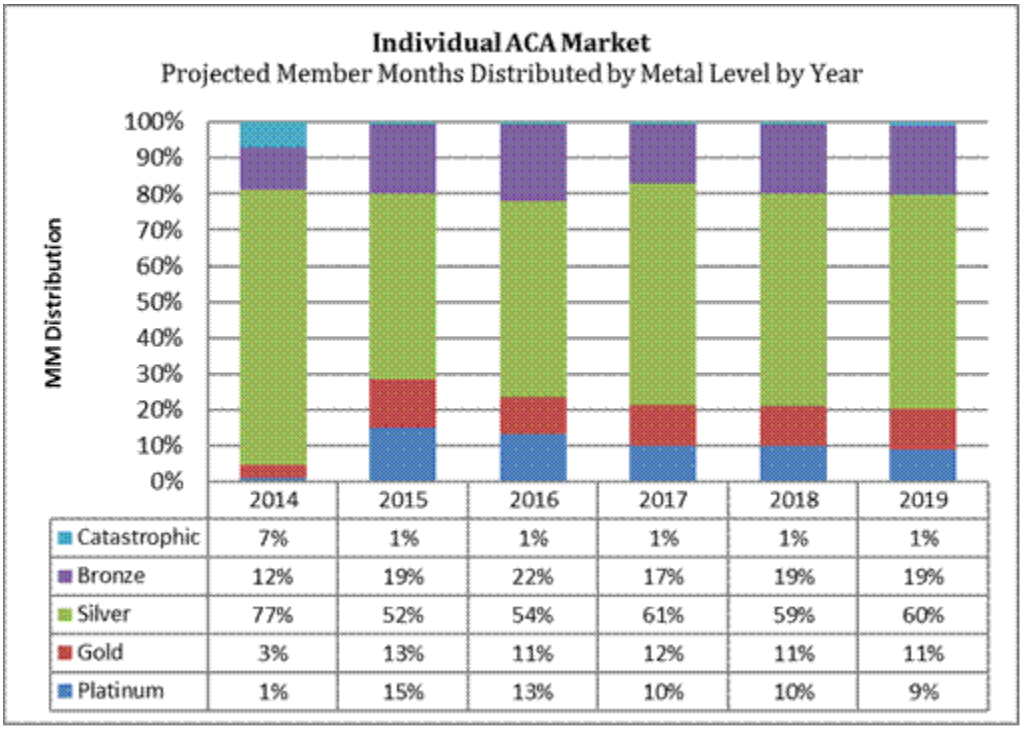
Figure 3: Small Group Market
Number of Benefit Plans Filed by Year



	2013	2014	2015	2016	2017	2018	2019
Total	129	64	52	35	34	39	34
Non-ACA	129	41	34	15	13	13	0
Bronze	0	7	6	6	6	10	10
Silver	0	8	6	6	7	8	16
Gold	0	6	4	6	6	6	6
Platinum	0	2	2	2	2	2	2

The reduction in benefit plans through 2017 suggests that, as expected, the ACA makes shopping easier for the consumer because it standardizes product offerings; however, the ACA does so at the cost of flexibility. It is not clear which effect is dominant for consumers: the reduction in the variety of benefit plans or easier comparison shopping between understandable and standardized offerings. In 2014, with the introduction of state health insurance marketplaces by the ACA, there was considerable uncertainty regarding what level and type of benefit plans individual and small group consumers would choose. Insurance carriers are required to provide the anticipated distribution of membership by metal level and benefit plan in their QHP filings. In the individual market in 2014, carriers anticipated that the most popular metal tier would be Silver, with minimal membership in the richer tiers, Gold and Platinum. Individual premium subsidies are calculated based on the premium of the second least-expensive Silver plan in the market; it is likely this influenced the expectation.

Figure 4: Individual ACA Market
Projected Member Months Distributed by Metal Level by Year

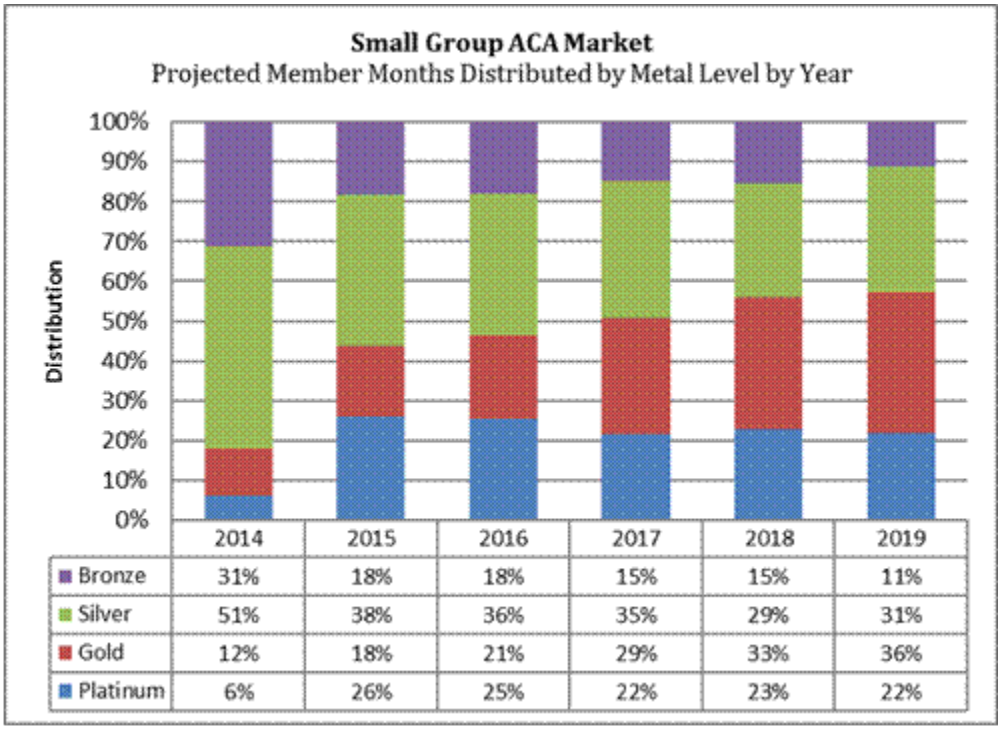


	2014	2015	2016	2017	2018	2019
Catastrophic	7%	1%	1%	1%	1%	1%
Bronze	12%	19%	22%	17%	19%	19%
Silver	77%	52%	54%	61%	59%	60%
Gold	3%	13%	11%	12%	11%	11%
Platinum	1%	15%	13%	10%	10%	9%

The expected distributions in any given year's filings are likely based on the results from the previous year. In the 2015 filing, there were more individual Gold and Platinum members than were anticipated in the 2014 filing, and fewer catastrophic members. In 2016, there was an increase in Bronze and Silver plans with a decrease in Gold and Platinum plans. The distributions by metal tier for the individual market for 2017 through 2019 are relatively consistent, indicating stability in the marketplace. Figure 4 shows the expected distribution of benefit plans by metal tier filed in the individual market by year.

In the small group market, half of the membership was assumed to be in the Silver plans in the 2014 filings, and very little membership in the Platinum metal level. In the 2015 filing, the Platinum metal level membership comprised one quarter of the small group market, substantially higher than anticipated. Since 2015, there has been an increase in the proportion of members anticipated in Gold plan designs and a decrease in the proportion of members in other metal levels. The distributions by metal tier for the small group market in recent years have been relatively consistent, indicating stability in the marketplace. Figure 5 shows the expected distribution of benefit plans by metal tier filed in the small group market by year.

Figure 5: Small Group ACA Market
Projected Member Months Distributed by Metal Level by Year



	2014	2015	2016	2017	2018	2019
Bronze	31%	18%	18%	15%	15%	11%
Silver	51%	38%	36%	35%	29%	31%
Gold	12%	18%	21%	29%	33%	36%
Platinum	6%	26%	25%	22%	23%	22%

3.2 Actuarial Value and Rate Relativity

BerryDunn has summarized each carrier's range in actuarial value and pricing spread for plans offered in the individual and small group markets. The range in premium rates is an indicator of the breadth of benefit options, from richest to leanest. The availability of plans offered across the allowable range and at reasonable intervals along the range is a good indication that there are sufficient plans to offer consumers value in the marketplace.

The price range from the lowest-cost non-catastrophic plan to the highest-cost plan was greater in 2013, prior to the introduction of the health insurance marketplace. In 2013 (and 2014 on a grandfathered basis), the leanest benefit plan available in the market was a $100,000 deductible plan, and the next leanest was a $25,000 deductible plan (both offered by MVP). Excluding Catamount, approximately 8% of the pre-ACA individual membership was in one of these two plans. Only one carrier (MVP) opted to grandfather its benefit plans in 2014 for both the individual and small group market. In 2015, MVP chose to eliminate the individual grandfathered benefit plans and beginning 2019, MVP eliminated small group grandfathered plans. Between 2014 and 2019, there has been a slight narrowing of the spread between the richest benefit plan and the leanest plan for ACA plans. For grandfathered plans, the spread decreased more dramatically between 2014 and 2019, driven by a decline in the number of grandfathered options available to consumers.

The ACA set allowable actuarial values for new benefit plans beginning 2014. These restrictions on actuarial values tightened the range of available benefit plans in both the individual and small group markets.

While the range between the high-cost plan and the low-cost plan gives a sense of the breadth of the benefit plan offerings in the market, the average premium gives a sense of where a typical plan premium falls in the range for that particular carrier in that particular year. The average premium PMPM represents a projected member-weighted average of the benefit plan premiums. It is difficult to compare average premium over time and across carriers since it is dependent on the membership distribution by benefit plan and the benefit plans offered that are unique to that period and carrier.

Table 10 shows the premium PMPMs for the high-cost and low-cost benefit plans, the spread between the two plans, and the average premium PMPM for all benefit plans by market segment, carrier, and year.

Table 10: High, Low, and Average Premium PMPMs by Market Segment

	MVP											
Small Group	2013	2014 ACA	2015 ACA	2016 ACA	2017 ACA	2018 ACA	2019 ACA	2014 GF	2015 GF	2016 GF	2017 GF	2018 GF
High Cost Plan	$1,042	$513	$589	$577	$602	$650	$656	$673	$701	$495	$538	$564
Low Cost Plan	$252	$290	$348	$333	$363	$389	$390	$304	$333	$335	$381	$399
Spread (1-low/high)	76%	43%	41%	42%	40%	40%	41%	55%	53%	32%	29%	29%
Average Premium	$417	$383	$448	$431	$467	$497	$521	$480	$403	$408	$435	$480
Individual	2013	2014 ACA	2015 ACA	2016 ACA	2017 ACA	2018 ACA	2019 ACA	2014 GF				
High Cost Plan	$320	$513	$589	$577	$602	$650	$656	$268				
Low Cost Plan	$18	$290	$348	$333	$363	$389	$390	$17				
Spread (1-low/high)	95%	43%	41%	42%	40%	40%	41%	94%				
Average Premium	$223	$353	$392	$404	$430	$435	$495	$26				
Catamount												

	BCBSVT						
Small Group	2013	2014 ACA	2015 ACA	2016 ACA	2017 ACA	2018 ACA	2019 ACA
High Cost Plan	$1,087	$521	$555	$589	$618	$671	$703
Low Cost Plan	$440	$305	$321	$360	$395	$433	$443
Spread (1-low/high)	60%	41%	42%	39%	36%	36%	37%
Average Premium	$447	$365	$442	$476	$503	$551	$576
Individual	2013	2014 ACA	2015 ACA	2016 ACA	2017 ACA	2018 ACA	2019 ACA
High Cost Plan	$565	$521	$555	$589	$618	$671	$703
Low Cost Plan	$262	$305	$321	$360	$395	$433	$443
Spread (1-low/high)	54%	41%	42%	39%	36%	36%	37%
Average Premium	$367	$356	$425	$448	$477	$517	$566
Catamount	$451						

3.3 Affordability

Affordability is critical to consumer access to health insurance and health care. Defining what is affordable can be challenging as it is dependent on an individual's unique circumstances of income, expenses, health care needs, and availability of other insurance (such as from a spouse). BerryDunn considered two different metrics to assess affordability over time: (i) average total cost of health care PMPM (average premium plus average member cost share), and (ii) the annualized single policyholder premium for the most popular average Standard Silver plan divided by the median income for Vermont full-time, year-round workers.

Average total cost of health care is designed to measure the total cost of health care to consumers by including their portion of cost-sharing (co-pays, co-insurance, and deductibles) along with the premium paid to the insurer. This measure does not take into account premium subsidization, either through federal or state government, or through an employer. The average

cost of health care may change over time due to changes in benefit plan offerings, the distribution of benefit plans purchased, or changes in the underlying risk profile of insured individuals in the market. In 2014, in both the small group and individual markets, the average total cost of health care was artificially low when compared to 2015 and 2016, due to the carriers estimating a lower penetration in the Gold and Platinum products than materialized. Richer benefit plans have higher induced utilization and thus a higher total cost of health care than leaner benefit plans.

In the small group market, the average total cost of health care across all carriers increased between 2013 and 2019, averaging 3.9% per year over the six-year period. The increase of the average total cost of health care in the individual market averaged 4.7% per year over the six-year period. In 2015, grandfathered (pre-ACA) benefit plans were no longer being sold in the individual market. Prior to 2015, very high deductible plans were being offered; as noted above, the leanest benefit plan available was a $100,000 deductible plan. These high-deductible benefit plan offerings contributed to a lower average total cost of health care in those years. Table 11 provides average premium, cost sharing, and total cost of health care PMPM by year and market segment.

Table 11: Average Premium, Cost Sharing, and Total Cost of Health Care by Market Segment

Small Group	2013	2014	2015	2016	2017	2018	2019
Avg Premium PMPM	$435	$383	$440	$466	$496	$543	$558
Avg Cost Sharing PMPM	$107	$125	$109	$102	$84	$84	$121
Avg Total Cost of Health Care	$541	$508	$549	$568	$580	$626	$679
Individual	2013	2014	2015	2016	2017	2018	2019
Avg Premium PMPM	$422	$349	$421	$438	$471	$503	$543
Avg Cost Sharing PMPM	$78	$139	$177	$151	$147	$174	$115
Avg Total Cost of Health Care	$499	$488	$599	$589	$617	$677	$658

In setting premium subsidies in the individual market, the ACA caps the expected consumer contribution toward insurance premiums for individuals making 300% to 400% of the federal poverty level (FPL) at 9.56% of an individual's income. ACA premium subsidies pay the difference between the maximum consumer contribution and the premium cost of the second least-expensive Silver plan in the marketplace, regardless of the benefit plan purchased. Premium subsidies phase out as income increases and are not available for anyone making more than 400% FPL.

In order to evaluate the change in affordability over time, BerryDunn calculated the ratio of annualized premium cost (for a single plan member) of the most popular Standard Silver product in 2014 (the benchmark product was held constant for all six years to allow comparisons over time) to the median income for Vermont full-time, year-round workers, thus

expressing the premium cost of the benchmark product as a percent of income. Vermont full-time year-round worker income was calculated based on the 2017 Vermont median income from the American Community Survey (ACS) One Year Estimate[xxvi]. Historical median incomes through 2016 were derived using the one-year growth rates from the Bureau of Labor Statistics, Employment Cost Index. BerryDunn developed the projected median incomes for 2018 and 2019 using the projected growth rate from the CBO Economic Projection for the Employment Cost Index.

The premium cost of the benchmark plan has become less affordable as the median income of full-time year-round workers has grown at a slower rate than the annual premium cost of the Standard Silver plan. Between 2014 and 2018, the annual growth rate in the median income was 2.6% in comparison to the 7.1% annual increase in the Standard Silver plan for the same period. In 2019, the annual Standard Silver plan cost grew by 15.2% due to Silver loading. Removing the impact of Silver loading by calculating the 2019 costs using the corresponding Reflective plan design, results in an average annualized rate for 2019 of $6,815 *and a modest 1.5% growth rate for 2019*. Table 12 shows the projected growth in median income for Vermont full-time, year-round workers as compared to the growth in the premium rate for the most popular Standard Silver plan, and the ratio between the Standard Silver rate and the median income over time.

Table 12: Median Income Compared to Standard Silver Single Premium
Individual Market

	2013	2014	2015	2016	2017	2018	2019
Projected Median Income for FT, YR Worker	$41,531	$42,445	$43,336	$44,333	$45,574	$47,078	$48,632
Growth Rate in Income		2.2%	2.1%	2.3%	2.8%	3.3%	3.3%
Standard Silver Rate - Single (Annualized)		$5,105	$5,600	$5,825	$6,251	$6,716	$7,738
Growth Rate in Standard Silver			9.7%	4.0%	7.3%	7.4%	15.2%
Standard Siver Rate/Proj Median Income		12.0%	12.9%	13.1%	13.7%	14.3%	15.9%
Reflective Standard Silver Rate - Single (Annualized)							$6,815
Growth Rate in Reflective Standard Silver							1.5%
Reflective Standard Siver Rate/Proj Median Income							14.0%

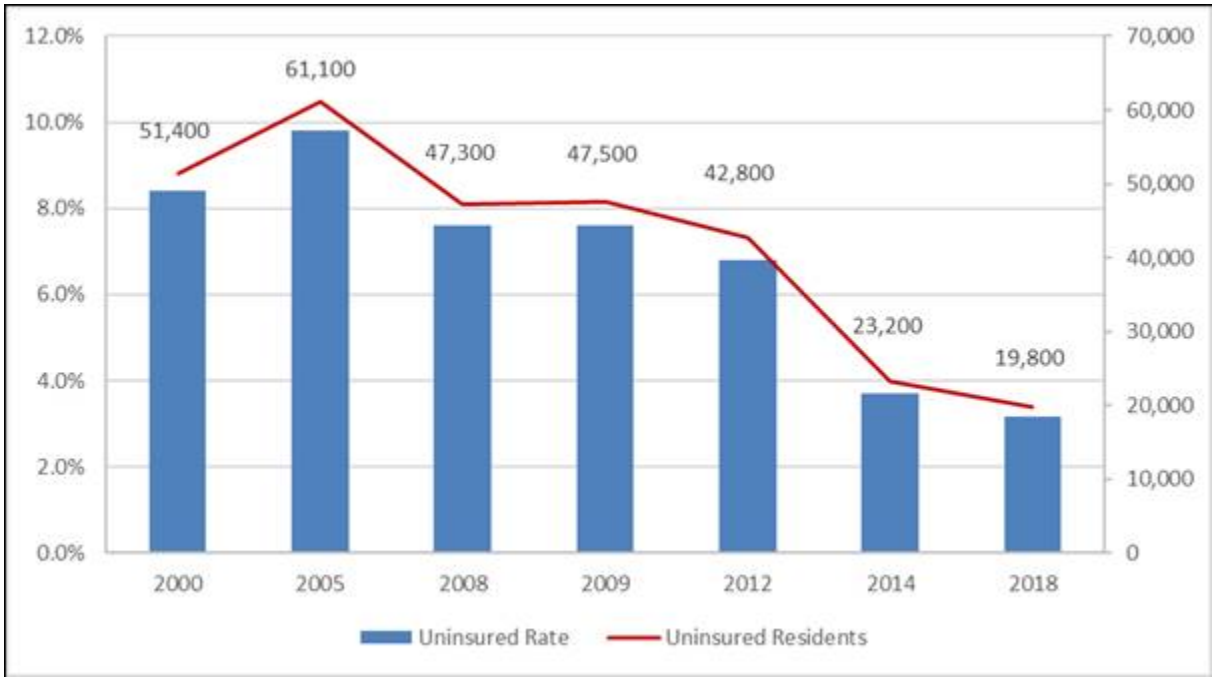
A large portion of individuals and employer groups in the individual and small group marketplace purchase products in the Gold and Platinum tiers, giving some indication that, for a portion of the market at least, premium levels are affordable. Insurance carriers anticipated that in 2019, 20% of individuals will purchase Gold or Platinum benefit plans and 58% of small group employees will be in the Gold or Platinum tiers. Silver loading that was introduced in 2019

[xxvi] The United States Census Bureau published one-year ACS income estimate in 2017.

resulted in higher premiums in 2019, and in turn increased the subsidies that eligible consumers will receive since the Standard Silver plan is the plan design used to determine the subsidy, regardless of the metal level purchased. This results in subsidy-eligible consumers being able to purchase richer plan designs than previously and is likely a contributing factor in the anticipated increase in the proportion of members enrolling in Gold and Platinum designs in 2019.

BerryDunn also reviewed the historical uninsured rates in Vermont as an indicator of affordability and access to coverage. In 2018, the uninsured rate for Vermont residents was 3.2%, or more than 50% lower than the 6.8% level in 2012 (prior to the implementation of the ACA). The ACA expanded coverage to previously uninsured people through the expansion of Medicaid and the establishment of health insurance exchanges.

Figure 6: Vermont Uninsured Rate and Uninsured Vermont Residents by Year



Data Source: Comprehensive Report 2014 Vermont Household Health Insurance Survey and the Comprehensive Report 2018 Vermont Household Health Insurance Survey

4 Consumer Experience

Beyond the assessment of the impact of the rate review process on rates and measures of affordability, a number of other factors reflect how Vermont's rate review process works for consumers. In this section, BerryDunn evaluates three aspects of the consumer experience (education, access to key information, and engagement), examines the effectiveness of the "plain language summaries" prepared for consumers, compares Vermont's consumer website to those available in other states, summarizes feedback from the HCA, and provides recommendations to improve the consumer experience.

4.1 Consumer Experience

BerryDunn reviewed three main facets of the consumer experience: consumer education, ease of access to key information, and consumer engagement.

4.1.1 Consumer Education

Consumer education is necessary to meaningfully engage the public in the rate review process. Rate filings, associated materials, and the rate review process are complex and may be confusing to individuals not familiar with the insurance industry, a category into which most purchasers of health insurance fall.

The GMCB addresses this need by providing a clearly identified link to consumer education material regarding rate review on its rate review internet homepage.[xxvii] Centered on the page is a large button labeled "Learn More About Rate Review," a hyperlink to a clear explanation of the steps in the process, including timing. The steps for rate review are well laid-out, with hyperlinks to a glossary that defines key rate review terms in each section. The timelines for public comments, actuarial opinions, and decisions are clearly presented. More in-depth and specialized information is available by following the provided hyperlinks to the applicable statute, Title 8, Chapter 107, and the GMCB's Rule 2.000 regarding health insurance rate review.

4.1.2 Ease of Access to Key Information

The educational materials described above and the public rate filing materials discussed throughout this section are readily accessible to an interested internet user. Consumers can navigate to the rate review homepage by clicking a "Rate Review" link on the left side of the GMCB's home page.[xxviii] As of this writing, the homepage is in the first page of results of a Google search on the phrase "Vermont health insurance rates." BerryDunn has found the rate review site easy to navigate throughout the Cycle IV Grant evaluation.

[xxvii] http://ratereview.vermont.gov/.
[xxviii] gmcboard.vermont.gov.

As noted in the process overview, the GMCB posts new rate requests on its website within five days of receiving the filing. Anyone who wishes to receive automatic alerts about new filings may do so by first clicking on the "View Filings and Decisions" link on the left side of the rate review homepage, navigating to an insurer's "Pending Reviews" or "Decisions" page, and signing up through the "Subscribe to RSS[xxix] for this provider" button. Rate filings are grouped by major carrier (BCBSVT, MVP, and The Vermont Health Plan [TVHP]) and by pending reviews and decisions; carriers with a smaller presence in the state are grouped together under "Other – Pending Reviews" and "Other – Decisions."

For each rate filing on the insurer's pending reviews or decision pages there is a filing name that acts as a link to detailed information regarding the filing as well as information on the filing status, decision date, docket number, date comments close, and a brief description of the carrier's requested increase, any carrier amendments, and the final approved increase.

On the page for a specific rate filing, the same information described above is provided and typically, links to the following are provided:

- The SERFF Portable Document Format (.pdf) version of the rate filing
- The carrier's actuarial memorandum (excerpted from the SERFF filing)
- The carrier's plain language summary
- Objection letters with responses
- The Notice of Hearing and all related hearing documents, notices of appearance, or memorandum in lieu of hearing
- The reviewing actuaries' memorandum
- The solvency analysis
- Public comments
- The GMCB's decision

In the past several years, the only hearings that have been held on rate filings are those for the Vermont Health Connect products. The hearings are open to the public, audiotaped, and videotaped by Onion River Community Access (ORCA) [20] Media; the video can be viewed on ORCA's website. Transcripts are available for the Health Connect hearings in the GMCB Rate Review website.

The comprehensive inclusion of all materials generated by the rate filing and approval process provides complete transparency to the educated consumer and allows for targeted input by consumers and advocates during the comment period.

[xxix] RSS, or rich site summary, refers to an automated format for electronically disseminating updates to frequently changing internet-based information, such as document postings, headlines, or blog entries.

4.1.3 Engagement

Once a rate filing is posted on the GMCB website, a public comment period begins. Anyone who wishes to comment on a filing may do so via the internet, by phone, or by mail. Instructions for how to submit public comments are available on the Public Comment page. A "Your Comments Count! Make a Public Comment" button is prominently displayed on the rate review front page, as well as on the view filings and decisions page and the insurers' pending reviews pages. Comments are accepted from the first day the filing is posted on the site until midnight on the fifteenth day after the actuarial and solvency opinions have been posted. The public can also comment directly at the rate hearing, if one is held. In 2015 and 2016, the majority of comments received by the GMCB were collected and submitted by the Vermont Public Interest Research Group (VPIRG) via a form on the group's website. GMCB posts the public comments with the documents related to the filings on its website. Table 13 summarizes the comments received for exchange filings by type.

Table 13: Exchange Filing Consumer Comments by Source

Year	Total Comments*	Verbal Public	Written Public	VPIRG
2014	80			
2015	275	2	39	234
2016	484	9	25	450
2017	133	13	120	0
2018	157	26	131	0
2019	202	28	174	0

Public engagement has been very strong over the past five years, as evidenced by the significant number of public comments each year. Verbal and written public comments that require consumer-initiated engagement have been steadily increasing, indicating that Vermont consumers' level of engagement is strong. The strong level of engagement is a result of the GMCB making opportunities available for public comment using many different modes with easy-to-use, consumer-friendly processes, the addition of an evening comment session where Vermonters unable to attend the daytime hearings can voice their concerns, and the efforts by the Vermont Workers' Center and the HCA to increase consumer awareness and participation.

4.2 Plain Language Filing Summaries

As an aid for consumer disclosure and transparency, Vermont requires filings requesting a rate increase to include a "plain language summary" of the request as part of the filing. The summaries are not to exceed one page and are required to include: the effective date(s) for which the increase is requested, the number of lives affected by the increase, the minimum, maximum, and average requested rate increase, the effective date of the increase, and a justification for the increase identifying the factors driving the proposed rate increase for the specific products contained in the filing. BerryDunn reviewed the 2018 and 2019 Vermont

Health Connect plain language summaries for content, clarity, and compliance with the outlined requirements.

One major carrier's 2018 and 2019 plain language summaries for QHPs state the listed facts clearly and are concise, at less than one page each. While the summaries include a general list of potential drivers of health insurance costs and premiums, discussion of specific drivers of the premium increases requested, and the extent of their impacts, is not provided.

Another major carrier's 2018 and 2019 plain language summaries state the required facts clearly and detail the factors driving the requested increases in transparent language that does not require specialized industry knowledge to understand. However, the summaries exceed the single page limit, in part because they include mission statements and introductory materials running to half a page, and in part due to the necessity of outlining the premium impacts relating to the mandated changes associated with the ACA. Although this carrier's summary exceeds one page, BerryDunn recommends that Vermont carriers be encouraged to emulate this carrier's approach in presenting the required data and describing the relevant premium increase drivers.

4.3 Other States

BerryDunn reviewed the rate review websites of other states as a benchmark for evaluating transparency and consumer experience in Vermont. The review included representation from states with federally facilitated marketplaces, state-partnership marketplaces, and state-based marketplaces, such as Vermont. In general, the review found that the states with state-based marketplaces had better rate review sites from a consumer perspective. Vermont was no exception, and GMCB's site was among the better state rate review sites explored. The review found that GMCB's site is well constructed and easy to navigate, with information designed to further consumer education, as well as complete filing information that is easy to locate and access. In contrast, some state websites are challenging to navigate and lack complete filing information. Where filing documents are available, many states simply offer a link to a SERFF search engine, and of those, some do not even provide SERFF tracking numbers for filings, making finding specific filings inconvenient for even knowledgeable professionals. BerryDunn notes that some states do have separate sections accessed on their landing page set up for consumers. We recommend that GMCB consider this approach in the future and design the layout with information most important to the consumer. More on this recommendation is included in the following section.

4.4 HCA Feedback

A goal of the GMCB is to ensure useful consumer content is easily accessible on its website in order to aid in consumer education and provide transparency into the rate review process. The Vermont HCA is a part of Vermont Legal Aid and Law Line of Vermont. Since the HCA is in a good position to provide key insight on behalf of consumers, BerryDunn conducted an interview

with a health care law and policy analyst from the HCA. The purpose of the interview was to determine how consumers use the GMCB website, what additional content would be helpful, the ease of use of the website, and any other suggestions for improvement.

The HCA indicated that consumers go to the Vermont Health Connect website to find the facts about Vermont Health Connect plan designs, subsidy calculations, and board activities. Based on interaction with consumers, the HCA had the following suggestions:

- Develop a separate, less technical section of the GMCB's main website for consumers and include this section on the landing page.
- The HCA indicated the GMCB's board meeting information portion of their website, has a wealth of great information. Currently that information is organized by board meeting date. It would also be helpful it the information was organized by topic. For example, set up the Vermont All Payer Model Agreement as a topic.
- Continue to provide key data points such as a proposed and issued rate changes but also keep a history, which is valuable.
- When posting data, if possible, replace .pdf formats with tabular data.
- When presenting data, provide visible charts that are interactive.

The HCA also suggested focus groups for different audiences to find out what they would find most useful. Focus groups could include consumers, employers, researchers, brokers, and board staff. For consumer focus groups, the HCA suggested different focus groups for individual consumers and those covered by a group employer.

4.5 Enhancements for Consideration

BerryDunn suggests the following enhancements to increase consumer access to key information and promote consumer engagement.

BerryDunn suggests that GMCB consider adding a section for consumer access on the landing page of GMCB's main website and reorganize available information on that section based upon suggestions from consumers.

The GMCB provides a comprehensive list of all the documentation generated during the rate review process. However, understanding the context surrounding the filing information can be challenging for the average consumer, given the complexity and length of some of the rate filing documents. Therefore, BerryDunn recommends the GMCB compile brief, consumer-friendly summaries of all filings stating the average rate change requested, the average rate change approved, plans and lives impacted, proposed MLR, base-year results, expected percent change in medical expense for the rating period, benefit changes, and requested and approved rate changes for the preceding rating period. An example of such a summary is included in Appendix B. The carriers' plain language summaries for proposed increases could be included

in (or linked to) these summaries. BerryDunn also recommends grouping those documents into a few sections and adding brief descriptions of the purpose of those documents. This can help users to navigate those files more efficiently.

The GMCB provides a clearly written decision and order upon approval of the rate increase. The decision and order is a legal document and organized as such. Some consumers may find that format challenging to read. In addition to the formal decision and order available on the GMCB's website, BerryDunn recommends the GMCB consider providing plain language decision summaries. Such summaries might also include tables of requested and approved rate changes and benefit changes by individual plan included in the filing.[21] An example of one such summary is included in Appendix B.

Finally, some state rate review websites include a dual-purpose interactive filing search and reporting tool that BerryDunn suggests the GMCB consider implementing in lieu of its carrier-based and decision status-based pages. The tool interface provides a summary report of rate review results that the user can customize using filters on any combination of carrier, filing status, market segment, or rating period. Additionally, by clicking on a row, users may drill into any of the filing documents currently provided on the Vermont site. Two of these sites allow the consumer to access public comments through the tool, and one allows public comments to be submitted through the tool.[22] A screenshot from one of these sites appears in Appendix B.

The GMCB may also consider implementing a dashboard for certain summary statistics, such as historical rate increases approved by carrier. This dashboard would contain key statistics from the recommended consumer friendly filing summaries and would include rate filings for all carriers over time. Some of the recommendations may require additional resources to implement. Defining the required resources for implementation of the recommendations is outside of the scope of this report.

5 Conclusions and Recommendations

This study of Vermont's rate review process found that for rates effective January 2013 to calendar year 2019 (filed and approved prior to September 2018), the total adjustments made in the rate review process have saved Vermonters approximately $108 million, or about 2.8%. In the absence of the rate review process, and state regulators' power under statute to disapprove or modify requested rate increases, it is likely the unadjusted rates would have been implemented, increasing consumer premium cost and carrier premium revenue.

Despite these reductions, and the implied reductions to approved MLR, the realized loss ratios for Vermont Health Connect plans for 2014 through 2017, the period studied since ACA implementation for which realized carrier loss ratios are available, both carriers experienced reasonable results. The actual MLRs for Health Exchange plans from 2014 to 2017 averaged 1.4% lower than projected for MVP, and 0.5% higher than projected for BCBSVT. This suggests that the portion of the premium increase denied by the GMCB was unnecessary to reaching the carriers' target MLRs.

However, GMCB's target loss ratios for exchange products have allowed for CTR of only 0.5% to 1% annually. BerryDunn recommends the GMCB continue to closely monitor reserve levels to ensure adequate carrier reserves for exchange products.

In addition, throughout the period of the Cycle IV Rate Review Grant, Vermont regulators, including the GMCB, have continued to enhance the premium rate review process to help ensure fair, reasonable, and equitable results. Vermont regulators ensure that carriers provide appropriate documentation to support the rate review process, including an actuarial justification for the rates developed in each filing, the standardized actuarial memo data, and improved population of SERFF. These data support GMCB's consulting actuaries in determining if the filings are reasonable. Both the in-depth actuarial reviews and the enhanced documentation provide the GMCB with a sound empirical basis to make fair and informed decisions to approve, modify, or disapprove proposed rates, and strike an appropriate balance between carrier solvency and affordable prices for consumers.

Further, the enhanced documentation, along with the standardization of filings under the ACA, reductions in the number of filings in Vermont owing to the merged individual and small group markets after ACA implementation, and regulators' direction to carriers to include the development of rate factors in their rate filings (instead of as separate rate factor filings), have improved the administrative efficiency of Vermont's rate review process during the period of the Cycle IV Grant.

This study also reviewed the number of benefit plan options available in the market over the grant period in order to assess changes in the type and variety of benefit plans available to consumers. The total number of benefit options currently available in the individual market is double the number of benefits options before ACA implementation. Initially, the number of

benefit options increased in 2014, due to newly available ACA-compliant benefit options, then decreased back to near pre-ACA levels driven by the elimination of non-ACA (grandfathered) benefit options in 2015 and a decrease in the ACA Bronze and Silver benefit options between 2014 and 2017. The passage of Act 210 in 2018 brought on the introduction of Bronze plan designs without a pharmacy maximum out-of-pocket limit, increasing the number of Bronze plans in the merged market. In 2019, the number of Silver plans doubled due to the passing of Act 88 (2018), which allows carriers to offer reflective Silver plans outside of the exchange that do not include the cost of CSR payments—no longer reimbursed to the carrier by the federal government—added to the premium.

The number of benefit options available to small groups on Vermont Health Connect is roughly one-fourth of the available small group benefit plans prior to the ACA (2013). Metal actuarial value requirements for QHPs that limit the number of potential benefit plans, coupled with the potential for selection risk[xxx] in the merged small group and individual markets, is likely driving the decrease in plans available to small group employers. In addition, the non-ACA benefit options (grandfathered plans) have been decreasing over the period 2014 to 2018 and eliminated in 2019. The number of ACA benefit plans has remained fairly stable through 2017. In 2018, there was an increase in Bronze plan designs, and in 2019, there was an increase in Silver plan designs outlined in the previous section.

The premium cost of the benchmark plan has become less affordable as the median income of a full-time year-round worker has grown at a slower rate that the annual premium cost of the Standard Silver plan. Between 2014 and 2018, the annual growth rate in the median income was 2.6% in comparison to the 7.1% annual increase in the Standard Silver plan for the same period. In 2019, the annual Standard Silver plan cost grew by 15.2% due to Silver loading. If BerryDunn removed the impact of Silver loading and calculated the 2019 costs using the corresponding Reflective plan design that does not include the loading due to CSR payment being eliminated, then the average annualized rate for 2019 would be $6,815, resulting in a modest 1.5% growth rate for 2019.

BerryDunn created data collection tools for use in the analysis of the GMCB rate review process, including for rate review and consumer access. BerryDunn recommends that the GMCB maintain these data collection tools going forward in order to continue to analyze and enhance the rate review process.

[xxx] Individual choice among a large number of health insurance policies may result in “risk-based sorting” across plans. Individuals who expect high health care costs tend to prefer richer benefit plans while those who expect low costs choose leaner benefit plans. This individual selection process increases the average cost to the insurer for each separate benefit plan. Insurers are not allowed to adjust their pricing to account for selection. This is generally less impactful in the small group market where an employer chooses a plan or metal level on behalf of its employees.

BerryDunn reviewed the GMCB's rate review consumer resources and the rate review websites of other states to evaluate transparency and consumer experience in Vermont. The review found that the GMCB's website offers an above-average opportunity for consumer education and participation.

BerryDunn reviewed the Vermont Health Connect plain language summaries for Vermont's two major carriers. Both carriers listed facts clearly. One carrier provided concise information but did not include a discussion of the specific drivers of the premium increases requested. The second carrier included facts driving the requested increases in transparent language; however, the summaries exceeded a single page and included unnecessary information. BerryDunn recommends that Vermont carriers adopt the best of both approaches and be encouraged by GMCB to present the required data describing the premium increase drivers without including unnecessary information to achieve this goal.

BerryDunn makes several suggestions that would improve and increase consumer access to rate review information and promote consumer engagement. BerryDunn suggests brief, consumer-friendly summaries of filings that include key rate statistics needed for consumers to understand if a filing will impact their benefit plans, and if so, how their benefits and costs will change. BerryDunn also recommends that GMCB provide plain language decision and order summaries. BerryDunn suggests that GMCB consider adding a section for consumers on the landing page of its website and reorganize available information on that section based upon suggestions from consumers. Finally, BerryDunn suggests GMCB consider implementing a dual-purpose interactive filing search and reporting tool. The tool interface would provide a summary report of rate review results that the user can customize with filters on any combination of carrier, filing status, market segment, or rating period.

The GMCB has a strong rate review process and robust consumer resources. With the improvements suggested in this report, the GMCB can continue to improve and enhance its rate review process.

Appendix A: Rate Filing Summary Statistics and Rating Statistics

Please see Appendix A.pdf, attached.

GMCB Rate Filing - Summary Statistics

Carrier	Market Segment	Type of Filing	SERFF Tracking #	Effective Date	Member Months	Members	Realized Members	Proposed Premium (000's)	Proposed Rate Increase	Rate Hearing (Yes=1)	Approved Premium (000's)	Approved Rate Increase	Premium Saved by GMCB (000's)	% Reduction	Premium Saved Realized Lives (000's)
BCBSVT	Factor	Trend Factor Q3 Q4 13	BCVT-128904541	7/1/2013	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	Factor	Agg STL, Risk & Admin for Refund Agmt.	BCVT-128846582	12/1/2013	152,892	12,741	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	Factor	Exper. Refund Risk and Admin 12/13	BCVT-128846706	12/1/2013	152,892	12,741	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Provis. for Lg Claims & STL 2013	BCVT-128809318	9/1/2013	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Provis. for Lg Claims 2013	BCVT-128829841	9/1/2013	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG SG Factor	Admin & CTR 4Q13-3Q14	BCVT-129035275	10/1/2013	192,000	16,000	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Trend Q1 Q2 13	BCVT-128609558	1/1/2013	475,908	39,659	NA	NA	NA	1	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Admin & CTR Q1 13	BCVT-128623222	1/1/2013	419,916	34,993	NA	NA	NA	1	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Trend Q1 Q2 13	BCVT-128694637	1/1/2013	410,868	34,239	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Trend Q3 Q4 13	BCVT-128904800	7/1/2013	175,968	14,664	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Admin & CTR Q3 Q4 13	BCVT-129035390	7/1/2013	961,740	80,145	NA	NA	NA	0	NA	NA	NA	NA	NA
		2013 Total			**2,942,184**	**245,182**				**2**					
BCBSVT	LG Factor	Trend/ Admin Trend Q1 Q2 14	BCVT-129197073	1/1/2014	373,908	31,159	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend Q1 Q2 14	BCVT-129197313	1/1/2014	139,704	11,642	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Risk & Admin Refund Agmt. Q1 Q2 14	BCVT-129373905	1/1/2014	2,400	200	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Group Merit Rating Formula 2014	BCVT-128888672	1/1/2014	455,392	37,949	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Agg STL, Risk & Admin for Refund Agmt	BCVT-129373971	5/1/2014	166,800	13,900	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Provision for Large Claims & STL 5/14	BCVT-129374060	5/1/2014	398,400	33,200	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Provision for Large Claims 5/14	BCVT-129374083	5/1/2014	127,200	10,600	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend Q3 Q4 14	BCVT-129403752	7/1/2014	397,200	33,100	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend Q3 Q4 14	BCVT-129403770	7/1/2014	128,400	10,700	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Admin & CTR 4Q14-3Q15	BCVT-129486744	10/1/2014	397,836	33,153	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Admin & CTR 4Q14-3Q15	BCVT-129486804	10/1/2014	128,916	10,743	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG SG Factor	LG & Assoc., Ben Relativity Factor Q2	BCVT-129370654	4/1/2014	397,944	33,162	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG SG Factor	LG and Assoc., Ben Relativity Factor Q2	BCVT-129370736	4/1/2014	124,380	10,365	NA	NA	NA	0	NA	NA	NA	NA	NA
MVP	LG Factor	2014 Out of Pocket Maximum	MVPH-129138704	1/1/2014	74,808	6,234	NA	NA	NA	0	NA	NA	NA	NA	NA
MVP	LG Factor	2014 LG Rate Schedules	MVPH-129184612	1/1/2014	4,992	416	NA	NA	NA	0	NA	NA	NA	NA	NA
		2014 Total			**3,318,280**	**276,523**				**0**					
BCBSVT	LG Factor	Rating Program, Trend/Admin Q3 15	BCVT-129910512	7/1/2015	322,800	26,900	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Rating Program, Trend/Admin Q3 15	BCVT-129912021	7/1/2015	92,040	7,670	NA	NA	NA	0	NA	NA	NA	NA	NA
		2015 Total			**414,840**	**34,570**				**0**					
TVHP	LG Factor	Trend & Admin Change	BCVT-130457790	7/1/2016	186,000	15,500	NA	NA	4.3%	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend & Admin Change	BCVT-130453174	7/1/2016	186,000	15,500	NA	NA	4.3%	0	NA	NA	NA	NA	NA
		2016 Total			**372,000**	**31,000**				**0**					
TVHP	LG Factor	Trend & Admin Change	BCVT-130935776	7/1/2017	190,800	15,900	NA	NA	10.7%	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend & Admin Change	BCVT-130935599	7/1/2017	190,800	15,900	NA	NA	10.7%	0	NA	NA	NA	NA	NA
		2017 Total			**381,600**	**31,800**				**0**					
TVHP	LG Factor	Trend & Admin Change	BCVT-131424558	7/1/2018	170,592	14,216	NA	NA	11.2%	0	NA	NA	NA	NA	NA
BCBSVT	LG Factor	Trend & Admin Change	BCVT-131424513	7/1/2018	170,592	14,216	NA	NA	11.2%	0	NA	NA	NA	NA	NA
		2018 Total			**341,184**	**28,432**				**0**					
		Grand Total (Factor Filings)			**7,770,088**	**647,507**				**2**					
BCBSVT	SG Rate	Q1 Q2 2013 TVHP	BCVT-128713269	1/1/2013	262,236	21,853	21,853	$115,278	10.7%	0	$111,127	6.7%	$4,151	3.6%	$4,151
BCBSVT	SG Rate	Q1 -Q3 2013 BCBSVT	BCVT-128778918	1/1/2013	12,900	1,075	1,075	$7,525	12.3%	0	$7,496	11.9%	$28	0.4%	$28
BCBSVT	SG Rate	Assoc. of Chamber Execs	BCVT-128622776	1/1/2013	216,144	18,012	18,012	$74,818	11.7%	1	$74,349	11.0%	$469	0.6%	$469
BCBSVT	SG Rate	VT Health Services Gp	BCVT-128624612	1/1/2013	13,116	1,093	1,093	$7,809	13.0%	1	$8,026	16.2%	-$217	-2.8%	-$217
BCBSVT	SG Rate	VT State Dental Society Assoc.	BCVT-128606349	1/1/2013	2,616	218	218	$1,191	3.3%	0	$1,188	3.0%	$3	0.2%	$3
BCBSVT	SG Rate	2Q13-4Q13	BCVT-128900773	4/1/2013	132	11	11	$115	-3.7%	0	$112	-5.6%	$2	2.0%	$2
BCBSVT	IND Rate	Q3 13 Catamount	BCVT-128916274	7/1/2013	184,212	15,351	15,351	$92,697	24.4%	0	$83,408	11.9%	$9,289	10.0%	$9,289

GMCB Rate Filing - Summary Statistics

Carrier	Market Segment	Type of Filing	SERFF Tracking #	Effective Date	Member Months	Members	Realized Members	Proposed Premium (000's)	Proposed Rate Increase	Rate Hearing (Yes=1)	Approved Premium (000's)	Approved Rate Increase	Premium Saved by GMCB (000's)	% Reduction	Premium Saved Realized Lives (000's)
BCBSVT	SG Rate	VT Ed. Health Initiative 2013	BCVT-128779451	7/1/2013	506,256	42,188	42,188	$264,091	12.8%	1	$257,536	10.0%	$6,555	2.5%	$6,555
BCBSVT	SG Rate	VT Auto Dealers' Assoc.	BCVT-129124084	11/1/2013	27,612	2,301	2,301	$10,190	1.9%	0	$10,190	1.9%	$	0.0%	$
MVP	IND Rate	Indemnity Q1 Q2 2013	MVPH-128620422	1/1/2013	12,840	1,070	1,070	$2,981	15.0%	0	$2,872	10.8%	$109	3.7%	$109
MVP	LG Rate	PPO/EPO Q1 Q2 13	MVPH-128635622	1/1/2013	91,212	7,601	7,601	$38,330	12.0%	1	$37,577	9.8%	$753	2.0%	$753
MVP	LG Rate	HMO Manual Q1 Q2 13	MVPH-128644371	1/1/2013	3,252	271	271	$1,757	4.9%	1	$1,751	4.6%	$5	0.3%	$5
MVP	LG Rate	Agri Services Indemnity 2013	MVPH-128691180	1/1/2013	17,964	1,497	1,497	$6,651	7.2%	0	$6,540	5.2%	$111	1.7%	$111
MVP	SG Rate	Healthy Lifestyles Rider Q1 Q2 13	MVPH-128487509	1/1/2013	0	0	0	NA	NA	0	NA	NA	NA	NA	NA
MVP	SG Rate	PPO/EPO Q1 Q2 13	MVPH-128627829	1/1/2013	140,916	11,743	11,743	$57,845	14.5%	1	$56,683	12.2%	$1,162	2.0%	$1,162
MVP	SG Rate	HMO Q1 Q2 13	MVPH-128644483	1/1/2013	732	61	61	$549	9.0%	1	$547	8.5%	$3	0.5%	$3
MVP	SG Rate	New Product Q1 Q2 13	MVPH-128696224	1/1/2013	0	0	0	$	0.0%	0	$	0.0%	$	NA	$
MVP	IND Rate	Indemnity Q3 Q4 13	MVPH-128889199	7/1/2013	13,704	1,142	1,142	$5,403	9.7%	0	$5,403	9.7%	$	0.0%	$
MVP	LG Rate	PPO/EPO Q3 Q4 13	MVPH-128880517	7/1/2013	21,504	1,792	1,792	$9,074	3.9%	0	$9,074	3.9%	$	0.0%	$
MVP	LG Rate	HMO Q3 Q4 13	MVPH-128882392	7/1/2013	108	9	9	$60	7.6%	0	$60	7.6%	$	0.0%	$
MVP	SG Rate	PPO/EPO Q3 Q4 13	MVPH-128879614	7/1/2013	48,300	4,025	4,025	$22,563	13.3%	0	$21,866	9.8%	$697	3.1%	$697
MVP	SG Rate	HMO Q3 Q4 13	MVPH-128882155	7/1/2013	732	61	61	$561	7.9%	0	$561	7.9%	$	0.0%	$
MVP	IND Rate	Agri Services Assoc.	MVPH-129148249	12/1/2013	18,456	1,538	1,538	$5,761	5.1%	0	$5,678	3.6%	$82	1.4%	$82
		2013 Total			**1,594,944**	**132,912**	**132,912**	**$725,246**		**7**	**$702,043**		**$23,202**	**3.2%**	**$23,202**
BCBSVT	Merged Rate	Health Exchange 2014	BCVT-128957017	1/1/2014	758,664	63,222	*61,300*	$285,507	NP	1	$273,234	NP	$12,273	4.3%	$11,900
Cigna	LG Rate	PPO Manual 2014	CCGP-129378424	1/1/2014	3,984	332	332	$1,547	3.8%	0	$1,391	-6.6%	$155	10.0%	$155
Conn. Gen.	LG Rate	PPO Manual 2014	CCGP-129378365	1/1/2014	121,488	10,124	10,124	$27,564	3.8%	0	$24,795	-6.6%	$2,769	10.0%	$2,769
MVP	IND Rate	GF Q1 Q2 14	MVPH-129145840	1/1/2014	10,200	850	850	$2,097	0.0%	0	$1,986	-5.3%	$111	5.3%	$111
MVP	LG Rate	HMO Q1 Q2 15	MVPH-129682581	1/1/2014	2,940	245	245	$1,637	5.5%	0	$1,619	4.4%	$18	1.1%	$18
MVP	LG Rate	GF PPO Q1 Q2 14	MVPH-129145560	1/1/2014	74,808	6,234	6,234	$37,531	5.9%	0	$36,822	3.9%	$709	1.9%	$709
MVP	LG Rate	GF HMO Q1 Q2 14	MVPH-129145649	1/1/2014	4,992	416	416	$3,109	10.2%	0	$2,898	2.7%	$212	6.8%	$212
MVP	Merged Rate	Health Exchange 2014	MVPH-128956063	1/1/2014	242,105	20,175	*5,041*	$93,486	NP	1	$89,092	NP	$4,394	4.7%	$1,098
MVP	SG Rate	GF PPO/EPO Q1 Q2	MVPH-129144870	1/1/2014	45,072	3,756	3,756	$18,986	10.4%	0	$17,627	2.5%	$1,359	7.2%	$1,359
MVP	IND Rate	GF Indemnity Q3 Q4 14	MVPH-129401327	7/1/2014	8,100	675	675	$1,887	9.4%	0	$1,863	8.0%	$24	1.3%	$24
MVP	LG Rate	PPO HIC Q3 Q4 14	MVPH-129389053	7/1/2014	91,488	7,624	7,624	$36,298	0.8%	0	$36,298	0.8%	$	0.0%	$
MVP	LG Rate	HMO Q3 Q4 14	MVPH-129391759	7/1/2014	4,872	406	406	$2,638	5.0%	0	$2,638	5.0%	$	0.0%	$
MVP	SG Rate	GF PPO/EPO HIC Q3 Q4 14	MVPH-129389265	7/1/2014	58,440	4,870	4,870	$22,628	4.4%	0	$22,628	4.4%	$	0.0%	$
MVP	LG Rate	Agriservices Min. Prem	MVPH-129640114	12/1/2014	18,074	1,506	1,506	$6,413	16.0%	0	$6,337	14.6%	$76	1.2%	$76
		2014 Total			**1,445,227**	**120,436**	**103,380**	**$541,327**		**2**	**$519,228**		**$22,099**	**4.1%**	**$18,430**
4 Ever Life Ins	LG Rate	2015	BCSF-130097000	1/1/2015	0	0	0	$519	0.0%	0	$519	0.0%	$	0.0%	$
BCBSVT	Merged Rate	Health Exchange 2015	BCVT-129572217	1/1/2015	698,280	58,190	58,190	$310,011	9.8%	1	$304,052	7.7%	$5,960	1.9%	$6,538
Cigna	LG Rate	PPO 2015	CCGP-129725944	1/1/2015	63,214	5,268	5,268	$30,382	6.0%	0	$28,089	-2.0%	$2,293	7.5%	$2,293
MVP	LG Rate	HIC Existing Products Q1 Q2 15	MVPH-129676042	1/1/2015	74,028	6,169	6,169	$30,862	-2.5%	0	$30,514	-3.6%	$348	1.1%	$348
MVP	LG Rate	PPO HIC New Products Q1 Q2 15	MVPH-129681821	1/1/2015	0	0	0	$	NP	0	$	NP	$	1.1%	$
MVP	Merged Rate	Health Exchange 2015	MVPH-129560321	1/1/2015	57,576	4,798	4,798	$23,546	15.4%	1	$22,587	10.7%	$959	4.1%	$1,081
MVP	SG Rate	GF PPO Q1 Q2 2015	MVPH-129662230	1/1/2015	33,672	2,806	2,806	$15,253	10.1%	0	$14,893	7.5%	$360	2.4%	$360
MVP	SG Rate	GF PPO New Product Q1 Q2 15	MVPH-129710583	1/1/2015	0	0	0	$	NP	0	$	NP	$	2.2%	$
MVP	LG Rate	PPO HIC Existing Products Q3 Q4 15	MVPH-129877690	7/1/2015	7,536	628	628	$3,369	8.5%	0	$3,335	7.4%	$34	1.0%	$34
MVP	LG Rate	HMO Q3 Q4 15	MVPH-129877747	7/1/2015	2,628	219	219	$1,128	5.5%	0	$1,116	4.4%	$12	1.0%	$12
MVP	SG Rate	GF PPO HIC Q3 Q4 15	MVPH-129866393	7/1/2015	28,488	2,374	2,374	$11,823	5.1%	0	$11,677	3.8%	$146	1.2%	$146
		2015 Total			**965,422**	**80,452**	**80,452**	**$426,895**		**2**	**$416,783**		**$10,112**	**2.4%**	**$10,813**
BCBSVT	Merged Rate	Health Exchange 2016	BCVT-130082559	1/1/2016	840,168	70,014	70,014	$398,229	8.4%	1	$389,134	5.9%	$9,095	2.3%	$9,046
MVP	Merged Rate	Health Exchange 2016	MVPH-130053210	1/1/2016	77,004	6,417	6,417	$32,629	3.0%	1	$32,428	2.4%	$201	0.6%	$215
Cigna	LG Rate	PPO Manual 2016	CCGP-130243269	6/1/2016	33,266	2,772	0	$18,883	-1.1%	0	$18,349	-3.9%	$535	2.8%	$535
MVP	LG Rate	HMO Q3 & Q4 2016	MVPH-130467866	7/1/2016	2,627	219	219	$	-4.4%	0	$	-4.5%	$	0.0%	$

GMCB Rate Filing - Summary Statistics

Carrier	Market Segment	Type of Filing	SERFF Tracking #	Effective Date	Member Months	Members	Realized Members	Proposed Premium (000's)	Proposed Rate Increase	Rate Hearing (Yes=1)	Approved Premium (000's)	Approved Rate Increase	Premium Saved by GMCB (000's)	% Reduction	Premium Saved Realized Lives (000's)
MVP	LG Rate	PPO Q3 & Q4 2016	MVPH-130454426	7/1/2016	34,016	2,835	2,835	$12,378	-8.6%	0	$11,890	-12.2%	$488	3.9%	$488
MVP	SG Rate	PPO Q3 & Q4 2016	MVPH-130435575	7/1/2016	25,849	2,154	2,154	$9,581	9.3%	0	$9,467	8.0%	$114	1.2%	$114
MVP	LG Rate	PPO Q1 & Q2 2016	MVPH-130178700	1/1/2016	44,998	3,750	3,750	$15,741	9.2%	0	$15,684	8.8%	$58	0.4%	$58
MVP	SG Rate	PPO Q1 & Q2 2016	MVPH-130186136	1/1/2016	32,828	2,736	2,736	$10,315	2.6%	0	$10,292	2.4%	$22	0.2%	$22
		2016 Total			**1,090,756**	**90,897**	**88,125**	**$497,756**		**2**	**$487,244**		**$10,512**	**2.1%**	**$10,477**
Cigna	LG Rate	PPO Manual 2017	CCGP-130705386	8/1/2017	25,081	2,090	2,090	$13,495	-3.7%	0	$13,257	-5.4%	$238	1.8%	$238
4 Ever Life Ins	LG Rate	Expatriate Health Coverage	BCSF-131049258	10/1/2017	0	0	0	$395	0.0%	0	$374	0.0%	$21	5.4%	$21
BCBSVT	Merged Rate	Health Exchange 2017	BCVT-130567350	1/1/2017	816,633	68,053	68,053	$459,789	8.2%	1	$455,820	7.3%	$3,969	0.9%	$3,984
MVP	LG Rate	HMO Q3 & Q4 2017	MVPH-130977835	7/1/2017	0	0	0	$	3.0%	0	$	3.0%	$	0.0%	$
MVP	LG Rate	PPO Q3 & Q4 2017	MVPH-130913726	7/1/2017	21,322	1,777	1,777	$11,979	5.4%	0	$11,979	5.4%	$	0.0%	$
MVP	SG Rate	PPO Q3 & Q4 2017	MVPH-130912027	7/1/2017	22,469	1,872	1,872	$10,071	3.9%/5.9%	0	$10,071	3.9%	$	0.0%	$
MVP	LG Rate	HMO Q1 & Q2 2017	MVPH-130720563	1/1/2017	1,399	117	117	$	8.2%	0	$	4.1%	$	0.0%	$
MVP	LG Rate	PPO Q1 & Q2 2017	MVPH-130682523	1/1/2017	24,606	2,051	2,051	$12,198	-11.1%	0	$12,198	-11.1%	$	0.0%	$
MVP	SG RATE	PPO Q1 & Q2 2017	MVPH-130681893	1/1/2017	22,746	1,896	1,896	$9,411	9.1%	0	$9,411	9.1%	$	0.0%	$
MVP	Merged Rate	Health Exchange 2017	MVPH-130558905	1/1/2017	127,171	10,598	10,598	$37,001	8.8%	1	$35,290	3.7%	$1,711	4.6%	$1,822
		2017 Total			**1,061,427**	**88,454**	**88,454**	**$554,339**		**2**	**$548,399**		**$5,940**	**1.1%**	**$6,066**
BCBSVT	Merged Rate	Health Exchange 2018	BCVT-131037743	1/1/2018	844,973	70,414	70,414	$467,157	12.7%	1	$452,763	9.2%	$14,394	3.1%	$14,394
MVP	LG Rate	HMO Manual 1Q/2Q 2018	MVPH-131213366	1/1/2018	0	0	0	$	-5.1%	0	$	-6.1%	$	0.0%	$
MVP	LG Rate	PPO 2018	MVPH-131148723	1/1/2018	29,674	2,473	2,473	$10,427	5.7%	0	$10,427	5.7%	$	0.0%	$
MVP	SG Rate	PPO 2018	MVPH-131146158	1/1/2018	20,743	1,729	1,729	$9,632	4.2%	0	$9,632	4.2%	$	0.0%	$
MVP	Merged Rate	Health Exchange 2018	MVPH-131034103	1/1/2018	82,377	6,865	6,865	$58,741	6.7%	1	$56,914	3.4%	$1,827	3.1%	$1,827
MVP	LG Rate	HMO Manual 3Q/4Q 2018	MVPH-131435335	7/1/2018	26,184	2,182	2,182	$12,358	3.8%	0	$12,182	2.3%	$176	1.4%	$176
Cigna	LG Rate	PPO Manual 2017	CCGP-131268605	7/1/2018	8,759	730	730	$7,016	6.2%	0	$6,784	2.7%	$231	3.3%	$231
MVP	SG Rate	PPO 2018	MVPH-131432994	7/1/2018	16,054	1,338	1,338	$7,860	2.1%	0	$7,760	0.8%	$100	1.3%	$100
		2018 Total			**1,028,764**	**85,731**	**85,731**	**$573,190**		**2**	**$556,462**		**$16,728**	**2.9%**	**$16,728**
MVP	Merged Rate	Health Exchange 2019	MVPH-131497138	1/1/2019	302,676	25,223	25,223	$160,364	10.9%	1	$154,190	6.6%	$6,175	3.9%	$6,175
BCBSVT	Merged Rate	Health Exchange 2019	BCVT-131497882	1/1/2019	819,824	68,319	68,319	$381,113	9.6%	1	$367,812	5.8%	$13,301	3.5%	$13,301
		2019 Total			**1,122,500**	**93,542**	**93,542**	**$541,477**		**2**	**$522,001**		**$19,475**	**3.6%**	
		Grand Total (Rate Filings)			**8,309,040**	**692,423**	**672,596**	**$3,860,229**		**19**	**$3,752,160**		**$108,069**	**2.8%**	**$85,717**

Note:

1) For rate filings where realized covered members were not available they were reported the same as members so a total could be calculated. Realized members are indicated in italics.

2) NP in the rate increase columns indicates a new product so no rate increase is applicable.

3) The following filings set rates for more than one quarter with different rate increases by quarter and the detail is provided below. Increases in the exhibit are the weighted average.

SERFF Tracking #	Proposed Rate Increases by Quarter	Approved Rate Increases by Quarter
MVPH-128889199	Q3=13.3% GF, 14.0% NGF, Q4=5.4%	Q3=13.3% GF, 14.0% NGF, Q4=5.4%
MVPH-128880517	Q3=5.7%, Q4=3.1%	Q3=5.7%,Q4=3.1%
MVPH-128879614	Q3=13.5%, Q4=13.0%	Q3=10.5%, Q4=10.0%
MVPH-128882155	Q3=7.8%, Q4=8.0%	Q3=7.8%, Q4=8.0%
MVPH-129145840	Q1=0.0%,Q2=0.0%	Q1=-5.3%, Q2=-5.3%
MVPH-129144870	Q1=10.4%, Q2=10.3%	Q1=2.5%,Q2=2.5%
MVPH-129391759	Q3=5.0%, Q4=4.8%	Q3=5.0%, Q4=4.8%
MVPH-129389265	Q3=4.9%, Q4=3.5%	Q3=4.9%, Q4=3.5%
MVPH-129676042	Q1=(-6.8%, 6.3%) Q2=(-6.7%, 6.5%)	Q1=(-7.9%, 5.2%) Q2=(-7.7%, 5.5%)
MVPH-129662230	Q1=10.1%, Q2=10.2%	Q1=7.4%, Q2=7.5%

Rate reductions are for high deductible plans and rate increases are non high deductible plans.

Appendix A GMCB - Rating Statistics

Carrier	Market Segment	Filing Description	SERFF Tracking #	Effective Date	Benefit Expense (pmpm)	Target Loss Ratio	Realized Loss Ratio	Trend			Retention									
								Medical	Rx	Total	Admin	CTR	Assess	Taxes	Total	Admin	CTR	Assess	Taxes	Total
BCBSVT	SG	Q1 Q2 2013 TVHP	BCVT-128713269	1/1/2013	$365.60	86.27%	90.1%	7.0%	6.9%	7.0%	12.47%	0.00%	0.30%	0.96%	13.73%	$52.83	$0.00	$1.28	$4.06	$58.17
BCBSVT	SG	Q1 -Q3 2013 BCBSVT	BCVT-128778918	1/1/2013	$574.43	98.85%	102.5%	6.3%	7.8%	6.6%	14.20%	0.00%	0.76%	0.13%	15.10%	$82.54	$0.00	$4.44	$0.74	$87.73
BCBSVT	SG	Assoc. of Chamber Execs	BCVT-128622776	1/1/2013	$305.98	88.95%	96.1%	NA	NA	5.2%	9.83%	0.00%	1.04%	0.18%	11.05%	$33.83	$0.00	$3.57	$0.61	$38.00
BCBSVT	SG	VT Health Services Gp	BCVT-128624612	1/1/2013	$522.54	85.39%	94.7%	4.7%	5.2%	5.0%	13.68%	0.00%	0.78%	0.15%	14.61%	$83.74	$0.00	$4.75	$0.89	$89.38
BCBSVT	IND	Q3 13 Catamount	BCVT-128916274	7/1/2013	$418.11	92.34%	91.7%	3.8%	4.5%	3.9%	5.95%	0.00%	1.71%	0.00%	7.66%	$26.92	$0.00	$7.76	$0.00	$34.68
MVP	SG	PPO/EPO Q1 Q2 13	MVPH-128627829	1/1/2013	$320.44	79.66%	90.5%	5.3%	4.2%	5.2%	14.28%	3.00%	1.06%	2.00%	20.34%	$57.44	$12.07	$4.25	$8.04	$81.81
MVP	SG	HMO Q1 Q2 13	MVPH-128644483	1/1/2013	$635.58	85.08%	112.3%	5.1%	4.2%	5.0%	10.75%	3.00%	1.17%	0.00%	14.92%	$80.30	$22.41	$8.71	$0.00	$111.43
MVP	IND	Indemnity Q1 Q2 2013	MVPH-128620422	1/1/2013	$181.17	81.00%		8.0%	2.9%	7.8%	13.50%	3.00%	1.32%	2.00%	19.82%	$30.20	$6.71	$2.94	$4.47	$44.32
MVP	IND	Indemnity Q3 Q4 13	MVPH-128889199	7/1/2013	$312.08	79.16%	76.3%	6.2%	-1.6%	5.9%	13.50%	3.00%	0.94%	3.40%	20.84%	$53.22	$11.83	$3.71	$13.40	$82.16
BCBSVT	Merged	Health Exchange 2014	BCVT-128957017	1/1/2014	$316.92	88.00%	86.0%	3.8%	4.5%	3.9%	8.29%	0.50%	0.05%	3.16%	12.00%	$30.25	$1.82	$0.18	$11.38	$43.64
MVP	Merged	Health Exchange 2014	MVPH-128956063	1/1/2014	$315.52	85.74%	86.7%	4.7%	4.5%	4.7%	9.75%	0.50%	1.99%	2.02%	14.26%	$35.88	$1.84	$7.31	$7.44	$52.47
MVP	SG	GF PPO/EPO Q1 Q2	MVPH-129144870	1/1/2014	$327.72	83.80%	94.2%	5.4%	6.6%	5.5%	9.75%	1.00%	1.45%	4.00%	16.20%	$38.13	$3.91	$5.69	$15.64	$63.37
MVP	IND	GF Q1 Q2 14	MVPH-129145840	1/1/2014	$161.10	82.74%	104.1%	5.5%	3.3%	5.4%	11.00%	1.00%	1.26%	4.00%	17.26%	$21.42	$1.95	$2.45	$7.79	$33.60
BCBSVT	Merged	Health Exchange 2015	BCVT-129572217	1/1/2015	$387.69	89.04%	87.9%	4.4%	8.4%	5.1%	6.27%	1.00%	0.78%	2.91%	10.96%	$27.31	$4.36	$3.39	$12.69	$47.75
MVP	Merged	Health Exchange 2015	MVPH-129560321	1/1/2015	$334.26	85.20%	89.3%	7.7%	9.0%	7.8%	10.11%	1.00%	1.67%	2.02%	14.80%	$41.83	$4.14	$6.89	$8.35	$61.21
MVP	SG	GF PPO Q1 Q2 2015	MVPH-129662230	1/1/2015	$369.56	83.55%	NA	7.7%	9.9%	7.9%	9.75%	1.00%	1.70%	4.00%	16.45%	$43.12	$4.42	$7.51	$17.69	$72.75
BCBSVT	Merged	Health Exchange 2016	BCVT-130082559	1/1/2016	$412.12	88.98%	92.8%	7.1%	6.5%	7.0%	6.43%	1.00%	0.77%	2.82%	11.02%	$29.78	$4.63	$3.56	$13.07	$51.04
MVP	Merged	Health Exchange 2016	MVPH-130053210	1/1/2016	$367.19	87.19%	88.5%	4.4%	12.6%	5.7%	9.23%	-0.20%	1.74%	2.04%	12.81%	$38.26	($0.83)	$7.24	$8.46	$53.12
BCBSVT	Merged	Health Exchange 2017	BCVT-130567350	1/1/2017	$501.52	89.85%	91.2%	3.7%	10.2%	4.9%	6.97%	2.25%	0.75%	0.18%	10.15%	$34.22	$11.05	$3.69	$0.87	$49.83
MVP	Merged	Health Exchange 2017	MVPH-130558905	1/1/2017	$245.91	88.62%	76.7%	2.8%	12.2%	3.9%	8.60%	1.00%	1.76%	0.03%	11.38%	$38.38	$4.46	$7.84	$0.13	$50.81
BCBSVT	Merged	Health Exchange 2018	BCVT-131037743	1/1/2018	$475.85	88.81%	NA	3.6%	8.9%	4.4%	6.71%	0.70%	1.01%	2.77%	11.19%	$36.06	$3.76	$5.40	$14.90	$60.12
MVP	Merged	Health Exchange 2018	MVPH-131034103	1/1/2018	$597.13	86.43%	NA	3.5%	12.7%	4.7%	8.64%	2.00%	1.90%	1.03%	13.57%	$39.96	$9.25	$8.79	$4.77	$62.77
BCBSVT	Merged	Health Exchange 2019	BCVT-131497882	1/1/2019	$408.83	91.12%	NA	4.1%	13.3%	5.2%	7.06%	0.56%	1.07%	0.18%	8.88%	$40.29	$3.19	$6.14	$1.05	$50.67
MVP	Merged	Health Exchange 2019	MVPH-131497138	1/1/2019	$459.58	90.22%	NA	3.9%	12.5%	5.2%	8.15%	0.50%	1.11%	0.03%	9.78%	$41.40	$2.54	$5.65	$0.15	$49.74

Note: For the Q1-Q3 13 SG Filing BCVT-128778918, the BRS association which is the majority of the membership had a rate cap. The cap was adjusted for, and the expectation was that the filing results in a loss, and the adjusted expected loss ratio is 98.85%.

Appendix B: Consumer Experience Enhancements for Consideration

Please see Appendix B. pdf, attached.

Example of Single-Page Plain-Language Filing Summary

Rate request summary

Washington State Office of the Insurance Commissioner | www.insurance.wa.gov

Premera Blue Cross – Small group plans

Rate request filing ID #270173- This information is supplied by the company. It has not been verified by the Office of the Insurance Commissioner and may change.

Overview

Requested average* rate change:	5.4%
Requested effective date:	Jan. 1, 2015
Plans impacted:	Premera's small group health plans
People impacted:	19,457

Key information used to develop the rate request
(Jan. 2013-Dec. 2013)

Premiums	$337,045,599
Claims	$288,122,457
Administrative expenses	$38,643,459
Company made (or lost)	**$10,279,682**

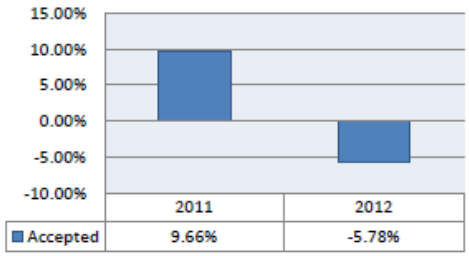
How it plans to spend your premium
If this rate is approved, here's how your insurance company plans to spend your premium:

Claims:	74.94%
Administrative:	22.57%
Profit:	2.50 %

The company expects its annual medical costs to increase **6.0%**.

Are there any benefit changes?
Yes. Part of the pediatric dental benefit will no longer be subject to deductible and coinsurance. To see a description, go to the beginning of the Initial Request or Complete Request and look under 'General Information.'

Company's annual rate request history
No rate changes were requested for 2013.



Need Help?
Call our Insurance Consumer Hotline at 1-800-562-6900 8 a.m. to 5 p.m., Monday – Friday.

**The employer's premium may vary based on the employees' age, where they live, the size of their family, and the benefits they choose.*

Premera Blue Cross, ID #270173
May 9, 2014

Example of Plain-Language Decision Summary

Rate request decision
Washington State Office of the Insurance Commissioner | www.insurance.wa.gov

Premera Blue Cross Company – Small group plans

Rate request filing ID #243581 - This document is a consumer tool to help explain the rate filing and decision made by the Office of the Insurance Commissioner. It is not intended to describe or include all factors or information considered in our review process. For more information, see the complete rate filing.

Overview

Approved average rate change:	**-5.8%**
Requested average rate change:	1.0%
Approved effective date:	**Nov. 1, 2012**
Requested effective date:	Nov. 1, 2012
Plans impacted:	All the company's small group plans
People impacted:	9,568

Our decision:

The company is terminating all its current small group plans (grandfathered and non-grandfathered) and offering one replacement plan.

We have reviewed the company's request and have disapproved the 1.0% rate increase.

We disagreed with the company's projections that its annual medical costs would increase by 16.5% and instead have accepted a projection of 12.7%.

According to the company's latest financial statement, it has $973M in surplus – which is enough to pay 5.5 months of claims. We do not have the authority to order a company to use surplus to subsidize or lower its rates. With these rates, the company projects to make a 1.0% profit.

What we consider

Premium is made up of three parts: medical claims, administrative expenses, and profit or loss. We review all of the information in rate filings for individual and small group health plans, including the plans' medical claims, administrative expenses, and projected profit or loss.

A key component used to calculate projected claims is medical trend. Medical trend is the change in claims costs over a specific period of time—usually one year—and is often based on both the company's past claims costs and what they expect to spend on claims in the future.

When we review administrative expenses, we look at any expenses not related to paying medical claims; including, but not limited to, employee salaries and benefits, the cost of the company's office and equipment, customer service, appeals costs, taxes, agent commissions, etc.

Example of Plain-Language Decision Summary (cont'd)

Rate request decision

Washington State Office of the Insurance Commissioner | www.insurance.wa.gov

The company's projected profit (or contribution to surplus) is a small part of the premium. The reasonableness of the projected profit may depend on the company's current surplus level and the type of plan (for example, some plans attract more sick people and therefore have more risk).

Key information the company used to develop its rate request

What the company says happened in the 12-month period from *Jan 2011-Dec, 2011.**

	Jan 2011 – Dec 2011	Per Member Per Month	% of premium
Premiums	$34,803,568	$282.14	
Claims	$32,808,495	$265.97	94.3%
Administrative expenses	$7,033,632	$57.02	20.2%
Company lost	($5,038,559)	($40.85)	(14.5%)

** The company usually bases its rate request on 12-months of experience. The time period used was the most recent 12-month period available at the time the rate change was filed.*

What the company predicts will happen with this rate change during a 12-month period, beginning with the requested effective date.

		Per Member Per Month	% of Premium
Premiums	$38,262,432	$333.25	
Claims	$32,176,036	$280.24	84.1%
Administrative expenses	$5,704,059	$49.68	14.9%
Company will make	$382,337	$3.33	1.0%

Why we disagreed with the company

The company's projections included an increase for annual medical costs of 16.5%; based on information it submitted, our review indicated that 12.7% increase was appropriate. As a result, its revised financial projection is as follows:

		Per Member Per Month	% of Premium
Premiums	$35,714,665	$311.06	
Claims	$29,922,198	$260.61	83.8%
Administrative expenses	$5,435,389	$47.34	15.2%
Company will make	$357,078	$3.11	1.0%

Example of Plain-Language Decision Summary (cont'd)

Rate request decision

Washington State Office of the Insurance Commissioner | www.insurance.wa.gov

Does the rate change include any benefit changes?

Yes. The new plan includes the federal requirements to cover women's preventive service. The company is also making significant changes to its cost sharing. For more information, see the chart below.

	Current Plan	Current Plan	Current Plan	Proposed
Medical Benefit	**Premera Balance**	**Premera Value**	**Premera Value**	**Value Plan**
Individual Deductible INN / OUT	$3,000 / $6,000	$3,500 / $7,000	$4,500 / $9,000	$5,000 / $14,000 (Shared with Rx)
Family Deductible INN / OUT	$9,000 / $18,000	$10,500 / $21,000	$13,500 / $27,000	$15,000 / $42,000 (Shared with Rx)
Coinsurance INN / OUT	30% / 50%	30% / 50%	30% / 50%	30% / 50%
Coinsurance Max INN / OUT	$4,500 / Unlimited	$5,500 / Unlimited	$5,500 / Unlimited	$35,000 / Unlimited
Individual OOPM (Includes Ded) INN / OUT	$7,500 / Unlimited	$9,000 / Unlimited	$10,000 / Unlimited	$40,000 / Unlimited
Family OOPM (Includes Ded) INN / OUT	$22,500 / Unlimited	$27,000 / Unlimited	$30,000 / Unlimited	$120,000 / Unlimited
Inpatient and Outpatient	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Office Visit INN	First 6 at $35 (Ded wavied), then Ded/Coins	First 6 at 30% (Ded wavied), then Ded/Coins	First 6 at 30% (Ded wavied), then Ded/Coins	First 6 at 30% (Ded wavied), then Ded/Coins
Office Visit OUT	OON Ded/Coins	OON Ded/Coins	OON Ded/Coins	OON Ded/Coins
ER	$100 Copay the Ded/Coins	$100 Copay the Ded/Coins	$100 Copay the Ded/Coins	$100 Copay the Ded/Coins
Prescription Drugs Benefit				
Individual Pharmacy Deductible	$500 Brand Only	$500 Brand Only	$500 Brand Only	$5,000 Shared with Medical
Generic/Preferred Brand/Non-Preferred Brand/Specialty INN Retail	$10/$50/50%/30%	$10/50%/50%/50%	$10/50%/50%/50%	$10/50%/50%/50%
Generic/Preferred Brand/Non-Preferred Brand/Specialty OUT Retail	In Network Cost Share Plus 40%	In Network Cost Share Plus 40%	In Network Cost Share Plus 40%	Not Covered
Individual Pharmacy OOPM INN / OUT	$5,000 / Unlimited	$10,000 / Unlimited	$10,000 / Unlimited	Unlimited

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Example of Dual-Purpose Interactive Filing Search Tool

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Company	Insurance type	% Requested	% Approved	Effective date	Status	Request details (PDF)	Public comments
PREMERA BLUE CROSS Request #243581 Received 6/28/2012	Small Group	1%	-5.8%	11/1/2012	Approved	Summary of request Complete request Our decision / rates	1 comments Comments closed
PREMERA BLUE CROSS Request #254684 Received 5/1/2013	Small Group	New plan	New plan	1/1/2014	Approved	Summary of request Complete request Our decision / rates	0 comments Comments closed
PREMERA BLUE CROSS Request #270173 Received 5/1/2014	Small Group	5.4%	4.6%	1/1/2015	Approved	Summary of request Complete request Our decision / rates	1 comments Comments closed
PREMERA BLUE CROSS Request #285656 Received 4/24/2015	Small Group	4.9%	4.6%	1/1/2016	Approved	Summary of request Complete request Our decision / rates	0 comments Comments closed
PREMERA BLUE CROSS Request #234100 Received 9/28/2011	Individual	4.7%	1.9% See rates by county	1/1/2012	Approved	Summary of request Complete request Our decision / rates	0 comments Comments closed
PREMERA BLUE CROSS Request #241797 Received 5/4/2012	Individual	0.7%	0.6% See rates by county	8/1/2012	Approved	Summary of request Complete request Our decision / rates	0 comments Comments closed
PREMERA BLUE CROSS Request #245225 Received 8/21/2012	Individual	9.5%	2.2% See rates by county	1/1/2013	Approved	Summary of request Complete request Our decision / rates	3 comments Comments closed
PREMERA BLUE CROSS Request #254695 Received 5/1/2013	Individual Exchange plan	New plan	New plan See rates by county	1/1/2014	Approved	Summary of request Complete request Our decision / rates	0 comments Comments closed
PREMERA BLUE CROSS Request #268449 Received 3/18/2014	Individual	4.6%	4.5% See rates by county	7/1/2014	Approved	Summary of request Complete request Our decision / rates	5 comments Comments closed
PREMERA BLUE CROSS Request #270474 Received 5/3/2014	Individual	8.1%	2.6% See rates by county	1/1/2015	Approved	Summary of request Complete request Our decision / rates	10 comments Comments closed

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SEE ALSO

Appendix C: Consumer Access and Affordability Summary Statistics

Please see Appendix C.pdf, attached.

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Small Group Market

(based on 1st Quarter Rate Filings)

		BCBSVT						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		1	1	1	1	1	1
	Gold		3	2	3	3	3	3
	Silver		4	3	3	4	4	8
	Bronze		3	3	3	3	5	5
	Catastrophic		-	-	-	-	-	-
	Total ACA Benefit Plans Filed		**11**	**9**	**10**	**11**	**13**	**17**
	Total non-ACA Benefit Plans Filed	**53**						
	Total Benefit Plans Filed	**53**	**11**	**9**	**10**	**11**	**13**	**17**
Anticipated Member Months	Platinum		1,968	109,008	125,328	113,256	116,112	91,116
	Gold		43,908	76,788	103,896	141,636	166,104	126,036
	Silver		171,720	155,868	159,108	183,012	145,032	103,764
	Bronze		110,004	74,316	78,072	70,056	68,652	42,720
	Catastrophic		-	-	-	-	-	-
	Total Anticipated ACA MMs		**327,600**	**415,980**	**466,404**	**507,960**	**495,900**	**363,636**
	Total Anticipated non-ACA MMs	**300,485**						
	Total Anticipated MMs	**300,485**	**327,600**	**415,980**	**466,404**	**507,960**	**495,900**	**363,636**
Anticipated Distribution of ACA MMs	Platinum		1%	26%	27%	22%	23%	25%
	Gold		13%	18%	22%	28%	33%	35%
	Silver		52%	37%	34%	36%	29%	29%
	Bronze		34%	18%	17%	14%	14%	12%
	Catastrophic		0%	0%	0%	0%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$365	$442	$476	$503	$551	$576
	non-ACA	$447						
	ACA & non-ACA	**$447**	**$365**	**$442**	**$476**	**$503**	**$551**	**$576**
Average Cost Sharing PMPM	ACA		$133	$109	$108	$82	$82	$135
	non-ACA	$118						
	ACA & non-ACA	**$118**	**$133**	**$109**	**$108**	**$82**	**$82**	**$135**
Average Total Cost of Health Care PMPM	ACA		$498	$551	$583	$585	$633	$711
	non-ACA	$565						
	ACA & non-ACA	**$565**	**$498**	**$551**	**$583**	**$585**	**$633**	**$711**
SERFF Number(s) for ACA Filings			128957017	129572217	130082559	130567350	131037743	131497882
SERFF Number(s) for non-ACA Filings		128713269 128778918						

Small Group Market

(based on 1st Quarter Rate Filings)

		MVP						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		1	1	1	1	1	1
	Gold		3	2	3	3	3	3
	Silver		4	3	3	3	4	8
	Bronze		4	3	3	3	5	5
	Catastrophic		-	-	-	-	-	-
	Total ACA Benefit Plans Filed		**12**	**9**	**10**	**10**	**13**	**17**
	Total non-ACA Benefit Plans Filed	**76**	**41**	**34**	**15**	**13**	**13**	
	Total Benefit Plans Filed	**76**	**53**	**43**	**25**	**23**	**26**	**17**
Anticipated Member Months	Platinum		27,893	4,848	11,531	7,932	9,840	25,260
	Gold		14,634	1,716	10,124	21,084	16,284	64,476
	Silver		76,308	9,432	34,259	10,812	12,864	64,920
	Bronze		42,324	6,288	20,093	12,528	16,428	17,604
	Catastrophic		-	-	-	-	-	-
	Total Anticipated ACA MMs		**161,159**	**22,284**	**76,007**	**52,356**	**55,416**	**172,260**
	Total Anticipated non-ACA MMs	**204,385**	**59,316**	**37,536**	**32,828**	**22,746**	**20,743**	**-**
	Total Anticipated MMs	**204,385**	**220,475**	**59,820**	**108,835**	**75,102**	**76,159**	**172,260**
Anticipated Distribution of ACA MMs	Platinum		17%	22%	15%	15%	18%	15%
	Gold		9%	8%	13%	40%	29%	37%
	Silver		47%	42%	45%	21%	23%	38%
	Bronze		26%	28%	26%	24%	30%	10%
	Catastrophic		0%	0%	0%	0%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$383	$448	$431	$467	$497	$521
	non-ACA	$417	$480	$403	$408	$414	$464	
	ACA & non-ACA	**$417**	**$409**	**$420**	**$424**	**$451**	**$488**	**$521**
Average Cost Sharing PMPM	ACA		$121	$128	$73	$92	$96	$92
	non-ACA	$89	$94	$102	$97	$98	$94	
	ACA & non-ACA	**$89**	**$114**	**$111**	**$81**	**$93**	**$96**	**$92**
Average Total Cost of Health Care PMPM	ACA		$504	$575	$505	$559	$593	$613
	non-ACA	$507	$574	$505	$505	$511	$559	
	ACA & non-ACA	**$507**	**$523**	**$531**	**$505**	**$545**	**$583**	**$613**
SERFF Number(s) for ACA Filings			128956063	129560321	130053210	130558905	131034103	131497138
SERFF Number(s) for non-ACA Filings		128627829 128696224 128644483	129144870	129662230 129710583	130186136	130681893	131146158	

Small Group Market

(based on 1st Quarter Rate Filings)

		All Small Group Carriers						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		2	2	2	2	2	2
	Gold		6	4	6	6	6	6
	Silver		8	6	6	7	8	16
	Bronze		7	6	6	6	10	10
	Catastrophic		-	-	-	-	-	-
	Total ACA Benefit Plans Filed		**23**	**18**	**20**	**21**	**26**	**34**
	Total non-ACA Benefit Plans Filed	**129**	**41**	**34**	**15**	**13**	**13**	**-**
	Total Benefit Plans Filed	**129**	**64**	**52**	**35**	**34**	**39**	**34**
Anticipated Member Months	Platinum		29,861	113,856	136,859	121,188	125,952	116,376
	Gold		58,542	78,504	114,020	162,720	182,388	190,512
	Silver		248,028	165,300	193,367	193,824	157,896	168,684
	Bronze		152,328	80,604	98,165	82,584	85,080	60,324
	Catastrophic		-	-	-	-	-	-
	Total Anticipated ACA MMs		**488,759**	**438,264**	**542,411**	**560,316**	**551,316**	**535,896**
	Total Anticipated non-ACA MMs	**504,870**	**59,316**	**37,536**	**32,828**	**22,746**	**20,743**	**-**
	Total Anticipated MMs	**504,870**	**548,075**	**475,800**	**575,239**	**583,062**	**572,059**	**535,896**
Anticipated Distribution of ACA MMs	Platinum		6%	26%	25%	22%	23%	22%
	Gold		12%	18%	21%	29%	33%	36%
	Silver		51%	38%	36%	35%	29%	31%
	Bronze		31%	18%	18%	15%	15%	11%
	Catastrophic		0%	0%	0%	0%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$371	$443	$469	$499	$546	$558
	non-ACA	$435	$480	$403	$408	$414	$464	
	ACA & non-ACA	**$435**	**$383**	**$440**	**$466**	**$496**	**$543**	**$558**
Average Cost Sharing PMPM	ACA		$129	$110	$103	$83	$83	$121
	non-ACA	$107	$94	$102	$97	$98	$94	
	ACA & non-ACA	**$107**	**$125**	**$109**	**$102**	**$84**	**$84**	**$121**
Average Total Cost of Health Care PMPM	ACA		$500	$552	$572	$582	$629	$679
	non-ACA	$541	$574	$505	$505	$511	$559	
	ACA & non-ACA	**$541**	**$508**	**$549**	**$568**	**$580**	**$626**	**$679**

SERFF Number(s) for ACA Filings
SERFF Number(s) for non-ACA Filings

Individual Market

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		BCBSVT							
		2013	**2013 Catamount**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum			1	1	1	1	1	1
	Gold			3	2	3	3	3	3
	Silver			4	3	3	4	4	8
	Bronze			3	3	3	3	5	5
	Catastrophic			1	1	1	1	1	1
	Total ACA Benefit Plans Filed			**12**	**10**	**11**	**12**	**14**	**18**
	Total non-ACA Benefit Plans Filed	**7**	**1**						
	Total Benefit Plans Filed	**7**	**1**	**12**	**10**	**11**	**12**	**14**	**18**
Anticipated Member Months	Platinum			2,580	45,276	50,184	42,684	39,108	32,028
	Gold			16,032	41,448	45,504	41,280	41,952	35,952
	Silver			338,124	153,180	219,372	284,376	212,916	162,012
	Bronze			40,188	41,340	57,264	52,128	47,736	34,296
	Catastrophic			34,140	1,056	1,440	2,028	2,808	3,168
	Total Anticipated ACA MMs			**431,064**	**282,300**	**373,764**	**422,496**	**344,520**	**267,456**
	Total Anticipated non-ACA MMs	**16,111**	**184,212**						
	Total Anticipated MMs	**16,111**	**184,212**	**431,064**	**282,300**	**373,764**	**422,496**	**344,520**	**267,456**
Anticipated Distribution of ACA MMs	Platinum			1%	16%	13%	10%	11%	12%
	Gold			4%	15%	12%	10%	12%	13%
	Silver			78%	54%	59%	67%	62%	61%
	Bronze			9%	15%	15%	12%	14%	13%
	Catastrophic			8%	0%	0%	0%	1%	1%
	Total			**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA			$356	$425	$448	$477	$517	$566
	non-ACA	$367	$451						
	ACA & non-ACA	**$367**	**$451**	**$356**	**$425**	**$448**	**$477**	**$517**	**$566**
Average Cost Sharing PMPM	ACA			$141	$180	$163	$151	$181	$127
	non-ACA	$52	$69						
	ACA & non-ACA	**$52**	**$69**	**$141**	**$180**	**$163**	**$151**	**$181**	**$127**
Average Total Cost of Health Care PMPM	ACA			$497	$605	$611	$628	$697	$694
	non-ACA	$419	$520						
	ACA & non-ACA	**$419**	**$520**	**$497**	**$605**	**$611**	**$628**	**$697**	**$694**
Affordability Comparison									
	Proj Median Income for FT, YR Worker*	$41,531		$42,445	$43,336	$44,333	$45,574	$47,078	$48,632
	Growth Rate in Income**			2.2%	2.1%	2.3%	2.8%	3.3%	3.3%
	Standard Silver Rate - Single (Annualized)			$5,102	$5,587	$5,814	$6,251	$6,732	$7,744
	Growth Rate in Standard Silver				9.5%	4.1%	7.5%	7.7%	15.0%
	Standard Siver Rate/Proj Median Income			12.0%	12.9%	13.1%	13.7%	14.3%	15.9%
SERFF Number(s) for ACA Filings			128916274	128957017	129572217	130082559	130567350	131037743	131497882
SERFF Number(s) for non-ACA Filings		128713014 128916274							

* 2017 is from the American Community Survey (ACS) 1 Year Estimate and other years are derived from the Growth Rate in Income Statistic

** 2014 to 2017 growth rates are from the Bureau of Labor Statistics Employment Cost Index; Projected growth rate for 2017 and 2018 is from the Congressional Budget Office Economic Projection for the Employment Cost Index

Individual Market

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		MVP						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		1	1	1	1	1	1
	Gold		3	2	3	3	3	3
	Silver		4	3	3	3	4	8
	Bronze		4	3	3	3	5	5
	Catastrophic		1	1	1	1	1	1
	Total ACA Benefit Plans Filed		**13**	**10**	**11**	**11**	**14**	**18**
	Total non-ACA Benefit Plans Filed	**10**	**5**	-	-	-	-	-
	Total Benefit Plans Filed	**10**	**18**	**10**	**11**	**11**	**14**	**18**
Anticipated Member Months	Platinum		3,008	2,664	11,961	5,496	2,436	3,684
	Gold		1,578	1,260	5,197	15,144	3,192	8,604
	Silver		54,644	10,764	39,856	14,916	31,200	75,564
	Bronze		19,028	19,416	45,800	28,260	31,080	42,288
	Catastrophic		2,689	1,188	1,123	588	336	276
	Total Anticipated ACA MMs		**80,947**	**35,292**	**103,937**	**64,404**	**68,244**	**130,416**
	Total Anticipated non-ACA MMs	**22,818**	**10,198**					
	Total Anticipated MMs	**22,818**	**91,145**	**35,292**	**103,937**	**64,404**	**68,244**	**130,416**
Anticipated Distribution of ACA MMs	Platinum		4%	8%	12%	9%	4%	3%
	Gold		2%	4%	5%	24%	5%	7%
	Silver		68%	30%	38%	23%	46%	58%
	Bronze		24%	55%	44%	44%	46%	32%
	Catastrophic		3%	3%	1%	1%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$353	$392	$404	$430	$435	$495
	non-ACA	$223	$26					
	ACA & non-ACA	**$223**	**$317**	**$392**	**$404**	**$430**	**$435**	**$495**
Average Cost Sharing PMPM	ACA		$132	$154	$109	$118	$137	$91
	non-ACA	$161	$101					
	ACA & non-ACA	**$161**	**$129**	**$154**	**$109**	**$118**	**$137**	**$91**
Average Total Cost of Health Care PMPM	ACA		$485	$546	$514	$547	$572	$586
	non-ACA	$385	$127					
	ACA & non-ACA	**$385**	**$445**	**$546**	**$514**	**$547**	**$572**	**$586**
Affordability Comparison								
	Proj Median Income for FT, YR Worker*	$41,531	$42,445	$43,336	$44,333	$45,574	$47,078	$48,632
	Growth Rate in Income**		2.2%	2.1%	2.3%	2.8%	3.3%	3.3%
	Standard Silver Rate - Single (Annualized)		$5,130	$5,819	$5,921	$6,261	$6,345	$7,666
	Growth Rate in Standard Silver			13.4%	1.7%	5.7%	1.4%	20.8%
	Standard Siver Rate/Proj Median Income		12.1%	13.4%	13.4%	13.7%	13.5%	15.8%
SERFF Number(s) for ACA Filings			128956063	129560321	130053210	130558905	131034103	131497138
SERFF Number(s) for non-ACA Filings		128620422	129145840					

* 2017 is from the American Community Survey (ACS) 1 Year Estimate and other years are derived from the Growth Rate in Income Statistic

** 2014 to 2017 growth rates are from the Bureau of Labor Statistics Employment Cost Index; Projected growth rate for 2017 and 2018 is from the Congressional Budget Office Economic Projection for the Employment Cost Index

Individual Market

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		All Individual Carriers						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		2	2	2	2	2	2
	Gold		6	4	6	6	6	6
	Silver		8	6	6	7	8	16
	Bronze		7	6	6	6	10	10
	Catastrophic		2	2	2	2	2	2
	Total ACA Benefit Plans Filed		**25**	**20**	**22**	**23**	**28**	**36**
	Total non-ACA Benefit Plans Filed	**18**	**5**	**-**	**-**	**-**	**-**	**-**
	Total Benefit Plans Filed	**18**	**30**	**20**	**22**	**23**	**28**	**36**
Anticipated Member Months	Platinum		5,588	47,940	62,145	48,180	41,544	35,712
	Gold		17,610	42,708	50,701	56,424	45,144	44,556
	Silver		392,768	163,944	259,228	299,292	244,116	237,576
	Bronze		59,216	60,756	103,064	80,388	78,816	76,584
	Catastrophic		36,829	2,244	2,563	2,616	3,144	3,444
	Total Anticipated ACA MMs		**512,011**	**317,592**	**477,701**	**486,900**	**412,764**	**397,872**
	Total Anticipated non-ACA MMs	**223,141**	**10,198**					
	Total Anticipated MMs	**223,141**	**522,209**	**317,592**	**477,701**	**486,900**	**412,764**	**397,872**
Anticipated Distribution of ACA MMs	Platinum		1%	15%	13%	10%	10%	9%
	Gold		3%	13%	11%	12%	11%	11%
	Silver		77%	52%	54%	61%	59%	60%
	Bronze		12%	19%	22%	17%	19%	19%
	Catastrophic		7%	1%	1%	1%	1%	1%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$356	$421	$438	$471	$503	$543
	non-ACA	$422	$26					
	ACA & non-ACA	**$422**	**$349**	**$421**	**$438**	**$471**	**$503**	**$543**
Average Cost Sharing PMPM	ACA		$139	$177	$151	$147	$174	$115
	non-ACA	$78	$101					
	ACA & non-ACA	**$78**	**$139**	**$177**	**$151**	**$147**	**$174**	**$115**
Average Total Cost of Health Care PMPM	ACA		$495	$599	$589	$617	$677	$658
	non-ACA	$499	$127					
	ACA & non-ACA	**$499**	**$488**	**$599**	**$589**	**$617**	**$677**	**$658**
Affordability Comparison								
	Proj Median Income for FT, YR Worker*	$41,531	$42,445	$43,336	$44,333	$45,574	$47,078	$48,632
	Growth Rate in Income**		2.2%	2.1%	2.3%	2.8%	3.3%	3.3%
	Standard Silver Rate - Single (Annualized)		$5,105	$5,600	$5,825	$6,251	$6,716	$7,738
	Growth Rate in Standard Silver			9.7%	4.0%	7.3%	7.4%	15.2%
	Standard Siver Rate/Proj Median Income		12.0%	12.9%	13.1%	13.7%	14.3%	15.9%
SERFF Number(s) for ACA Filings								
SERFF Number(s) for non-ACA Filings								

* 2017 is from the American Community Survey (ACS) 1 Year Estimate and other years are derived from the Growth Rate in Income Statistic

** 2014 to 2017 growth rates are from the Bureau of Labor Statistics Employment Cost Index; Projected growth rate for 2017 and 2018 is from the Congressional Budget Office Economic Projection for the Employment Cost Index

Combined Small Group and Individual_Updated Markets

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		BCBSVT						
		2013	2014	2015	2016	2017	2018	2019
Number of Benefit Plans Filed	Platinum		1	1	1	1	1	1
	Gold		3	2	3	3	3	3
	Silver		4	3	3	4	4	8
	Bronze		3	3	3	3	5	5
	Catastrophic		1	1	1	1	1	1
	Total ACA Benefit Plans Filed		**12**	**10**	**11**	**12**	**14**	**18**
	Non-ACA Benefit Plans Filed	61						
	Total Benefit Plans Filed	**61**	**12**	**10**	**11**	**12**	**14**	**18**
Anticipated ACA Member Months	Platinum		4,548	154,284	175,512	155,940	155,220	123,144
	Gold		59,940	118,236	149,400	182,916	208,056	161,988
	Silver		509,844	309,048	378,480	467,388	357,948	265,776
	Bronze		150,192	115,656	135,336	122,184	116,388	77,016
	Catastrophic		34,140	1,056	1,440	2,028	2,808	3,168
	Total Anticipated ACA MMs		**758,664**	**698,280**	**840,168**	**930,456**	**840,420**	**631,092**
	Anticipated non-ACA MMs	500,808						
	Total Anticipated MMs	**500,808**	**758,664**	**698,280**	**840,168**	**930,456**	**840,420**	**631,092**
Anticipated Distribution of ACA MMs	Platinum		1%	22%	21%	17%	18%	20%
	Gold		8%	17%	18%	20%	25%	26%
	Silver		67%	44%	45%	50%	43%	42%
	Bronze		20%	17%	16%	13%	14%	12%
	Catastrophic		5%	0%	0%	0%	0%	1%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Realized ACA Member Months	Platinum		138,556	NA	NA	NA	NA	NA
	Gold		104,850	NA	NA	NA	NA	NA
	Silver		288,167	NA	NA	NA	NA	NA
	Bronze		101,812	NA	NA	NA	NA	NA
	Catastrophic		961	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		101,257	NA	NA	NA	NA	NA
	Total Realized ACA MMs		**735,603**	**NA**	**NA**	**NA**	**NA**	**NA**
Realized Distribution of MMs	Platinum		19%	NA	NA	NA	NA	NA
	Gold		14%	NA	NA	NA	NA	NA
	Silver		39%	NA	NA	NA	NA	NA
	Bronze		14%	NA	NA	NA	NA	NA
	Catastrophic		0%	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		14%	NA	NA	NA	NA	NA
	Total		**100%**	**NA**	**NA**	**NA**	**NA**	**NA**
Average Premium PMPM	ACA		**$360**	**$435**	**$463**	**$491**	**$537**	**$572**
	non-ACA	**$446**						
	ACA & non-ACA	**$446**	**$360**	**$435**	**$463**	**$491**	**$537**	**$572**
Average Cost Sharing PMPM	ACA		**$137**	**$138**	**$132**	**$114**	**$122**	**$132**
	non-ACA	**$98**						
	ACA & non-ACA	**$98**	**$137**	**$138**	**$132**	**$114**	**$122**	**$132**
Average Total Cost of Health Care PMPM	ACA		**$498**	**$573**	**$595**	**$605**	**$659**	**$704**
	non-ACA	**$544**						
	ACA & non-ACA	**$544**	**$498**	**$573**	**$595**	**$605**	**$659**	**$704**

Combined Small Group and Individual_Updated Markets

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		MVP						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Number of Benefit Plans Filed	Platinum		1	1	1	1	1	1
	Gold		3	2	3	3	3	3
	Silver		4	3	3	3	4	8
	Bronze		4	3	3	3	5	5
	Catastrophic		1	1	1	1	1	1
	Total ACA Benefit Plans Filed		**13**	**10**	**11**	**11**	**14**	**18**
	Non-ACA Benefit Plans Filed	86	46	34	15	13	13	-
	Total Benefit Plans Filed	**86**	**59**	**44**	**26**	**24**	**27**	**18**
Anticipated ACA Member Months	Platinum		30,901	7,512	23,492	13,428	12,276	28,944
	Gold		16,212	2,976	15,321	36,228	19,476	73,080
	Silver		130,952	20,196	74,115	25,728	44,064	140,484
	Bronze		61,352	25,704	65,893	40,788	47,508	59,892
	Catastrophic		2,689	1,188	1,123	588	336	276
	Total Anticipated ACA MMs		**242,106**	**57,576**	**179,944**	**116,760**	**123,660**	**302,676**
	Anticipated non-ACA MMs	227,203	69,514	37,536	32,828	22,746	20,743	-
	Total Anticipated MMs	**227,203**	**311,620**	**95,112**	**212,772**	**139,506**	**144,403**	**302,676**
Anticipated Distribution of ACA MMs	Platinum		13%	13%	13%	12%	10%	10%
	Gold		7%	5%	9%	31%	16%	24%
	Silver		54%	35%	41%	22%	36%	46%
	Bronze		25%	45%	37%	35%	38%	20%
	Catastrophic		1%	2%	1%	1%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Realized ACA Member Months	Platinum		8,208	NA	NA	NA	NA	NA
	Gold		3,220	NA	NA	NA	NA	NA
	Silver		20,198	NA	NA	NA	NA	NA
	Bronze		27,407	NA	NA	NA	NA	NA
	Catastrophic		1,123	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		341	NA	NA	NA	NA	NA
	Total Realized ACA MMs		**60,497**	**NA**	**NA**	**NA**	**NA**	**NA**
Realized Distribution of MMs	Platinum		14%	NA	NA	NA	NA	NA
	Gold		5%	NA	NA	NA	NA	NA
	Silver		33%	NA	NA	NA	NA	NA
	Bronze		45%	NA	NA	NA	NA	NA
	Catastrophic		2%	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		1%	NA	NA	NA	NA	NA
	Total		**100%**	**NA**	**NA**	**NA**	**NA**	**NA**
Average Premium PMPM	ACA		**$373**	**$414**	**$416**	**$447**	**$463**	**$510**
	non-ACA	**$398**	**$414**	**$403**	**$408**	**$414**	**$464**	
	ACA & non-ACA	**$398**	**$382**	**$410**	**$414**	**$441**	**$463**	**$510**
Average Cost Sharing PMPM	ACA		**$125**	**$144**	**$94**	**$106**	**$119**	**$92**
	non-ACA	**$97**	**$95**	**$102**	**$97**	**$98**	**$94**	
	ACA & non-ACA	**$97**	**$118**	**$127**	**$95**	**$105**	**$115**	**$92**
Average Total Cost of Health Care PMPM	ACA		**$498**	**$557**	**$510**	**$553**	**$582**	**$602**
	non-ACA	**$494**	**$508**	**$505**	**$505**	**$511**	**$559**	**$0**
	ACA & non-ACA	**$494**	**$500**	**$537**	**$509**	**$546**	**$578**	**$602**

Combined Small Group and Individual_Updated Markets

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		All Small Group & Individual_Updated Carriers						
		2013	2014	2015	2016	2017	2018	2019
Number of Benefit Plans Filed	Platinum		2	2	2	2	2	2
	Gold		6	4	6	6	6	6
	Silver		8	6	6	7	8	16
	Bronze		7	6	6	6	10	10
	Catastrophic		2	2	2	2	2	2
	Total ACA Benefit Plans Filed		**25**	**20**	**22**	**23**	**28**	**36**
	Non-ACA Benefit Plans Filed	147	46	34	15	13	13	-
	Total Benefit Plans Filed	**147**	**71**	**54**	**37**	**36**	**41**	**36**
Anticipated ACA Member Months	Platinum		35,449	161,796	199,004	169,368	167,496	152,088
	Gold		76,152	121,212	164,721	219,144	227,532	235,068
	Silver		640,796	329,244	452,595	493,116	402,012	406,260
	Bronze		211,544	141,360	201,229	162,972	163,896	136,908
	Catastrophic		36,829	2,244	2,563	2,616	3,144	3,444
	Total Anticipated ACA MMs		**1,000,770**	**755,856**	**1,020,112**	**1,047,216**	**964,080**	**933,768**
	Anticipated non-ACA MMs	728,011	69,514	37,536	32,828	22,746	20,743	-
	Total Anticipated MMs	**728,011**	**1,070,284**	**793,392**	**1,052,940**	**1,069,962**	**984,823**	**933,768**
Anticipated Distribution of ACA MMs	Platinum		4%	21%	20%	16%	17%	16%
	Gold		8%	16%	16%	21%	24%	25%
	Silver		64%	44%	44%	47%	42%	44%
	Bronze		21%	19%	20%	16%	17%	15%
	Catastrophic		4%	0%	0%	0%	0%	0%
	Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Realized ACA Member Months	Platinum		146,764	NA	NA	NA	NA	NA
	Gold		108,070	NA	NA	NA	NA	NA
	Silver		308,365	NA	NA	NA	NA	NA
	Bronze		129,219	NA	NA	NA	NA	NA
	Catastrophic		2,084	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		101,598	NA	NA	NA	NA	NA
	Total Realized ACA MMs		**796,100**	**NA**	**NA**	**NA**	**NA**	**NA**
Realized Distribution of MMs	Platinum		18%	NA	NA	NA	NA	NA
	Gold		14%	NA	NA	NA	NA	NA
	Silver		39%	NA	NA	NA	NA	NA
	Bronze		16%	NA	NA	NA	NA	NA
	Catastrophic		0%	NA	NA	NA	NA	NA
	Terminated Products (any metal level)		13%	NA	NA	NA	NA	NA
	Total		**100%**	**NA**	**NA**	**NA**	**NA**	**NA**
Average Premium PMPM	ACA		**$363**	**$434**	**$455**	**$486**	**$527**	**$552**
	non-ACA	**$431**	**$414**	**$403**	**$408**	**$414**	**$464**	
	ACA & non-ACA	**$431**	**$367**	**$432**	**$453**	**$484**	**$526**	**$552**
Average Cost Sharing PMPM	ACA		**$134**	**$138**	**$125**	**$113**	**$122**	**$119**
	non-ACA	**$98**	**$95**	**$102**	**$97**	**$98**	**$94**	
	ACA & non-ACA	**$98**	**$132**	**$136**	**$125**	**$112**	**$121**	**$119**
Average Total Cost of Health Care PMPM	ACA		**$498**	**$572**	**$580**	**$599**	**$649**	**$670**
	non-ACA	**$528**	**$508**	**$505**	**$505**	**$511**	**$559**	
	ACA & non-ACA	**$528**	**$498**	**$569**	**$578**	**$597**	**$648**	**$670**

Appendix D: Major Product Attributes

Please see Appendix D.pdf, attached.

Small Group Market

(based on 1st Quarter Rate Filings)

		BCBSVT						
		2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Major Product Attributes (in-network benefits)	**Highest Cost Plan**							
	Medical Deductible	$100	$150	$150	$150	$250	$300	$350
	Coinsurance %	Ded	10%	10%	10%	10%	10%	10%
	Medical OOP Max	no max	$1,250	$1,250	$1,250	$1,300	$1,300	$1,350
	Med Ded waived for:		Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Pediatric Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Pediatric Dental Class I, Vision
	PCP/Specialist OV Copay	$15 / $15	$10 / $20	$10 / $20	$10 / $20	$10 / $30	$10 / $30	$10 / $30
	ER Copay	Ded	$100	$100	$100	$100	$100	$100
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$1 / $1 / $1	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $50 / 50%	$5 / $50 / 50%	$5 / $50 / 50%
	Lowest Cost Plan (not catastrophic)							
	Medical Deductible	$5,000	$5,000	$5,000	$6,550	$7,150	$6,650	$5,500
	Coinsurance %	0%	50%	50%	0%	0%	0%	50%
	Medical OOP Max	no max	$6,250	$6,250	$6,550	$7,150	$6,650	$7,900
	Med Ded waived for:	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care, Pediatric Dental Class I
	PCP/Specialist OV Copay	Ded	50% / 50%	50% / 50%	0% / 0%	0% / 0%	0% / 0%	$35/$90
	ER Copay	Ded	50%	50%	0%	0%	0%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$5 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$20 / $85 / 60%
Average Premium PMPM	Highest Cost Plan	$ 1,086.94	$ 521.20	$ 555.04	$ 588.85	$ 618.31	$ 671.15	$ 702.74
	Lowest Cost Plan (not catastrophic)	$ 440.18	$ 305.02	$ 320.56	$ 360.43	$ 394.51	$ 432.51	$ 443.32
	Spread (1-lowest/highest)	60%	41%	42%	39%	36%	36%	37%
Metal Actuarial Value	Highest Cost Plan		0.881	0.881	0.890	0.891	0.899	0.901
	Lowest Cost Plan (not catastrophic)		0.616	0.613	0.620	0.616	0.615	0.613
SERFF Number(s)		BCVT_128713269 BCVT_128778918	BCVT_128957017	BCVT_129572217	BCVT_130082559	BCVT_130567350	BCVT_131037743	BCVT_131497882

* cost sharing applies after deductible is met

Small Group Market
(based on 1st Quarter Rate Filings)

		MVP										
		2013	2014 non-ACA	2015 non-ACA	2016 non-ACA	2017 non-ACA	2018 non-ACA	2014	2015	2016	2017	2018	2019
Major Product Attributes (in-network benefits)	**Highest Cost Plan**												
	Medical Deductible	$2,000	$300 IP/$100 OP	$300 IP/$100 OP	$1,500	$1,500	$1,500	$150	$150	$150	$250	$300	$350
	Coinsurance %	0%	0%	0%	0%	0%	0%	10%	10%	10%	10%	10%	10%
	Medical OOP Max	no max	no max	no max	$2,500	$2,500	$2,500	$1,250	$1,250	$1,250	$1,300	$1,300	$1,350
	Med Ded waived for:	-						Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	$25 / $25	$15 / $40	$15 / $40	Ded	Ded	Ded	$10 / $20	$10 / $20	$10 / $20	$10 / $30	$10 / $30	$10 / $30
	ER Copay	$75	$75	$75	Ded	Ded	Ded	$100	$100	$100	$100	$100	$100
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	50%/50%/50%	$0 / $30 / $50	$0 / $30 / $50	$10 / $30 /$ 50	$10 / $30 /$ 50	$10 / $30 / $50	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $50 / 50%	$5 / $50 / 50%	$5 / $50 / 50%
	Lowest Cost Plan (not catastrophic)												
	Medical Deductible	$9,500	$5,000	$5,000	$5,000	$5,000	$5,000	$3,500	$3,500	$4,400	$5,500	$7,350	$5,500
	Coinsurance %	0%	0%	0%	0%	0%	0%	50%	50%	50%	50%	0%	50%
	Medical OOP Max	$9,500	$5,000	$5,000	$5,000	$5,000	$5,000	$6,350	$6,350	$6,500	$7,150	$7,350	$7,900
	Med Ded waived for:							Preventive Care	Preventive Care	Preventive Care	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	$0 / $40	Ded	Ded	Ded	Ded	Ded	$35* / $80*	$35* / $80*	50% / 50%	$40/ $100	0% / 0%	$35/ $90
	ER Copay	$0	Ded	Ded	Ded	Ded	Ded	50%	50%	50%	50%	0%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$10/100%/100%	$0 after Ded	$0 after Ded	$0 after Ded	$0 after Ded	$0 after Ded	$20 / $80 / 60%	$20 / $80 / 60%	$12 / 40% / 60%	$20 / $90 / 60%	$30 / 0% / 0%	$20/ $85 / 60%
Average Premium PMPM	Highest Cost Plan	$ 1,042.23	$ 673.01	$ 700.92	$ 495.03	$ 538.19	$ 563.84	$ 513.21	$ 589.04	$ 576.79	$ 602.16	$ 650.16	$ 656.17
	Lowest Cost Plan (not catastrophic)	$ 251.90	$ 303.88	$ 332.61	$ 335.33	$ 380.82	$ 398.96	$ 290.27	$ 348.22	$ 332.50	$ 363.40	$ 389.03	$ 390.22
	Spread (1-lowest/highest)	76%	55%	53%	32%	29%	29%	43%	41%	42%	40%	40%	41%
Metal Actuarial Value	Highest Cost Plan							0.881	0.880	0.890	0.891	0.899	0.901
	Lowest Cost Plan (not catastrophic)							0.618	0.615	0.610	0.604	0.617	0.613
SERFF Number(s)		MVP_128627829 MVP_128696224 MVP_128644483	MVP_129144870	MVP_129662230 MVP_129710583	MVP_130186136	MVP_130681893	MVP_131146158	MVP_128956063	MVP_129560321	MVP_130053210	MVP_130558905	MVP_131034103	MVP_131497138

* cost sharing applies after deductible is met

Individual Market

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		BCBSVT							
		2013	**2013 Catamount**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Major Product Attributes (in-network benefits)	**Highest Cost Plan**								
	Medical Deductible	$3,500	$500	$150	$150	$150	$250	$300	$350
	Coinsurance %	20%	20%	10%	10%	10%	10%	10%	10%
	Medical OOP Max	$9,500	$1,050	$1,250	$1,250	$1,250	$1,300	$1,300	$1,350
	Med Ded waived for:	Physician OV, Preventive OV, MH/SA OV	Preventive Care, Physician OV, MH/SA OV, Chiropractic Care	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Pediatric Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Pediatric Dental Class I, Vision
	PCP/Specialist OV Copay	$30	$10	$15 / $20	$10 / $20	$10 / $20	$10 / $30	$10 / $30	$10 / $30
	ER Copay	Ded, Coins	Ded, Coins	$100	$100	$100	$100	$100	$100
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$10 / 50% / 60%	$10 / $35 / $55	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $50 / 50%	$5 / $50 / 50%	$5 / $50 / 50%
	Lowest Cost Plan (not catastrophic)								
	Medical Deductible	$10,000	$500	$5,000	$5,000	$6,550	$7,150	$6,650	$5,500
	Coinsurance %	30%	20%	50%	50%	0%	0%	0%	50%
	Medical OOP Max	$23,500	$1,050	$6,250	$6,250	$6,550	$7,150	$6,650	$7,900
	Med Ded waived for:	Preventive Care (federal definition)	Preventive Care, Physician OV, MH/SA OV, Chiropractic Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care	Preventive Care, Pediatric Dental Class I
	PCP/Specialist OV Copay	$15 / Ded, Coins	$10	50% / 50%	50% / 50%	Ded / Ded	0% / 0%	0% / 0%	$35 / $90
	ER Copay	Ded, Coins	Ded, Coins	50%	50%	Ded	0%	0%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$15 / 50% / 60%	$10 / $35 / $55	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$20 / $85 / 60%
Average Premium PMPM	Highest Cost Plan	$ 564.89	$ 451.04	$ 521.20	$ 555.04	$ 588.85	$ 618.31	$ 671.15	$ 702.74
	Lowest Cost Plan (not catastrophic)	$ 262.00	$ 451.04	$ 305.02	$ 320.56	$ 360.43	$ 394.51	$ 432.51	$ 443.32
	Spread (1-lowest/highest)	54%	0%	41%	42%	39%	36%	36%	37%
Metal Actuarial Value	Highest Cost Plan			0.881	0.881	0.890	0.891	0.899	0.901
	Lowest Cost Plan (not catastrophic)			0.616	0.613	0.620	0.616	0.615	0.613
SERFF Number(s)		BCVT_128713014 BCVT_128916274	BCVT_128916274	BCVT_128957017	BCVT_129572217	BCVT_130082559	BCVT_130567350	BCVT_131037743	BCVT_131497882

* cost sharing applies after deductible is met

Individual Market

(based on 1st Quarter Rate Filings and 3rd Quarter 2013 Catamount)

		MVP							
		2013	**2014 non-ACA**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Major Product Attributes (in-network benefits)	**Highest Cost Plan**								
	Medical Deductible	$3,500	$3,500	$150	$150	$150	$250	$300	$350
	Coinsurance %	30%	30%	10%	10%	10%	10%	10%	10%
	Medical OOP Max	no max	no max	$1,250	$1,250	$1,250	$1,300	$1,300	$1,350
	Med Ded waived for:			Preventive Care	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	Ded, Coins	Ded, Coins	$10 / $20	$10 / $20	$10 / $20	$10 / $30	$10 / $30	$10 / $30
	ER Copay	Ded, Coins	Ded, Coins	$100	$100	$100	$100	$ 100	$ 100
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$250 Ded, 50%	$250 Ded, 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $50 / 50%	$5 / $50 / 50%	$5 / $50 / 50%
	Lowest Cost Plan (not catastrophic)								
	Medical Deductible	$100,000	$100,000	$3,500	$3,500	$4,400	$5,500	$7,350	$5,500
	Coinsurance %	30%	30%	50%	50%	50%	50%	0%	50%
	Medical OOP Max	no max	no max	$6,350	$6,350	$6,500	$7,150	$7,350	$7,900
	Med Ded waived for:			Preventive Care	Preventive Care	Preventive Care	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	Ded, Coins	Ded, Coins	$35* / $80*	$35* / $80*	50% / 50%	$40/ $100	0% / 0%	$35/ $90
	ER Copay	Ded, Coins	Ded, Coins	50%	50%	50%	50%	0%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$250 Ded, 50%	$250 Ded, 50%	$20 / $80 / 60%	$20 / $80 / 60%	$12 / 40% / 60%	$20/ $90/ 60%	$30 / 0% / 0%	$20 / $85/ 60%
Average Premium PMPM	Highest Cost Plan	$320	$ 267.82	$ 513.21	$ 589.04	$ 576.79	$ 602.16	$ 650.16	$ 656.17
	Lowest Cost Plan (not catastrophic)	$ 17.51	$ 16.55	$ 290.27	$ 348.22	$ 332.50	$ 363.40	$ 389.03	$ 390.22
	Spread (1-lowest/highest)	95%	94%	43%	41%	42%	40%	40%	41%
Metal Actuarial Value	Highest Cost Plan			0.881	0.880	0.890	0.891	0.899	0.901
	Lowest Cost Plan (not catastrophic)			0.618	0.615	0.610	0.604	0.617	0.613
SERFF Number(s)		MVP_128620422	MVP_129145840	MVP_128956063	MVP_129560321	MVP_130053210	MVP_130558905	MVP_130558905	MVP_130558905

* cost sharing applies after deductible is met

Endnotes

1 The comprehensive health care reform law was enacted in March 2010 in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name ”Affordable Care Act,” (ACA),Act’ is used to refer to the final, amended version of the law. Centers for Medicare & Medicaid Services (CMS): Health care.gov glossary. Accessed 10 October 2018: https://www.healthcare.gov/glossary/affordable-care-act/.

2 Centers for Medicare & Medicaid Services. The Center for Consumer Information & Insurance Oversight: New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes and to Enhance Health Pricing Transparency. Accessed 25 October 2018: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/rates.html

3 *Ibid.*

4 Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(2); GMCB Rule 2.000 (Rate Review) § 2.301(b).

5 *Ibid.*

6 Vt. Stat. Ann. tit. 18 V.S.A. § 9375(b)(6).

7 State of Vermont, Green Mountain Care Board (GMCB) Rule 2.000: HEALTH INSURANCE RATE REVIEW. p.9. Accessed 25 October 2018: http://gmcboard.vermont.gov/sites/gmcboard/files/13_12_12_Rule_2%20000_Health_Insurance_Rate_Review.pdf.

8 Green Mountain Care Board (GMCB). Vermont Rate Review, State of Vermont: How Rates are Reviewed. Accessed 4 November 2015: http://ratereview.vermont.gov/how_reviewed

9 Karaca-Mandic P, Fulton BD, Hollingshead A, and Scheffler RM. States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market in 2010-2013. Health Affairs. 34, No. 8 (2015): 1358-1367.

10 *Ibid.*

11 State of Vermont, GMCB Rule 2.000: HEALTH INSURANCE RATE REVIEW: 2.307 Public Hearings

12 *Op. cit.* State of Vermont, GMCB Rule 2.000: HEALTH INSURANCE RATE REVIEW:

> 2.309 Adjudication on the Record
>
> (a) The Board may render a decision based on the record and without holding a hearing pursuant
>
> to Section 2.307 of this rule in the following circumstances:
>
> (1) all Parties waive their respective rights to a hearing and agree to submit to adjudication
>
> on the record;
>
> (2) the proposed rates affect no more than 100 covered lives and the rate request seeks to
>
> increase rates by no more than 10%; or
>
> (3) the rate filing seeks to increase rates by no more than 3%.

[13] State of Vermont, GMCB Rule 2.000: HEALTH INSURANCE RATE REVIEW: 2.307 Timeline and Scope of Boards Reviews

[14] State of Vermont, GMCB Rule 2.000: HEALTH INSURANCE RATE REVIEW: 2.404 Appeal

[15] 2006 Health Care Reform Initiatives – The Details. Accessed 18 November 2015: http://www.leg.state.vt.us/Health care/2006_Health_Care_Constituent_Information_Sheet.htm.

[16] Vermont General Assembly, Title 08 Banking and Insurance, 4085d(1):Accessed 25 November 2015: http://legislature.vermont.gov/statutes/section/08/107/04085

[17] United States Department of Labor, Consumer Price Index, Northeast Region: Accessed 28 October 2018: https://data.bls.gov/pdq/SurveyOutputServlet?data_tool=dropmap&series_id=CUUR0100SA0,CUUS0100SA0

[18] The Vermont Statutes on Line, Title 18 Health Chapter 200, 18 V.S.A. § 9374) § 9374. Board membership authority: Accessed 9 October 2018: https://legislature.vermont.gov/statutes/section/18/220/09374

[19] Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(3).

[20] ORCA Media is a local, non-profit television production facility operating in the Central Vermont areas. We provide public, educational, and governmental programming to the residents of the Central Vermont towns of Berlin, Bethel, Braintree, Calais, Duxbury, East Montpelier, Middlesex, Montpelier, Moretown, Randolph, Rochester, Waterbury, and Worcester. ORCA Media strives to provide diverse programming which informs, educates, and entertains. http://www.orcamedia.net/

[21] Washington State Office of the Insurance Commissioner. Our decision/rates (hyperlink). Accessed 23 November 2015: http://www.insurance.wa.gov/health-rates/Search.aspx, WAOIC_Filing_285690_239730_20151123094109.pdf.

[22] California Department of Insurance. Interactive Rate Filing Search. Accessed 23 November 2015: https://interactive.web.insurance.ca.gov/apex/f?p=102:4:0::NO.

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