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

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Prepared by
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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 2011, Vermont was awarded a grant in the second round of Health Insurance Premium Review Grants funding, known as Cycle II.[3]

Vermont's health insurance rate review program has been transformed since the beginning of the Cycle II Rate Review Grant in 2012. Effective January 2014, the Green Mountain Care Board (GMCB or the Board) became the primary reviewer of comprehensive major medical rate filings. Under statute, the GMCB must determine whether proposed rates are "excessive, inadequate or unfairly discriminatory,"[4] ensure that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading, or contrary to Vermont law.[5]

The Green Mountain Care Board engaged Compass Health Analytics, Inc. (Compass), an actuarial and health analytics consulting firm, to provide an evaluation of Vermont's rate review process as required by the Cycle II 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 three percent. This study found that for rates effective July 2012 through calendar year 2016 (filed through November 2015), the total premium rate adjustments made in the rate review process have saved Vermonters approximately $66 million, or about three percent. In the absence of the rate review process and state regulators' power under statute to deny 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 Commissioner's (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 as 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. In addition, carrier administrative costs as a percentage of premium have on average come down significantly and become more consistent.

Medical loss ratios are near carrier targets, though margins are thin. Despite the reduction in rates resulting from the review process, which averaged 4.7 percent for MVP[6] and 4.3 percent for Blue Cross Blue Shield of Vermont (BCBSVT), carrier financial results were comparable to their projected levels.

For 2014, the only year of the period studied since ACA implementation for which realized carrier loss ratios are available, both carriers experienced favorable results. The actual medical loss ratios for Health Exchange plans in 2014 were one percent higher than projected for MVP and 1.7 percent lower than projected for BCBSVT. The MVP actual loss ratio is higher than target but excludes an adjustment for transitional reinsurance recoveries; once adjusted, it is very likely its loss ratio would be lower than target. 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 GMCB's target loss ratios for exchange products have allowed for contribution to reserve or profit (CTR/profit) of only 0.5 to one percent annually. Compass recommends the Board continue to closely monitor surplus levels to ensure adequate carrier surplus for exchange products.

Process supports thorough, fair rate review. Throughout the period of the Cycle II 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 the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filing (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 Board with a sound empirical basis to make fair and informed decisions to approve, modify, or deny proposed rates, and strike an appropriate balance between carrier solvency and affordable prices for consumers.

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 initially became less affordable but prices have stabilized. As a percent of median Vermont income, the annualized premium for a single subscriber to the second most popular silver plan increased from 11.7 percent in 2014 to 12.4 percent in 2015, and remained at 12.4 percent in 2016. This pattern may be the result of aggressive pricing to attract market share in 2014 followed by larger increases in 2015 to calibrate to the enrolled population, which allowed more reasonable increases for 2016.

Compass will provide enhanced data collection tools for GMCB to maintain. Compass created data collection tools for use in the analysis of the GMCB rate review process, including for rate review and consumer access. Compass would recommend that the GMCB maintain these data collection tools going forward in order to continue to analyze and make continuous enhancements to the rate review process.

Consumer experience and transparency very good but improvable. Compass 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 Compass 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] Affordable Care Act: "The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was

[2] Centers for Medicare and 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 November 2015: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/rates.html

[3] *Ibid.*

[4] Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(2).

[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 29 November, 2015: https://www.healthcare.gov/glossary/qualified-health-plan/, accessed 29 November 2015.

[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 their employees.

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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 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 2011, Vermont was awarded a grant in the second round of Health Insurance Premium Review Grants funding, known as the Cycle II Grant.[3]

Vermont's health insurance rate review program has been transformed since the beginning of the federally-funded Cycle II Rate Review Grant in 2012. Prior to 2014, the Department of Financial Regulation (DFR) reviewed health insurance rate filings, including performing the actuarial review, resulting in recommendations that the Green Mountain Care Board (GMCB or the Board) approve, modify or disapprove the proposed rates. Effective January 2014, the GMCB became, with the assistance of consulting actuaries contracted by the GMCB, the primary reviewer of comprehensive major medical rate filings, with advice from DFR related to the impact of the proposed rates on insurer solvency.

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

This study, a requirement of the Cycle II 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 Compass Health Analytics, Inc. (Compass), an actuarial and health analytics consulting firm, to conduct the study and provide this report, which summarizes the evaluation of these components and provides a comparison of Vermont's rate review process to those of other states.

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 II 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 is charged with reviewing rates for all commercial health insurance plans regulated by the State of Vermont.[i] However, in consultation with the GMCB, Compass 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, Compass 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." [7]

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," 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 recent national study comparing premium outcomes for 2010 through 2013 between states with approval authority and loss ratio requirements[iii] and states with no approval authority found that states with approval authority and loss ratio requirements had, on average, 3.5 percent lower premiums in the individual market than states without such authority.[8] The 3.5 percent difference across states in this research finding is not a directly comparable measure to the three percent 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.[iv] Within five days of receiving the filing, the GMCB makes new rate requests publically available through its website. A fifteen-day public

[i] That is, 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] Compass 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] The Affordable Care Act implemented loss ratio requirements nationwide in 2011.

[iv] 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 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.

comment period begins once the actuarial memorandum is posted, which is on or before the sixtieth day after the initial filing submission date.[9]

The GMCB and its actuaries review each filing for completeness, accuracy, and the validity of assumptions and rating factors, and is charged with procuring an actuarial opinion on the requested rate change. In addition, DFR must submit an opinion on the impact each filing has on insurer solvency. Both of these opinions must be posted to the GMCB website within sixty days of GMCB receiving the rate filing.[10]

Within thirty days of posting the opinions, the GMCB must hold a public hearing on the filing[11] unless the Board 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 denial) within ninety days of receiving the filing.[13] The Board adjusts proposed rates (and rate factors) when they are viewed as excessive or inadequate. Rate changes, as approved, may be implemented only after the Board's decision. The Board's decisions may be appealed to the Vermont Supreme Court within thirty 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,[v] including proposed rates and rate factors, projected membership, approved rates and rate factors, realized medical loss ratios (MLR), 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.
- Results of a data request for premium, claims and membership by market segment, product, and ACA status, which was submitted by Compass to Blue Cross Blue Shield of Vermont (BCBSVT) and MVP.[vi]
- Clarification on rate filings as well as additional claim, membership, and factor data, where requested, from BCBSVT and MVP.
- GMCB and DFR public websites, as well as Vermont statutes and regulations.

[v] Rate filings were accessed directly from GMCB's instance of the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filing (SERFF), with any corresponding filing exhibits in Excel format provided by GMCB, and indirectly from DFR SERFF instance through the GMCB staff.
[vi] 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.

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 and allowed rating by age of the insured. The new policies sold in 2014 and beyond are part of a merged small group and individual market and no longer allow age rating. These changes created challenges in capturing consistent metrics between non-ACA filings and ACA filings. In addition, particularly in older periods (pre-GMCB SERFF filings), not all of the supporting exhibits in the filings were updated to support the final approved rates. To address these gaps, Compass requested additional information and clarification from the carriers on their filings. In a few necessary cases, Compass developed estimates based on publically available data and the professional judgment of Compass actuarial and pricing staff with over 75 years of combined industry experience.

2. Evaluation of the Rate Review Process and Results

As a starting point for evaluating the rate review process, Compass measured rate filing summary statistics including counts of filings, hearings, covered lives impacted, proposed and final premium dollars, premium 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, Compass developed measures for each carrier of the major pricing components, or "rating factors," of premium rates and studied them over the period of the Cycle II Grant. These measures included:

- Medical loss ratio (MLR),
- Pricing trends,
- Administrative expense,
- Taxes and fees, and
- Contribution to reserve or profit (CTR/profit).

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/profits. Compass 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 II Grant Rate Reviews Summary Statistics and Results

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

Since Vermont's Cycle II Grant federal funding began in 2012, the Department of Financial Regulation and the Green Mountain Care Board have reviewed 101 health insurance filings. Of these, 69 were rate filings and 32 were rate factor filings, and 50 of the 69 rate filings (72 percent) resulted in an adjustment to the proposed rates.

Thirteen rate filings and four rate factor filings, or about 17 percent 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, and the number of rate factor filings and hearings are presented in Table 2.

Table 1
Rate Filings

Year	Filings	Hearings	Members
2012	19	0	31,306
2013	23	7	132,912
2014	14	2	103,380
2015	11	2	80,452
2016	2	2	76,431
Total	69	13	424,481

Table 2
Rate Factor Filings

Year	Filings	Hearings
2012	6	2
2013	11	2
2014	13	0
2015	2	0
Total	32	4

The initial year of the evaluation (2012) is a partial year; rate filings submitted prior to the beginning of the Cycle II Grant were not part of this study, and therefore the number of filings and

corresponding members impacted are low compared to subsequent years. Also, as of the completion of data collection for this study, a number of filings with 2016 effective dates had not been filed or approved. For example, the MVP grandfathered small group filing had been submitted but not approved, and large group rates had not been filed.

The number of members affected decreases in each successive complete year 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.

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.

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. Fewer filings reduce the administrative burden on both carriers and regulators, and while changes to filing requirements under the ACA required an initial period of increased effort from stakeholders, more standardized filings will increase efficiency in the longer term.

Vermont regulators have created additional efficiencies in the rate review process by effectively directing the carriers to improve how they populate the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filing (SERFF), 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 and manipulable formats is extremely valuable to actuaries performing rate reviews.

For rates effective July 2012 to calendar year 2016 (filed through November, 2015), the total adjustments made in the rate review process have saved Vermonters approximately $66 million, or about three percent of total premiums proposed.

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

Table 3
Premium Dollars and Rate Review Savings (in millions)

Year	Filings	Proposed Premium	Final Premium	Savings	% Savings
2012	19	$150.9	$150.1	$0.8	0.5%
2013	23	$725.2	$702.0	$23.2	3.2%
2014	14	$541.3	$519.2	$22.1	4.1%
2015	11	$426.9	$416.8	$10.1	2.4%
2016	2	$430.9	$421.6	$9.3	2.2%
Total	69	$2,275.2	$2,209.7	$65.5	2.9%

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 2012 to 2014 filings were adjusted for realized membership.[vii] Separate data for projected and realized membership (where realized figures are available) are presented in Appendix A.

As noted above, in the absence of the approval requirement it is likely the unadjusted rates would have been implemented, increasing consumer premium cost and carrier premium revenue.

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, Compass 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 II 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, contribution to reserves, and taxes and fees. To support the Cycle II Grant evaluation, Compass compiled and measured these key rating factors and studied them over time.

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").

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

For the individual, small group, and merged market filings with 2013 to 2016 effective dates summarized in Table 4, total annual approved pricing trends ranged from 3.9 percent to 7.9 percent and averaged 5.8 percent.

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%
BCBSVT	IND	Q3 13 Catamount	7/1/2013	3.9%
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%
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%

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 five and seven percent. The lowest approved pricing trend in this period was the BCBSVT July 2013 Catamount[viii,15] pricing trend of 3.9 percent, a rate review reduction by GMCB from the proposed trend of 7.9 percent. The 7.8 percent pricing trend for the MVP individual indemnity product was the highest approved pricing trend for 2013. Indemnity trends tend to run higher than HMO and PPO 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 also ranged between 3.9 percent and 7.8 percent, with the lowest trends used in the 2014 filings. Aggressive carrier pricing with the launch of the

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

exchange in an attempt to gain market share is a likely factor in this result. The requested and approved pricing trends for both carriers increased in 2015.

BCBSVT has been approved for an additional increase 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 percent versus five percent in the previous rating period and a utilization trend increase from near zero to two percent. MVP projects similar unit cost increases, but has flat or negative utilization projections.

All pricing trends in these markets ranged from 3.9 to 7.9 percent during 2013 to 2016. Excluding outliers, the range tightens to five to seven percent. Based on the experience of Compass staff with over thirty years of pricing experience in the New England market, these ranges are fairly narrow considering the ongoing transformation of the health insurance market in this period. A narrow pricing trend range suggests that the rate review process 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.

Retention

Retention is the portion of the rate that carriers collect to pay expenses; it consists of three main components: administrative expense, taxes and fees, and CTR/profit. GMCB approved total carrier retention expenses per member per month (PMPM) and percentage breakouts by major component are presented by product and effective date in Table 5. 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/profit and taxes as a fixed percentage of premiums. Table 5 displays administrative expense as both a PMPM and percent of premium for clarity.

Table 5
Carrier Retention

Carrier	Market Segment	Filing Description	Effective Date	Admin Expense PMPM	Admin Expense	CTR/Profit	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	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	$31.00	8.6%	0.5%	3.2%	12.3%
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	$39.69	10.1%	1.0%	3.7%	14.9%
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	9.1%	0.0%	3.8%	12.8%

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 Exchange, carriers were prohibited from paying and including broker commissions for small group and individual plans.[16]

After accounting for changes in measurement occurring during the Cycle II Grant period, administrative expenses have been relatively stable. In 2013, both MVP and BCBSVT included broker commissions in their administrative expense. As shown in Table 5, the level of administrative expense varied widely for 2013 filings, from $26.92 PMPM to $82.54 PMPM (from 5.9 to 14.3 percent of premium), a wider and higher range than seen in the succeeding years.[ix] 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 $3.69 PMPM, from $31.00 (8.6 percent of premium) to $27.31 (6.3 percent of premium), an 11.9 percent 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 percent. Over a two-year period BCBSVT reduced its PMPM administrative expense by two percent per year on average. MVP's administrative expense rose between 2014 and 2015 from 9.8 percent to 10.1 percent of premium, and the PMPM increased by $3.81, or by 10.6 percent. MVP's administrative expense then fell to 9.1 percent of premium in 2016, a $1.43 (3.6 percent) reduction in the PMPM.

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

Over a two-year period MVP's PMPM administrative expense increased by 3.3 percent per year on average. The carriers' changes in administrative expense compare closely to general Consumer Price Index changes (CPI) in the Northeast region, which increased between 0.4 percent and two percent for twelve-month periods ending in 2014.[17] Given the added expense of implementing the ACA, the administrative expense has remained relatively stable for both carriers.

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 two percent premium tax requirement. The carriers filed their 2014 merged market filings on HMO products. However, as shown in the "Taxes" column of Table 5, taxes and fees have increased for both MVP and BCBSVT due to the ACA insurer fee and other ACA-related fees. At any given premium level, higher taxes and fees result in a lower target loss ratio for the carriers.

Contribution to reserves/profit

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

As shown in the CTR/profit column of Table 5, CTR/profit has varied between zero percent and three percent during the Cycle II Grant period. Since 2014 and the implementation of the ACA, CTR/profit has been between one half of one percent and one percent, with the exception of the 2016 MVP filing in which the carrier filed a zero percent contribution to reserve to help improve its competitive position in the market in 2016. Given the uncertainty in the market in these early years of ACA implementation, these percentages are somewhat low. However, as part of the review process, a solvency analysis is performed by DFR to ensure that the approved rates do not adversely impact the solvency of the insurer.

Medical Loss Ratio

MLR[xi] 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

[x] MVP Health Plan and BCBSVT are not-for-profit insurers. MVP Health Insurance Company is a for-profit insurance company and this component of retention is considered profit.

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

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 then 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 that 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 plans are all rated appropriately. It is therefore important to be cautious when using this measure.

Many factors can impact this loss ratio variance, including, but not limited to: changes in the demographic make-up of the membership, a different benefit plan distribution than anticipated, unexpected expensive services or technologies, and random claims fluctuations. Because of this inherent volatility, when evaluating carrier results it is important to compare realized to target loss ratios over time.

Realized loss ratios are available through calendar year 2014. Rating periods have been standardized to the calendar year for rating periods 2015 and beyond; actual loss ratios for 2015 are therefore unknown as of this writing.

Table 6 presents target benefit expense (claims cost), approved target loss ratio, and realized loss ratio for individual, small group, and merged market rate filings with projected membership greater than 2,500 members for rating periods 2013 to 2016. Smaller risk pools have greater inherent claims volatility and thus a comparison of target loss ratios to realized loss ratios is less meaningful for rate filings with low membership.

Table 6
Approved and Realized Medical Loss Ratios

Carrier	Market Segment	Filing Description	Effective Date	Members	Benefit Expense (PMPM)	Approved Target Loss Ratio	Realized Loss Ratio
BCBSVT	SG	Q1 Q2 2013 TVHP	1/1/2013	21,853	$365.60	86.3%	90.1%
BCBSVT	SG	Assoc. of Chamber Execs	1/1/2013	18,012	$305.98	89.0%	96.1%
BCBSVT	IND	Q3 13 Catamount	7/1/2013	15,351	$418.11	92.3%	91.7%
MVP	SG	PPO/EPO Q1 Q2 13	1/1/2013	11,743	$320.44	79.7%	90.5%
BCBSVT	Merged	Health Exchange 2014	1/1/2014	63,222	$315.79	87.7%	86.0%
MVP	Merged	Health Exchange 2014	1/1/2014	20,175	$315.52	85.7%	86.7%
MVP	SG	GF PPO/EPO Q1 Q2	1/1/2014	3,756	$327.72	83.8%	94.2%
BCBSVT	Merged	Health Exchange 2015	1/1/2015	58,190	$387.69	89.0%	NA
MVP	Merged	Health Exchange 2015	1/1/2015	4,798	$334.01	85.1%	NA
MVP	SG	GF PPO Q1 Q2 2015	1/1/2015	2,806	$369.56	83.6%	NA
BCBSVT	Merged	Health Exchange 2016	1/1/2016	70,014	$412.12	89.0%	NA
MVP	Merged	Health Exchange 2016	1/1/2016	6,417	$367.02	87.2%	NA

In 2013, rate review resulted in premium reductions of 3.2 percent in aggregate for all market segments. Realized loss ratios in the small group and individual pools that had 2,500 or more projected members were very close to or above the target loss ratios. For BCBSVT's Catamount pool, the realized loss ratio was just under target and suggests that it was rated close to appropriately. The 2013 realized loss ratios in the small group pools were greater than target and suggest that rates were somewhat too low.

Despite rate review reductions to premiums of 4.7 percent for MVP and 4.3 percent for BCBSVT, the realized loss ratios for Vermont Health Connect plans in 2014 were one percent higher than target for MVP and 1.7 percent lower for BCBSVT. It is important to note that while the MVP realized loss ratio was higher than the target, the realized loss ratio excludes an adjustment for transitional reinsurance. In the 2014 filing, MVP adjusted its index rate[xii] down by 3.2 percent to account for anticipated payments from this temporary program, reducing the loss ratio proportionately. However, after accounting for this adjustment the realized loss ratio would likely be favorable when compared to the target.

For MVP, the GMCB reduced the proposed rates in part by ordering revisions to its transitional reinsurance adjustment calculation, the catastrophic shortfall adjustment, and the adjustment for benefits not covered during the experience period that will be covered on the exchange. In addition, GMCB lowered the pricing trend approximately 0.6 percent and required a two percent claims reduction for anticipated improved morbidity in the reformed market. Many states expected and observed increased morbidity after ACA implementation due to stricter rating requirements, including the loss of medical underwriting. However, Vermont was a community-rated and guaranteed-issue state prior to ACA implementation. As discussed in the GMCB's decision, many sources suggested the ACA's subsidies would attract healthier members into the markets in these states and improve morbidity.[18] In total, the GMCB reduced MVP's 2014 Health Exchange rates by 4.7 percent. These adjustments appear to have been reasonable.

For BCBSVT, the Board adjusted the rates by lowering the pharmacy trend two percent, reducing the pediatric dental cost by $0.10 PMPM, recalculating the transitional reinsurance recovery, requiring the use of standard Department of Health and Human Services (HHS) induced utilization factors,[xiii,19] and, as discussed above for MVP, including a two percent claims reduction for anticipated improved morbidity. In total, the GMCB reduced BSBSVT's 2014 Vermont Health Connect rates by 4.3 percent. The adjustments made to the BCBSVT filing also appear to have been reasonable.

Because of the many factors that impact the realized loss ratios, including 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. In 2013, the individual and small group markets generally had realized loss ratios higher than approved loss ratios. In 2014, realized loss ratios were lower

[xii] The index rate represents the estimated total combined allowed claims experience PMPM for essential health benefits in the single risk pool, as defined by the Department of Health and Human Services.
[xiii] HHS-induced utilization factors recognize that enrollees in plans with higher actuarial values are expected to use more services because of lower cost sharing.

than approved (after adjustments for changes in measurement) despite the rate reductions made by the GMCB. Compass would recommend that the GMCB continue to make actual versus target loss ratio comparisons and track them over at least a rolling five year period to help ensure that rate filing adjustments are reasonable over time.

Changes to target loss ratios in the rate review process and the resulting comparison of approved to realized MLRs have strong implications for evaluating whether the rate review process is fair, reasonable, and equitable. Compass 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.[20] That is, the Board 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.

Table 7 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 7
Health Exchange Rate Review
Premium Reduction and Medical Loss Ratios

Carrier	Effective Date	Premium Reduction	Proposed	Approved	Realized
BCBSVT	1/1/2014	4.3%	88.1%	87.7%	86.0%
MVP*	1/1/2014	4.7%	84.8%	85.7%	86.7%
BCBSVT	1/1/2015	1.9%	89.1%	89.0%	NA†
MVP*	1/1/2015	4.1%	84.7%	85.1%	NA†
BCBSVT	1/1/2016	2.3%	88.0%	89.0%	NA†
MVP*	1/1/2016	0.6%	87.2%	87.2%	NA†

* Realized LR excludes adjustment for transitional reinsurance.

† NA = Not yet available.

Since the 2014 rating period, total premium adjustments made by the GMCB on the merged market health exchange plans have saved Vermonters approximately $29 million, or about 2.7 percent, in premium. For 2014, the only year for which actual carrier loss ratios are available for the merged market, both carriers experienced favorable results. The actual loss ratios for Health Exchange plans in 2014 were one percent higher than projected for MVP and 1.7 percent lower for BCBSVT. The MVP actual loss ratio is higher than target but excludes an adjustment for transitional

reinsurance recoveries; once adjusted it is very likely its loss ratio would be lower than target. This is true despite rate review premium reductions of 4.7 percent for MVP and 4.3 percent for BCBSVT. 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, Compass notes GMCB's target loss ratios for exchange products have allowed for CTR/profit of 0.5 to one percent annually. As noted in Section 2.2, these projected margins are low given the uncertainty in the reformed market. While the DFR has been performing solvency reviews, Compass recommends the State of Vermont and GMCB continue to closely monitor surplus levels and consider those levels in its decision-making on contribution to reserve rating factors to ensure adequate carrier surplus for exchange products.

Finally, throughout the period of the Cycle II 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 (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 Board with a sound empirical basis to make fair and informed decisions to approve, modify, or deny proposed rates, and strike an appropriate balance between carrier solvency and affordable prices for consumers.

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

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, small group, and merged markets, Compass reviewed carrier offerings for 2013 through 2016 rating periods. This approach showed the market's evolution from year to year from before implementation of the ACA (2013) through the third year of Vermont Health Connect (2016).

This review has three main components: (i) an assessment of product variety, as measured by the quantity of distinct benefit plans offered over time and the distribution of members across benefit

levels over time, (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 qualified health plan[xiv] (QHP) as a proportion of median income for a full-time year-round worker in Vermont.

Compass reviewed rate filings for 1st quarters 2013, 2014, 2015, and 2016 for the two carriers offering individual and small group health insurance coverage in Vermont and the Catamount filing for 3rd quarter 2013 to compile and analyze the following measures of access and affordability.

- Number of benefit plans filed: The simple count of benefit plans available to individuals and employees of small employer groups (by metal level[xv] for ACA filings), and its evolution over time, provides a starting point for assessing access to a sufficient variety of products. After discussion with the GMCB, it was decided 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 Rx benefit options.
- Anticipated member months and distribution of anticipated member months: This measure, by ACA metal level[xvi] and year, illuminates where the membership is 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[xvii] 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 per member per month (PMPM): Capturing the highest, lowest, and average premium per member per month 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

[xiv] "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/.
[xv] The qualified health plan standard benefit levels: platinum (on average, 90 percent of member health care costs paid by the carrier), gold (80 percent paid by carrier), silver (70 percent), and bronze (60 percent).
[xvi] Pre-ACA filings were not standardized and did not all include member months.
[xvii] 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.

of where the qualified health plan products are falling in the de minimis range over time.[xviii]

- 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). While for individual plan members 100 percent of this total cost of health care figure (exclusive of subsidies) represents direct personal expense, most employees covered by small group policies would likely pay a portion of the premium (the portion not covered by the employer) and all of the cost sharing.
- Affordability comparison: Affordability is critical to consumer access. Compass 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.

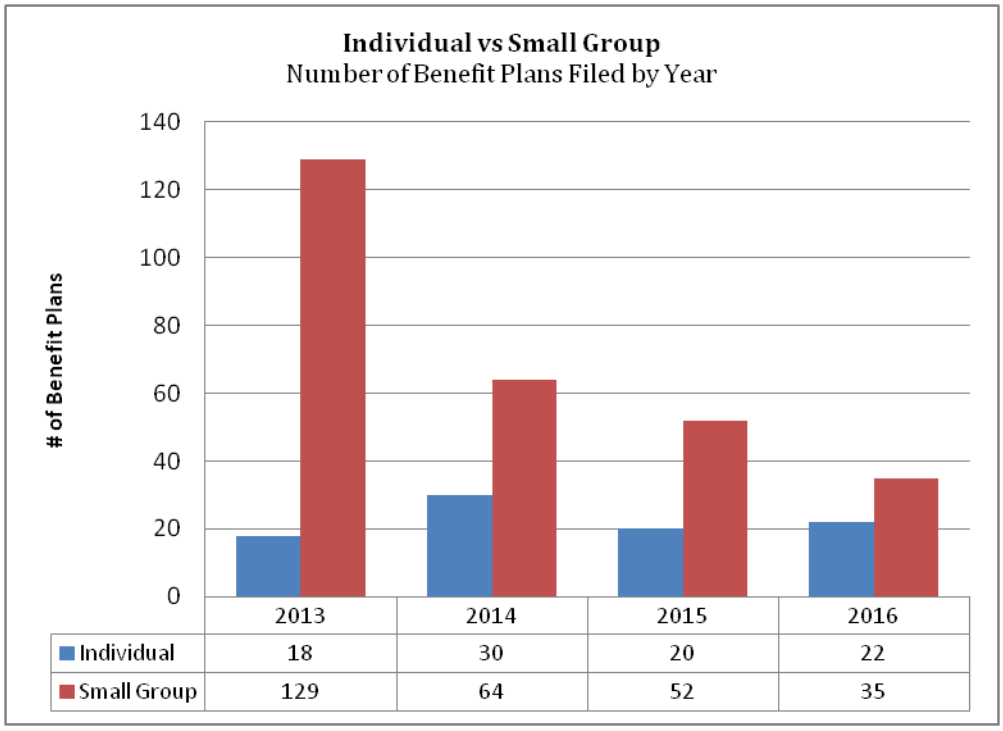
3.1. Products

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."[xix] 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.

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 but is now only slightly higher than the number of plans available in 2013. Figure 1 shows the number of benefit plans filed in the individual and small group markets by year, from 2013 to 2016.

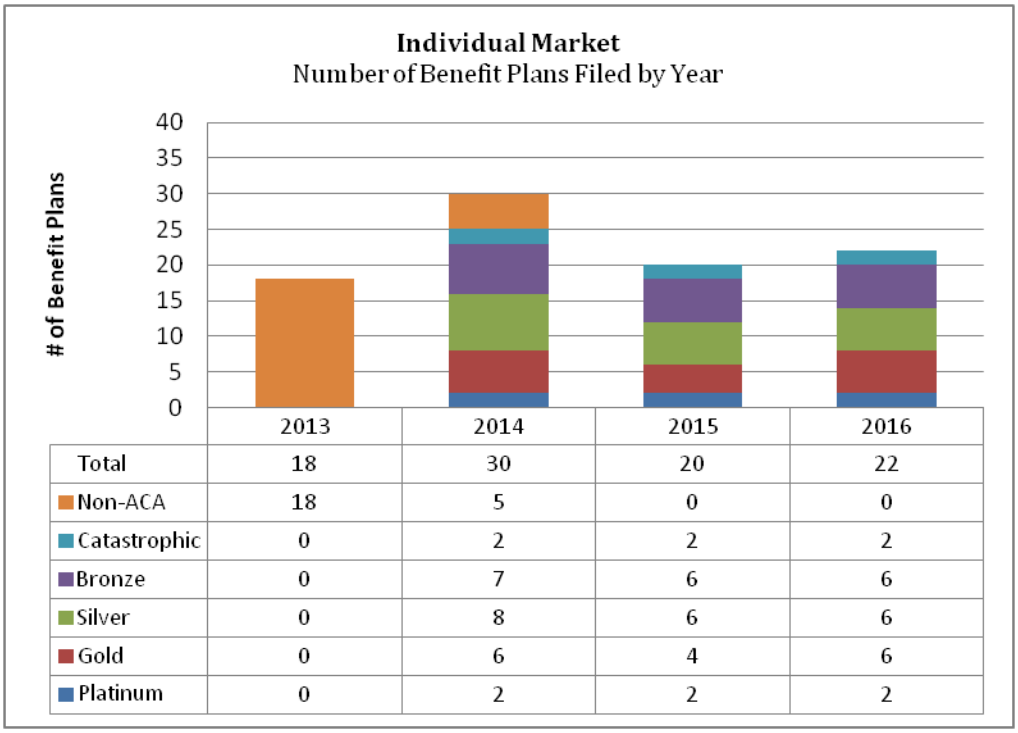
[xviii] The final rule establishes that a de minimis variation of +/- 2 percentage points of actuarial value is allowed for each metallic tier.
[xix] Grandfathered plans are health plans that were in existence on March 23, 2010, and haven't been changed in ways that substantially cut benefits or increase costs for plan holders.

Figure 1



The total number of benefit options currently available in the individual market is only slightly higher than before ACA implementation; however, the number of benefit options increased in 2014, due to newly-available ACA compliant benefit options, before decreasing back to pre-ACA levels. This decrease was 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 2016. 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

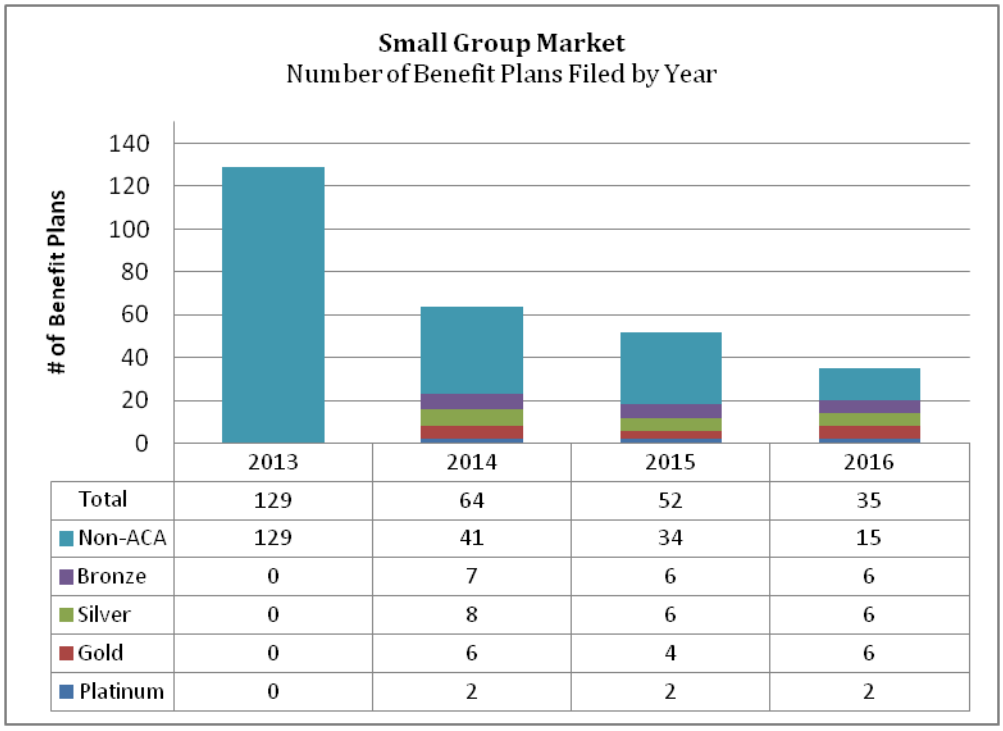


	2013	2014	2015	2016
Total	18	30	20	22
Non-ACA	18	5	0	0
Catastrophic	0	2	2	2
Bronze	0	7	6	6
Silver	0	8	6	6
Gold	0	6	4	6
Platinum	0	2	2	2

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 qualified health plans limiting the number of potential benefit plans coupled with the potential for selection risk[xx] 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 2016. The number of ACA benefit plans has remained fairly stable, with decreases of only one bronze and two silver options between 2014 and 2016. 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 qualified health plan offerings by metal level for 2014 to 2016 are exactly the same for small groups and individuals, except that catastrophic coverage is only available to certain individuals.

[xx] 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 their employees.

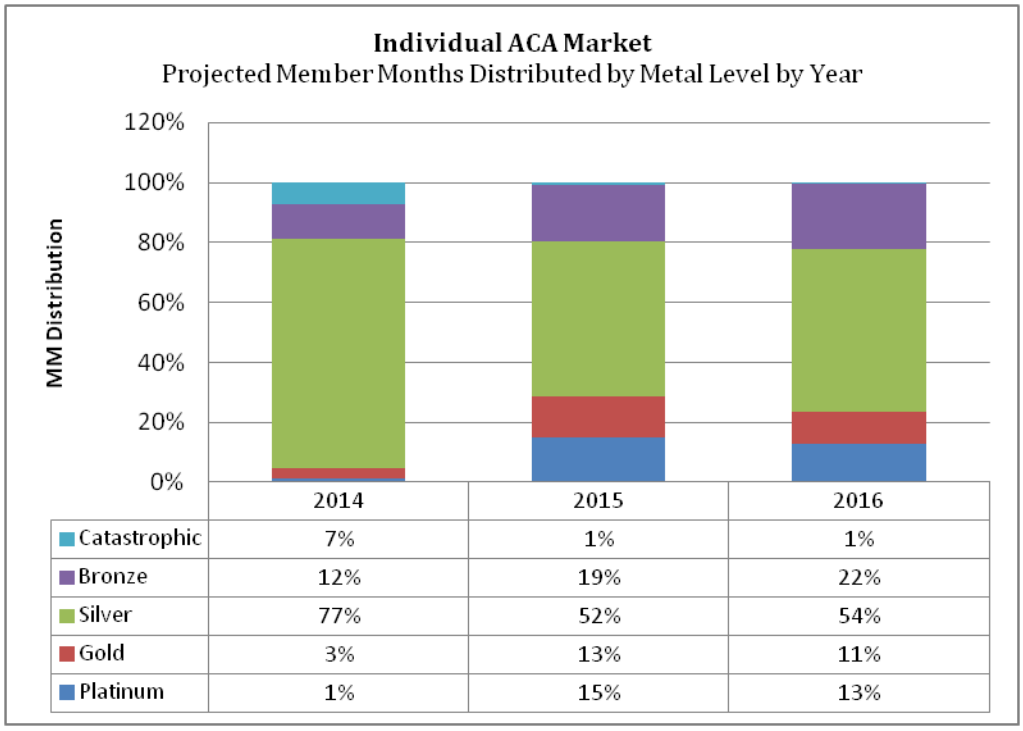
Figure 3



	2013	2014	2015	2016
Total	129	64	52	35
Non-ACA	129	41	34	15
Bronze	0	7	6	6
Silver	0	8	6	6
Gold	0	6	4	6
Platinum	0	2	2	2

The reduction in benefit plans over the analysis period suggests that, as expected, the ACA makes shopping easier for the consumer because it standardizes product offerings, but 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

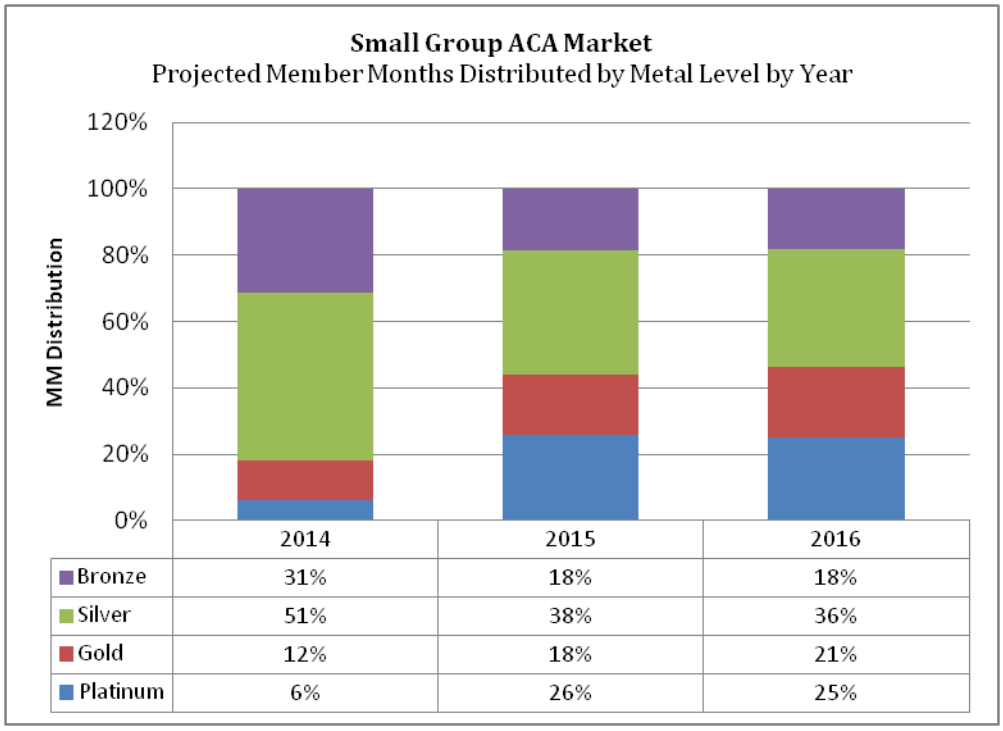


	2014	2015	2016
Catastrophic	7%	1%	1%
Bronze	12%	19%	22%
Silver	77%	52%	54%
Gold	3%	13%	11%
Platinum	1%	15%	13%

The expected distributions in the 2015 and 2016 filings are most likely based on the results from 2014 and 2015, respectively. In the 2015 filing there were more individual gold and platinum members than were anticipated in the 2014 filing, and fewer catastrophic members. The distributions by metal tier for the individual market for 2015 and 2016 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. As in the individual market, the distributions by metal tier for the small group market for 2015 and 2016 are 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



3.2. Actuarial Value & Rate Relativity

Compass 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 eight percent 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.

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 time period and carrier.

Table 8 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 8
High, Low and Average Premium PMPMs by Market Segment

	BCBSVT				MVP						
Small Group	2013	2014 ACA	2015 ACA	2016 ACA	2013	2014 ACA	2015 ACA	2016 ACA	2014 GF	2015 GF	2016 GF
High Cost Plan	$1,087	$521	$555	$589	$1,042	$513	$589	$577	$673	$701	$495
Low Cost Plan	$440	$305	$321	$360	$252	$290	$348	$333	$304	$333	$335
Spread (1-low/high)	60%	41%	42%	39%	76%	43%	41%	42%	55%	53%	32%
Average Premium	**$447**	**$365**	**$442**	**$476**	**$417**	**$383**	**$448**	**$431**	**$480**	**$403**	**$408**
Individual	2013	2014 ACA	2015 ACA	2016 ACA	2013	2014 ACA	2015 ACA	2016 ACA	2014 GF		
High Cost Plan	$565	$451	$521	$555	$320	$513	$589	$577	$268		
Low Cost Plan	$262	$451	$305	$321	$18	$290	$348	$333	$17		
Spread (1-low/high)	54%	0%	41%	42%	95%	43%	41%	42%	94%		
Average Premium	**$367**	**$356**	**$425**	**$448**	**$223**	**$353**	**$392**	**$404**	**$26**		
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, and availability of other insurance (such as from a spouse). Compass considered two different metrics to assess affordability over time: (i) average total cost of health care per member per month (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, coinsurance, and deductibles) along with the premium paid to the insurer. This measure does not take into account premium subsidization, either through the federal government or 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 is 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 modestly between 2013 and 2016, averaging 1.6 percent per year over the three-year time period. The increase of the average total cost of health care in the individual market was more significant, averaging 5.7 percent per year over the three-year time period. In 2015 there were no longer grandfathered (pre-ACA) benefit plans being sold in the individual market. Prior to 2015 there were very high deductible plans 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 9 provides average premium, cost sharing, and total cost of health care PMPMs by year and market segment.

Table 9
Average Premium, Cost Sharing and Total Cost of Health Care by Market Segment

Small Group	2013	2014	2015	2016
Avg Premium PMPM	$435	$383	$440	$466
Avg Cost Sharing PMPM	$107	$125	$109	$102
Avg Total Cost of Health Care	$541	$508	$549	$568
Individual	2013	2014	2015	2016
Avg Premium PMPM	$422	$349	$421	$438
Avg Cost Sharing PMPM	$78	$139	$177	$151
Avg Total Cost of Health Care	$499	$488	$599	$589

In setting premium subsidies in the individual market, the ACA caps the expected consumer contribution towards insurance premiums for individuals making 300 to 400 percent of the federal poverty level (FPL) at 9.66 percent 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 percent FPL.

In order to evaluate the change in affordability over time, Compass 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 three 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 as the 2013 Vermont median income from the American Community Survey (ACS) Five Year Estimate[xxi] projected into 2014, 2015, and 2016 using the 2014 growth rate

[xxi] The United States Census Bureau publishes one-year and five-year ACS income estimates. Compass tested the metric using both measures of income, and found that the results are not very sensitive to the choice of ACS income measure.

from the ACS One Year Data and 2015 and 2016 projected growth rates from the Congressional Budget Office (CBO).

The premium cost of the benchmark plan initially became less affordable but has stabilized, growing from 11.7 percent of the income measure in 2014 to 12.4 percent in 2015 and then remaining relatively stable in 2016. Table 10 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 10
Median Income Compared to Standard Silver Single Premium

	2013	2014	2015	2016
Projected Median Income for FT, YR Worker	$42,819	$43,785	$45,274	$46,813
Growth Rate in Income		2.3%	3.4%	3.4%
Standard Silver Rate - Single (Annualized)		$5,105	$5,600	$5,825
Growth Rate in Standard Silver			9.7%	4.0%
Standard Siver Rate/Proj Median Income		11.7%	12.4%	12.4%

A large portion of individuals and employer groups in the individual and small group marketplaces purchases products in the gold and platinum tiers, giving some indication that, for a portion of the market at least, premium levels are affordable. It is anticipated that in 2016, 24 percent of individuals will purchase gold or platinum benefit plans and that 44 percent of small group employees will be in the gold or platinum tiers.

4. Consumer Experience

Beyond the assessment of the impact of the rate review process on rates and measures of affordability, there are a number of other factors that reflect how Vermont's rate review process works for consumers. In this section Compass 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, and furnishes some recommendations to improve the consumer experience.

4.1. Consumer Experience

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

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 their rate review internet homepage.[xxii] 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 2.00 regarding health insurance rate review.

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 an "Insurance Rate Review" button on the right side of the GMCB's home page.[xxiii] As of this writing, the homepage is in the first page of results of a Google search on the phrase "Vermont health insurance rates." Compass has found the rate review site easy to navigate throughout the Cycle II Grant evaluation.

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" tab on the left side of the homepage, navigating to an insurer's "Pending Reviews" or "Decisions" page, and signing up through the "Subscribe to RSS[xxiv] for this provider" button. Rate filings are grouped by major carrier (BCBSVT, MVP, and 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 these pages, a filing name (e.g., "BCBSVT 2016 Exchange Filing"), a brief description of the request (e.g., "BCBSVT proposes an average annual increase of 8.4 percent over 2015 premiums offered on Vermont Health Connect"), a statement of the outcome (e.g., "Approved with Modification"), a docket number, a SERFF tracking number, and the dates of posting, updates, the close of comments, and the decision (if applicable), are displayed. Links are offered to:

- The SERFF Portable Document Format (.pdf) version of the rate filing
- The carrier's plain language summary, for rate filings requesting a five percent or greater premium increase
- The GMCB's decision
- The Notice of Hearing and all related hearing documents, or memorandum in lieu of hearing

[xxii] http://ratereview.vermont.gov/.
[xxiii] gmcboard.vermont.gov.
[xxiv] 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.

- The reviewing actuaries' actuarial memorandum
- The solvency analysis
- Public comments

Hearings are open to the public and are recorded by ORCA Media;[21] they can be viewed later upon request.

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.

Engagement

Once a rate filing is posted on the Board's website, a public comment period begins. Anyone who wishes to post a comment or question about the filing may do so on the internet, by phone, or by mail by following the directions on the Public Comment page. A "Your Comments Count! Make a Public Comment" button is prominently displayed on the rate review front page. 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. The majority of comments received by the Board have been collected and submitted by the Vermont Public Interest Research Group (VPIRG) via a form on their website. The form contains standard language; however, consumers are encouraged to share their personal views in addition to the pre-populated template comments, though the majority of the comments received for exchange filings are from the VPIRG form in the standard template language. GMCB includes public comments in the documents related to the filings on its website. Table 11 summarizes the comments received for exchange filings by type:

Table 11
Exchange Filing Consumer Comments by Source

Year	Total Comments	VPIRG Template	VPIRG Adapted	Verbal Public	Written Public
2014	80				
2015	275	178	56	2	39
2016	484	315	135	9	25

Rate hearings are televised and open to the public. The BCBSVT and MVP 2016 Vermont Health Connect rate hearings, held in 2015 (the only year for which these figures are available), were attended by at least 28 and 18 members of the public (excluding government officials, GMCB members, and representatives from the carriers), respectively. These numbers may understate public attendance, as they were compiled from a voluntary sign-in sheet. In addition, the most recent hearings were held in a smaller room than previous years', and the BCBSVT hearing was standing-room only, raising the possibility that some interested members of the public were deterred from attending by lack of space and seating.

Public engagement has been steadily increasing over the past three years, as evidenced by the increase in public comments as well as the full attendance at the latest rate hearings.

4.2. Plain Language Filing Summaries

As an aid for consumer disclosure and transparency, Vermont requires filings requesting a rate increase of five percent or greater to include a "plain language summary" of the request as part of the filing. The summaries are not 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 that are driving the proposed rate increase for the specific products contained in the filing."[22] Compass reviewed the 2015 and 2016 Vermont Health Connect plain language summaries for content, clarity, and compliance with the outlined requirements.

One major carrier's 2015 and 2016 plain language summaries for qualified health plans state the listed facts clearly and are very concise, at less than one page each. However, the summaries do not include a discussion of the drivers of the specific premium increases requested, only a general explanation of potential drivers of health insurance costs and premiums.

Another major carrier's 2015 and 2016 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 to outline the premium impacts relating to the mandated changes associated with the ACA. On balance, however, Compass 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

Compass 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 the 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.

4.4. Enhancements for Consideration

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

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, Compass recommends the Board 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 rate change and approved rate change for the preceding rating period.[23] An example of such a summary is included in Appendix B. The carriers' plain language summaries for proposed increases of five percent or greater could be included in (or linked to) these summaries.

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 Board's website, Compass recommends the Board 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.[24] 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 Compass suggests the Board consider implementing in lieu of its carrier- 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.[25] A screenshot from one of these sites appears in Appendix B.

5. Conclusions and Recommendations

This study of Vermont's rate review process found that for rates effective July 2012 to calendar year 2016 (filed and approved prior to October, 2015), the total adjustments made in the rate review process have saved Vermonters approximately $66 million, or about three percent. In the absence of the rate review process, and state regulators' power under statute to deny 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 in 2014 were one percent higher than projected for MVP and 1.7 percent lower for BCBSVT, the only year for which actual results are available. The MVP realized

loss ratio is higher than target but excludes an adjustment for transitional reinsurance recoveries, and once adjusted it is very likely its loss ratio would be lower than the approved ratio. This suggests that the portion of the premium increase denied by the GMCB was unnecessary to reaching the carriers' target medical loss ratios.

However, GMCB's target loss ratios for exchange products have allowed for CTR/profit of only 0.5 to one percent annually. Compass recommends the Board continue to closely monitor surplus levels to ensure adequate carrier surplus for exchange products.

In addition, throughout the period of the Cycle II 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 Board with a sound empirical basis to make fair and informed decisions to approve, modify, or deny 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 II 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 number of available benefit plans in the individual and small group markets decreased significantly over the grant period in the small group market, with minimal changes in the number of benefits in the individual market. The combination of metal actuarial value requirements for qualified health plans limiting the number of potential benefit plans coupled with the potential for selection risk in the merged small group and individual markets is likely driving the decrease in plans available to small group employers. In addition, restrictions on the maximum allowable out-of-pocket costs for individuals and families eliminated very high-deductible individual products in the market.

The premium cost of the standard silver benchmark plan initially became less affordable as measured against the median income for Vermont full-time, year-round workers, but has stabilized, growing from 11.7 percent of the income measure in 2014 to 12.4 percent in 2015 and then remaining relatively stable in 2016.

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

Finally, Compass reviewed the GMCB's rate review consumer resources and the rate review websites of other states as 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.

Compass reviewed the Vermont Health Connect plain language summaries required for rate increases above five percent for 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 specific facts driving the requested increases in transparent language; however, the summaries exceeded a single page and included unnecessary information. Compass 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.

Compass makes several suggestions that would improve and increase consumer access to rate review information and promote consumer engagement. Compass 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. Compass also recommends that GMCB provide plain language decision and order summaries. Finally, Compass suggests the Board 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

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	IND Factor	Trend, Adjust. to Safety Net 4Q12-2Q13	BCVT-128553178	10/1/2012	13,668	1,139	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Trend Q3 12	BCVT-128097697	7/1/2012	175,968	14,664	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Admin & CTR Q3 12	BCVT-128100658	7/1/2012	175,968	14,664	NA	NA	NA	0	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Admin & CTR Q4 12	BCVT-128395160	10/1/2012	68,028	5,669	NA	NA	NA	1	NA	NA	NA	NA	NA
BCBSVT	SG Factor	Trend Q4 12	BCVT-128396978	10/1/2012	175,968	14,664	NA	NA	NA	1	NA	NA	NA	NA	NA
BCBSVT	SG LG Factor	Merit Rating Formula 2012	BCVT-128267446	11/1/2012	NA	NA	NA	NA	NA	0	NA	NA	NA	NA	NA
		2012 Total			**609,600**	**50,800**				**2**					
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	10/1/2103	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
		2014 Total			**3,238,480**	**269,873**				**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**					
		Grand Total (Factor Filings)			**7,205,104**	**600,425**				**4**					
BCBSVT	IND Rate	Catamount Q3 12	BCVT-128394283	7/1/2012	169,176	14,098	14,098	$68,476	0.0%	0	$68,476	0.0%	$	0.0%	$
BCBSVT	IND Rate	GF & New Business Q4 12	BCVT-128477958	10/1/2012	3,180	265	265	$1,213	-0.4%	0	$1,219	0.0%	-$6	-0.5%	-$6
BCBSVT	LG Rate	Q3 12	BCVT-128192722	7/1/2012	32,520	2,710	2,710	$13,374	4.3%	0	$13,117	2.3%	$257	1.9%	$257
BCBSVT	LG Rate	Merit Manual Rate Q4 12	BCVT-128478440	10/1/2012	10,188	849	849	$4,282	7.4%	0	$4,267	7.0%	$15	0.4%	$15
BCBSVT	SG Rate	Safety Net Rate 3Q12-2Q13	BCVT-128170289	7/1/2012	14,268	1,189	1,189	$6,070	-5.2%	0	$5,971	-6.7%	$99	1.6%	$99
BCBSVT	SG Rate	Q3 12	BCVT-128193805	7/1/2012	14,724	1,227	1,227	$6,169	5.5%	0	$6,046	3.4%	$123	2.0%	$123
BCBSVT	SG Rate	Q3 12	BCVT-128194447	7/1/2012	36	3	3	$25	-3.0%	0	$24	-5.7%	$1	2.8%	$1
BCBSVT	SG Rate	Q4 12	BCVT-128478136	10/1/2012	11,208	934	934	$4,941	7.3%	0	$4,893	6.3%	$47	1.0%	$47
BCBSVT	SG Rate	Q4 2012	BCVT-128478840	10/1/2012	0	0	0	$	6.1%	0	$	5.8%	NA	NA	NA
BCBSVT	SG Rate	VT Auto Dealers Assoc. Q4 12	BCVT-128562147	10/1/2012	27,960	2,330	2,330	$10,090	4.6%	0	$10,087	4.6%	$2	0.0%	$2

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	IND Rate	Nongroup Indemnity Q3 12	MVPH-128104989	7/1/2012	7,920	660	660	$1,719	-4.0%	0	$1,675	-6.5%	$45	2.6%	$45
MVP	IND Rate	Nongroup Q4 12	MVPH-128439588	10/1/2012	5,700	475	475	$1,139	0.8%	0	$1,111	-1.7%	$28	2.5%	$28
MVP	LG Rate	HIC Q3 12	MVPH-128099057	7/1/2012	13,224	1,102	1,102	$5,438	9.1%	0	$5,438	9.1%	$	0.0%	$
MVP	LG Rate	PPO/EPO Q4 12	MVPH-128445942	10/1/2012	14,340	1,195	1,195	$5,675	13.7%	0	$5,675	13.7%	$	0.0%	$
MVP	LG Rate	HMO Manual Q4 12	MVPH-128448180	10/1/2012	0	0	0	$	0.0%	0	$	0.0%	$	NA	$
MVP	SG Rate	PPO/EPO Q3 12	MVPH-128099074	7/1/2012	22,464	1,872	1,872	$9,173	10.0%	0	$9,173	10.0%	$	0.0%	$
MVP	SG Rate	HMO Q3 12	MVPH-128103901	7/1/2012	576	48	48	$422	8.0%	0	$422	8.0%	$	0.0%	$
MVP	SG Rate	PPO/EPO Q4 12	MVPH-128442883	10/1/2012	27,624	2,302	2,302	$12,275	14.4%	0	$12,136	13.1%	$139	1.1%	$139
MVP	SG Rate	HMO Q4 12	MVPH-128448198	10/1/2012	564	47	47	$403	8.8%	0	$403	8.8%	$	0.0%	$
		2012 Total			**375,672**	**31,306**	**31,306**	**$150,884**		**0**	**$150,134**		**$750**	**0.5%**	**$750**
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
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%	$

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	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%	$5,960
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%	$959
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%**	**$10,112**
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%	$9,095
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%	$201
		2016 Total			**917,172**	**76,431**	**76,431**	**$430,858**		**2**	**$421,562**		**$9,296**	**2.2%**	**$9,296**
		Grand Total (Rate Filings)			**5,298,437**	**441,536**	**424,481**	**$2,275,210**		**13**	**$2,209,749**		**$65,460**	**2.9%**	**$61,791**

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%)	Rate reductions are for high deductible plans and rate increases are non high deductible plans.
MVPH-129662230	Q1=10.1%, Q2=10.2%	Q1=7.4%, Q2=7.5%	

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%	76.3%	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%		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	$315.79	87.68%	86.0%	3.8%	4.5%	3.9%	8.61%	0.50%	0.05%	3.16%	12.32%	$31.00	$1.80	$0.18	$11.38	$44.36
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%	NA	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	$334.01	85.14%	NA	7.7%	9.0%	7.8%	10.12%	1.00%	1.72%	2.02%	14.86%	$39.69	$3.92	$6.76	$7.93	$58.30
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%	NA	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	$367.02	87.15%	NA	4.4%	12.6%	5.7%	9.08%	0.00%	1.73%	2.04%	12.85%	$38.26	$0.00	$7.27	$8.57	$54.10

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

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**

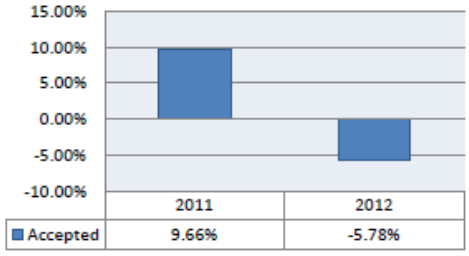
How it plans to spend your premium
If this rate is approved, here's how your insurance company plans to spend your premium:

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.

Premera Blue Cross, ID 243581

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%

Premera Blue Cross, ID 243581

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

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

Premera Blue Cross, ID 243581

Example of Dual-Purpose Interactive Filing Search Tool

1-10 of 14 Results

1 2 | Next » | All

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

Small Group Market

(based on 1st Quarter Rate Filings)

		BCBSVT				MVP				All Small Group Carriers			
		2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
Number of Benefit Plans Filed	Platinum		1	1	1		1	1	1		2	2	2
	Gold		3	2	3		3	2	3		6	4	6
	Silver		4	3	3		4	3	3		8	6	6
	Bronze		3	3	3		4	3	3		7	6	6
	Catastrophic		-	-	-		-	-	-		-	-	-
	Total ACA Benefit Plans Filed		**11**	**9**	**10**		**12**	**9**	**10**		**23**	**18**	**20**
	Total non-ACA Benefit Plans Filed	**53**				**76**	**41**	**34**	**15**	**129**	**41**	**34**	**15**
	Total Benefit Plans Filed	**53**	**11**	**9**	**10**	**76**	**53**	**43**	**25**	**129**	**64**	**52**	**35**
Anticipated Member Months	Platinum		1,968	109,008	125,328		27,893	4,848	11,531		29,861	113,856	136,859
	Gold		43,908	76,788	103,896		14,634	1,716	10,124		58,542	78,504	114,020
	Silver		171,720	155,868	159,108		76,308	9,432	34,259		248,028	165,300	193,367
	Bronze		110,004	74,316	78,072		42,324	6,288	20,093		152,328	80,604	98,165
	Catastrophic		-	-	-		-	-	-		-	-	-
	Total Anticipated ACA MMs		**327,600**	**415,980**	**466,404**		**161,159**	**22,284**	**76,007**		**488,759**	**438,264**	**542,411**
	Total Anticipated non-ACA MMs	**300,485**				**204,385**	**59,316**	**37,536**	**32,828**	**504,870**	**59,316**	**37,536**	**32,828**
	Total Anticipated MMs	**300,485**	**327,600**	**415,980**	**466,404**	**204,385**	**220,475**	**59,820**	**108,835**	**504,870**	**548,075**	**475,800**	**575,239**
Anticipated Distribution of ACA MMs	Platinum		1%	26%	27%		17%	22%	15%		6%	26%	25%
	Gold		13%	18%	22%		9%	8%	13%		12%	18%	21%
	Silver		52%	37%	34%		47%	42%	45%		51%	38%	36%
	Bronze		34%	18%	17%		26%	28%	26%		31%	18%	18%
	Catastrophic		0%	0%	0%		0%	0%	0%		0%	0%	0%
	Total		**100%**	**100%**	**100%**		**100%**	**100%**	**100%**		**100%**	**100%**	**100%**
Average Premium PMPM	ACA		$365	$442	$476		$383	$448	$431		$371	$443	$469
	non-ACA	$447				$417	$480	$403	$408	$435	$480	$403	$408
	ACA & non-ACA	**$447**	**$365**	**$442**	**$476**	**$417**	**$409**	**$420**	**$424**	**$435**	**$383**	**$440**	**$466**
Average Cost Sharing PMPM	ACA		$133	$109	$108		$121	$128	$73		$129	$110	$103
	non-ACA	$118				$89	$94	$102	$97	$107	$94	$102	$97
	ACA & non-ACA	**$118**	**$133**	**$109**	**$108**	**$89**	**$114**	**$111**	**$81**	**$107**	**$125**	**$109**	**$102**
Average Total Cost of Health Care PMPM	ACA		$498	$551	$583		$504	$575	$505		$500	$552	$572
	non-ACA	$565				$507	$574	$505	$505	$541	$574	$505	$505
	ACA & non-ACA	**$565**	**$498**	**$551**	**$583**	**$507**	**$523**	**$531**	**$505**	**$541**	**$508**	**$549**	**$568**
SERFF Number(s) for ACA Filings			128957017	129572217	130082559		128956063	129560321	130053210				
SERFF Number(s) for non-ACA Filings		128713269 128778918				128627829 128696224 128644483	129144870	129662230 129710583	130186136				

Individual Market

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

		BCBSVT					MVP				All Individual Carriers			
		2013	2013 Catamount	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
Number of Benefit Plans Filed	Platinum			1	1	1		1	1	1		2	2	2
	Gold			3	2	3		3	2	3		6	4	6
	Silver			4	3	3		4	3	3		8	6	6
	Bronze			3	3	3		4	3	3		7	6	6
	Catastrophic			1	1	1		1	1	1		2	2	2
	Total ACA Benefit Plans Filed			**12**	**10**	**11**		**13**	**10**	**11**		**25**	**20**	**22**
	Total non-ACA Benefit Plans Filed	**7**	**1**				**10**	**5**	**-**	**-**	**18**	**5**	**-**	**-**
	Total Benefit Plans Filed	**7**	**1**	**12**	**10**	**11**	**10**	**18**	**10**	**11**	**18**	**30**	**20**	**22**
Anticipated Member Months	Platinum			2,580	45,276	50,184		3,008	2,664	11,961		5,588	47,940	62,145
	Gold			16,032	41,448	45,504		1,578	1,260	5,197		17,610	42,708	50,701
	Silver			338,124	153,180	219,372		54,644	10,764	39,856		392,768	163,944	259,228
	Bronze			40,188	41,340	57,264		19,028	19,416	45,800		59,216	60,756	103,064
	Catastrophic			34,140	1,056	1,440		2,689	1,188	1,123		36,829	2,244	2,563
	Total Anticipated ACA MMs			**431,064**	**282,300**	**373,764**		**80,947**	**35,292**	**103,937**		**512,011**	**317,592**	**477,701**
	Total Anticipated non-ACA MMs	**16,111**	**184,212**				**22,818**	**10,198**			**223,141**	**10,198**		
	Total Anticipated MMs	**16,111**	**184,212**	**431,064**	**282,300**	**373,764**	**22,818**	**80,947**	**35,292**	**103,937**	**223,141**	**522,209**	**317,592**	**477,701**
Anticipated Distribution of ACA MMs	Platinum			1%	16%	13%		4%	8%	12%		1%	15%	13%
	Gold			4%	15%	12%		2%	4%	5%		3%	13%	11%
	Silver			78%	54%	59%		68%	30%	38%		77%	52%	54%
	Bronze			9%	15%	15%		24%	55%	44%		12%	19%	22%
	Catastrophic			8%	0%	0%		3%	3%	1%		7%	1%	1%
	Total			**100%**	**100%**	**100%**		**100%**	**100%**	**100%**		**100%**	**100%**	**100%**
Average Premium PMPM	ACA			$356	$425	$448		$353	$392	$404		$356	$421	$438
	non-ACA	$367	$451				$223	$26			$422	$26		
	ACA & non-ACA	**$367**	**$451**	**$356**	**$425**	**$448**	**$223**	**$317**	**$392**	**$404**	**$422**	**$349**	**$421**	**$438**
Average Cost Sharing PMPM	ACA			$141	$180	$163		$132	$154	$109		$139	$177	$151
	non-ACA	$52	$69				$161	$101			$78	$101		
	ACA & non-ACA	**$52**	**$69**	**$141**	**$180**	**$163**	**$161**	**$129**	**$154**	**$109**	**$78**	**$139**	**$177**	**$151**
Average Total Cost of Health Care PMPM	ACA			$497	$605	$611		$485	$546	$514		$495	$599	$589
	non-ACA	$419	$520				$385	$127			$499	$127		
	ACA & non-ACA	**$419**	**$520**	**$497**	**$605**	**$611**	**$385**	**$445**	**$546**	**$514**	**$499**	**$488**	**$599**	**$589**
Affordability Comparison														
	Proj Median Income for FT, YR Worker*	$42,819		$43,785	$45,274	$46,813	$42,819	$43,785	$45,274	$46,813	$42,819	$43,785	$45,274	$46,813
	Growth Rate in Income**			2.3%	3.4%	3.4%		2.3%	3.4%	3.4%		2.3%	3.4%	3.4%
	Standard Silver Rate - Single (Annualized)			$5,102	$5,587	$5,814		$5,130	$5,819	$5,921		$5,105	$5,600	$5,825
	Growth Rate in Standard Silver				9.5%	4.1%			13.4%	1.7%			9.7%	4.0%
	Standard Siver Rate/Proj Median Income			11.7%	12.3%	12.4%		11.7%	12.9%	12.6%		11.7%	12.4%	12.4%
SERFF Number(s) for ACA Filings			128916274	128957017	129572217	130082559		128956063	129560321	130053210				
SERFF Number(s) for non-ACA Filings		128713014 128916274					128620422	129145840						

* 2013 is from the American Community Survey (ACS) 5 Year Estimate

** 2014 growth rate is from the ACS 1 Year Data; growth rate for 2015 and 2016 is from the CBO

Combined Small Group and Individual Markets

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

		BCBSVT				MVP				All Small Group & Individual Carriers			
		2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
Number of Benefit Plans Filed	Platinum		1	1	1		1	1	1		2	2	2
	Gold		3	2	3		3	2	3		6	4	6
	Silver		4	3	3		4	3	3		8	6	6
	Bronze		3	3	3		4	3	3		7	6	6
	Catastrophic		1	1	1		1	1	1		2	2	2
	Total ACA Benefit Plans Filed		**12**	**10**	**11**		**13**	**10**	**11**		**25**	**20**	**22**
	Non-ACA Benefit Plans Filed	61				86	46	34	15	147	46	34	15
	Total Benefit Plans Filed	**61**	**12**	**10**	**11**	**86**	**59**	**44**	**26**	**147**	**71**	**54**	**37**
Anticipated ACA Member Months	Platinum		4,548	154,284	175,512		30,901	7,512	23,492		35,449	161,796	199,004
	Gold		59,940	118,236	149,400		16,212	2,976	15,321		76,152	121,212	164,721
	Silver		509,844	309,048	378,480		130,952	20,196	74,115		640,796	329,244	452,595
	Bronze		150,192	115,656	135,336		61,352	25,704	65,893		211,544	141,360	201,229
	Catastrophic		34,140	1,056	1,440		2,689	1,188	1,123		36,829	2,244	2,563
	Total Anticipated ACA MMs		**758,664**	**698,280**	**840,168**		**242,106**	**57,576**	**179,944**		**1,000,770**	**755,856**	**1,020,112**
	Anticipated non-ACA MMs	500,808				227,203	69,514	37,536	32,828	728,011	69,514	37,536	32,828
	Total Anticipated MMs	**500,808**	**758,664**	**698,280**	**840,168**	**227,203**	**311,620**	**95,112**	**212,772**	**728,011**	**1,070,284**	**793,392**	**1,052,940**
Anticipated Distribution of ACA MMs	Platinum		1%	22%	21%		13%	13%	13%		4%	21%	20%
	Gold		8%	17%	18%		7%	5%	9%		8%	16%	16%
	Silver		67%	44%	45%		54%	35%	41%		64%	44%	44%
	Bronze		20%	17%	16%		25%	45%	37%		21%	19%	20%
	Catastrophic		5%	0%	0%		1%	2%	1%		4%	0%	0%
	Total		**100%**	**100%**	**100%**		**100%**	**100%**	**100%**		**100%**	**100%**	**100%**
Realized ACA Member Months	Platinum		138,556	NA	NA		8,208	NA	NA		146,764	NA	NA
	Gold		104,850	NA	NA		3,220	NA	NA		108,070	NA	NA
	Silver		288,167	NA	NA		20,198	NA	NA		308,365	NA	NA
	Bronze		101,812	NA	NA		27,407	NA	NA		129,219	NA	NA
	Catastrophic		961	NA	NA		1,123	NA	NA		2,084	NA	NA
	Terminated Products (any metal level)		101,257	NA	NA		341	NA	NA		101,598	NA	NA
	Total Realized ACA MMs		**735,603**	**NA**	**NA**		**60,497**	**NA**	**NA**		**796,100**	**NA**	**NA**
Realized Distribution of MMs	Platinum		19%	NA	NA		14%	NA	NA		18%	NA	NA
	Gold		14%	NA	NA		5%	NA	NA		14%	NA	NA
	Silver		39%	NA	NA		33%	NA	NA		39%	NA	NA
	Bronze		14%	NA	NA		45%	NA	NA		16%	NA	NA
	Catastrophic		0%	NA	NA		2%	NA	NA		0%	NA	NA
	Terminated Products (any metal level)		14%	NA	NA		1%	NA	NA		13%	NA	NA
	Total		**100%**	**NA**	**NA**		**100%**	**NA**	**NA**		**100%**	**NA**	**NA**
Average Premium PMPM	ACA		**$360**	**$435**	**$463**		**$373**	**$414**	**$416**		**$363**	**$434**	**$455**
	non-ACA	**$446**				**$398**	**$328**	**$156**	**$172**	**$431**	**$414**	**$403**	**$408**
	ACA & non-ACA	**$446**	**$360**	**$435**	**$463**	**$398**	**$363**	**$312**	**$378**	**$431**	**$367**	**$432**	**$453**
Average Cost Sharing PMPM	ACA		**$137**	**$138**	**$132**		**$125**	**$144**	**$94**		**$134**	**$138**	**$125**
	non-ACA	**$98**				**$97**	**$95**	**$102**	**$97**	**$98**	**$95**	**$102**	**$97**
	ACA & non-ACA	**$98**	**$137**	**$138**	**$132**	**$97**	**$118**	**$127**	**$95**	**$98**	**$132**	**$136**	**$125**
Average Total Cost of Health Care PMPM	ACA		**$498**	**$573**	**$595**		**$498**	**$557**	**$510**		**$498**	**$572**	**$580**
	non-ACA	**$544**				**$494**	**$423**	**$258**	**$270**	**$528**	**$508**	**$505**	**$505**
	ACA & non-ACA	**$544**	**$498**	**$573**	**$595**	**$494**	**$481**	**$439**	**$473**	**$528**	**$498**	**$569**	**$578**

Appendix D: Major Product Attributes

Small Group Market

(based on 1st Quarter Rate Filings)

		BCBSVT				MVP						
		2013	2014	2015	2016	2013	2014 non-ACA	2015 non-ACA	2016 non-ACA	2014	2015	2016
Major Product Attributes (in-network benefits)	**Highest Cost Plan**											
	Medical Deductible	$100	$150	$150	$150	$2,000	$300 IP/$100 OP	$300 IP/$100 OP	$1,500	$150	$150	$150
	Coinsurance %	Ded	10%	10%	10%	0%	0%	0%	0%	10%	10%	10%
	Medical OOP Max	no max	$1,250	$1,250	$1,250	no max	no max	no max	$2,500	$1,250	$1,250	$1,250
	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, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	$15 / $15	$10 / $20	$10 / $20	$10 / $20	$25 / $25	$15 / $40	$15 / $40	Ded	$10 / $20	$10 / $20	$10 / $20
	ER Copay	Ded	$100	$100	$100	$75	$75	$75	Ded	$100	$100	$100
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$1 / $1 / $1	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%	50%/50%/50%	$0 / $30 / $50	$0 / $30 / $50	$10 / $30 /$ 50	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%
	Lowest Cost Plan (not catastrophic)											
	Medical Deductible	$5,000	$5,000	$5,000	$6,550	$9,500	$5,000	$5,000	$5,000	$3,500	$3,500	$4,400
	Coinsurance %	0%	50%	50%	0%	0%	0%	0%	0%	50%	50%	50%
	Medical OOP Max	no max	$6,250	$6,250	$6,550	$9,500	$5,000	$5,000	$5,000	$6,350	$6,350	$6,500
	Med Ded waived for:	Preventive Care	Preventive Care	Preventive Care	Preventive Care					Preventive Care	Preventive Care	Preventive Care
	PCP/Specialist OV Copay	Ded	50% / 50%	50% / 50%	0% / 0%	$0 / $40	Ded	Ded	Ded	$35* / $80*	$35* / $80*	50% / 50%
	ER Copay	Ded	50%	50%	0%	$0	Ded	Ded	Ded	50%	50%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$5 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$10/100%/100%	$0 after Ded	$0 after Ded	$0 after Ded	$20 / $80 / 60%	$20 / $80 / 60%	$12 / 40% / 60%
Average Premium PMPM	Highest Cost Plan	$1,087	$521	$555	$589	$1,042	$673	$701	$495	$513	$589	$577
	Lowest Cost Plan (not catastrophic)	$440	$305	$321	$360	$252	$304	$333	$335	$290	$348	$333
	Spread (1-lowest/highest)	60%	41%	42%	39%	76%	55%	53%	32%	43%	41%	42%
Metal Actuarial Value	Highest Cost Plan		0.881	0.881	0.890					0.881	0.880	0.890
	Lowest Cost Plan (not catastrophic)		0.616	0.613	0.620					0.618	0.615	0.610
SERFF Number(s)		BCVT_128713269 BCVT_128778918	BCVT_128957017	BCVT_129572217	BCVT_130082559	MVP_128627829 MVP_128696224 MVP_128644483	MVP_129144870	MVP_129662230 MVP_129710583	MVP_130186136	MVP_128956063	MVP_129560321	MVP_130053210

* cost sharing applies after deductible is met

Individual Market

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

		BCBSVT					MVP				
		2013	2013 Catamount	2014	2015	2016	2013	2014 non-ACA	2014	2015	2016
Major Product Attributes (in-network benefits)	**Highest Cost Plan**										
	Medical Deductible	$3,500	$500	$150	$150	$150	$3,500	$3,500	$150	$150	$150
	Coinsurance %	20%	20%	10%	10%	10%	30%	30%	10%	10%	10%
	Medical OOP Max	$9,500	$1,050	$1,250	$1,250	$1,250	no max	no max	$1,250	$1,250	$1,250
	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	Preventive Care, Office Visits, Emergency Room, Ambulance	Preventive Care, Office Visits, Emergency Room, Ambulance
	PCP/Specialist OV Copay	$30	$10	$15 / $20	$10 / $20	$10 / $20	Ded, Coins	Ded, Coins	$10 / $20	$10 / $20	$10 / $20
	ER Copay	Ded, Coins	Ded, Coins	$100	$100	$100	Ded, Coins	Ded, Coins	$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%	$250 Ded, 50%	$250 Ded, 50%	$5 / $40 / 50%	$5 / $40 / 50%	$5 / $40 / 50%
	Lowest Cost Plan (not catastrophic)										
	Medical Deductible	$10,000	$500	$5,000	$5,000	$6,550	$100,000	$100,000	$3,500	$3,500	$4,400
	Coinsurance %	30%	20%	50%	50%	0%	30%	30%	50%	50%	50%
	Medical OOP Max	$23,500	$1,050	$6,250	$6,250	$6,550	no max	no max	$6,350	$6,350	$6,500
	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
	PCP/Specialist OV Copay	$15 / Ded, Coins	$10	50% / 50%	50% / 50%	Ded / Ded	Ded, Coins	Ded, Coins	$35* / $80*	$35* / $80*	50% / 50%
	ER Copay	Ded, Coins	Ded, Coins	50%	50%	Ded	Ded, Coins	Ded, Coins	50%	50%	50%
	Rx Copay (Gen/Pr-Br/N-Pr-Br)	$15 / 50% / 60%	$10 / $35 / $55	$25 / 40% / 60%	$25 / 40% / 60%	$25 / 40% / 60%	$250 Ded, 50%	$250 Ded, 50%	$20 / $80 / 60%	$20 / $80 / 60%	$12 / 40% / 60%
Average Premium PMPM	Highest Cost Plan	$565	$451	$521	$555	$589	$320	$268	$513	$589	$577
	Lowest Cost Plan (not catastrophic)	$262	$451	$305	$321	$360	$18	$17	$290	$348	$333
	Spread (1-lowest/highest)	54%	0%	41%	42%	39%	95%	94%	43%	41%	42%
Metal Actuarial Value	Highest Cost Plan			0.881	0.881	0.890			0.881	0.880	0.890
	Lowest Cost Plan (not catastrophic)			0.616	0.613	0.620			0.618	0.615	0.610
SERFF Number(s)		BCVT_128713014 BCVT_128916274	BCVT_128916274	BCVT_128957017	BCVT_129572217	BCVT_130082559	MVP_128620422	MVP_129145840	MVP_128956063	MVP_129560321	MVP_130053210

* cost sharing applies after deductible is met

Endnotes

[1] Affordable Care Act: "The comprehensive health care reform law enacted in March 2010. The law was enacted 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" is used to refer to the final, amended version of the law." U.S. Centers for Medicare & Medicaid Services (CMS): Health care.gov glossary. Accessed 10 March 2014: https://www.health care.gov/glossary/affordable-care-act/.

[2] Centers for Medicare and 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 November 2015: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/rates.html

[3] *Ibid.*

[4] Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(2).

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

[6] State of Vermont, Green Mountain Care Board. Rule 2.000: HEALTH INSURANCE RATE REVIEW. p.9. Accessed 23 November 2015: http://gmcboard.vermont.gov/sites/gmcboard/files/13_12_12_Rule_2%20000_Health_Insurance_Rate_Review.pdf.

[7] 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

[8] 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.

[9] *Op cit.* GMCB: How Rates are Reviewed.

[10] *Ibid.*

[11] *Ibid.*

[12] *Op. cit.* State of Vermont, Green Mountain Care Board. 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] *Op cit.* GMCB: How Rates are Reviewed.

[14] *Ibid.*

[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 25 November 2015: http://www.bls.gov/regions/mid-atlantic/news-release/2015/consumerpriceindex_northeast_20150226.htm

[18] Green Mountain Care Board (GMCB). MVPH-128956063. Accessed 29 November 2015: http://gmcboard.vermont.gov/rate_review/MVP/128956063..

[19] U.S. Department of Health and Human Services Federal Register. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014. Final Rule: Accessed 17 November 2015:

https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014

[20] Vt. Stat. Ann. tit. 8 §§ 4512(b); 4062(a)(2).

[21] 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/.

[22] Vermont Department of Financial Regulation. Requirements for a Plain Language Summary for Comprehensive Major Medical and MedicareSupplement (Med-Supp) Filings. Accessed 21 November 2015: http://www.dfr.vermont.gov/sites/default/files/FINAL_VT_Filing_Summary_Requirements_updated_11_26_12.pdf.

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[25] 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.

Oregon Insurance Division. Find a Filing. Accessed 23 November 2015: http://www.oregon.gov/DCBS/Insurance/healthrates/Pages/find-filings.aspx.

Washington State Office of the Insurance Commissioner. Search health insurance rate increases. Accessed 23 November 2015: http://www.insurance.wa.gov/health-rates/Search.aspx.