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May 14, 2018

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

Re: The Vermont Health Plan Q3 2018 Large Group Filing (SERFF # BCVT-131424558)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2018 Large Group Filing for The Vermont Health Plan (TVHP) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. TVHP is a non-profit hospital and medical service corporation. TVHP provides large group coverage to employers and Medicare Supplement coverage in Vermont.

2. This filing establishes the formula, manual rate and accompanying factors that will be used for Large Group renewals. This filing includes support for key assumptions, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors. The overall impact of this filing was estimated based on the previously approved factors from the prior Q3 2017 Large Group Filing.

3. This filing addresses TVHP Insured large groups. There are approximately 1,600 subscribers and 2,800 lives affected across 17 groups for the TVHP Q3 2018 Large Group filing.

4. The overall impact of this filing is 11.2%[1] ($55.68 PMPM).[2] This percentage is itemized below and incorporates assumptions and changes from prior filings as well as this filing.
    - Change due to Trend: **6.0%**
    - Change in Administrative Charges: **1.2%**
    - Change in Contribution to Reserve: **-0.3%**
    - Changes in Federal Programs: **-2.5%**
        - Annual Fee on Health Insurance Providers Temporarily Suspended
    - Worse than Expected Experience: **7.1%**
    - Other: **-0.3%**

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes

[1] The components are multiplicative and therefore do not add up to exactly 11.2%.

[2] The Company estimated the overall impact by comparing rates calculated as of January 1, 2018 using the currently approved rate manual and rates calculated as of January 1, 2019 using the proposed rate manual.

access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

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

For medical trend development, the Company used claims incurred between August 1, 2013 and July 31, 2017. Completion factors[3] were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

The data includes claims from Blue Cross and Blue Shield of Vermont (BCBSVT) Cost Plus groups, BCBSVT Administrative Services Only (ASO) groups with less than 5,000 members, BCBSVT Insured Small and Large Groups including small groups enrolled in Qualified Health Plans and The Vermont Health Plan (TVHP) Insured Small and Large Groups. The company noted that the plan offerings and group size of the small group market is more analogous to the large group market than the benefits and experience of large ASO groups. BCBSVT and TVHP cover substantially similar populations under similar benefit packages. The Company felt that combining these homogeneous populations created greater consistency and credibility within the trend factor development. Adjustments were made to the data to reflect network differences between the two companies.

BCBSVT ASO groups with less than 5,000 members are included in the development of the trend factors, and benefit relativity factors. The Company indicated that the smaller ASO groups generally have similar benefits and use the same network contracts as the Insured and Cost Plus groups. It was noted that adding this experience increases the statistical credibility of the experience basis for the factor development.

Company's Analysis

1. *Medical Trend Development:* The Company is requesting a total allowed[4] medical trend of 5.9%. This total allowed medical trend amount is broken down into 3.0% for utilization and intensity and 2.8% for unit cost.

   Utilization and Intensity

   The Company normalized the allowed costs to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. This data was then analyzed by using exponential regression over the 24-month time period, ending July 2017, which resulted in a utilization trend estimate of 4.3%. Alternatively, by using a year-over-year rolling PMPM method, the Company calculated a utilization trend estimate of 7.1% for the year ending July 2017.

   The Company believes that these standard methodologies overstate the utilization trend. Therefore, they removed large claims for members who exceeded $500,000 in paid medical claims. Using this revised data, the resulting exponential regression over the 24-month time period ending July 2017 was 1.5% and the year-over-year rolling PMPM utilization trend was 3.6%.

[3] Completion factors are used to estimate the ultimate incurred claims based on the historical pattern of paid claims.

[4] Allowed cost trends are based on charges that reflect the total amount of claims paid by both the carrier and the policyholder. Paid trends reflect the actual claim payment made by the carrier only and are shown in section 5.

Trend Analysis	Standard Methodology	Excluding Claims above $500,000
Exponential Regression	4.3%	1.5%
Year-Over-Year	7.1%	3.6%

In addition to their standard approaches, the Company performed time series analyses using the data that excludes the large claims. The Company used six different times series methods and calculated each of them over 24, 36 and 48 months of historical data. The results range from a minimum utilization trend of 0.2% to a maximum of 3.6%.

After an evaluation of the different trend estimates, the Company selected a 3.0% utilization trend. This estimate is lower than the trends calculated using their standard methodologies and is in the range of trends produced by the alternative methods.

Given the recent increase in the utilization trends, the Company identified the following drivers for the 3.0% increase:

- Inpatient Services: The Company noted that previously inpatient days per member decreased as services moved away from an inpatient setting. However, year-over-year inpatient days per member increased by 0.7%. The Company expects the inpatient utilization will remain stable and no longer offset other components of utilization trend. Inpatient costs per admit, normalized for contract changes, increased 2.6% and continues to be driven by components of inpatient services, such as drugs and injectables administered in a facility.
- Economy: The Company cited a proprietary source that noted that over the past several years, utilization in several medical categories has been negative, due in part to economic recession. However, beginning in 2016, economic recovery has led to the reversal of the negative utilization trends, and this movement is expected to continue to increase utilization trends through 2019.
- Shift in Plans: Another reason cited by the Company is a plateau in the shift towards high-deductible health plans (HDHPs)[5]. According to a survey, the adoption of HDHPs has resulted in a decrease in utilization in past years, but since this migration has slowed, the dampening effect of benefit changes on utilization trends is disappearing.
- Consistent Statewide: The Company also noted that Cigna, in their large group filing, developed a utilization trend of 2.8% nationally and 3.2% for Vermont.
- Unit Costs: Finally, unit cost increases for Vermont hospitals have reached historical lows in part due to budget overages caused by excess utilization.

Unit Cost Trend

The unit cost trend for medical trend is projected to be 2.8% based on an analysis of the hospital budget increases implemented during 2017 as well as other providers in the TVHP service area. This projection includes a 2.3% increase for Vermont facilities and providers impacted by the GMCB's hospital budget review and a 3.4% for other facilities and providers. The Company started with the assumption that the GMCB would approve hospital budgets for October 1, 2018 and October 1, 2019 that support identical commercial increases as the approved increases for October 1, 2017. Then, TVHP's Provider

[5] https://www.pwc.com/us/en/health-industries/health-research-institute/behind-thenumbers/reports/hri-behind-the-numbers-2018.pdf

Contracting department provided estimates for specific facilities in 2018 and 2019 that replaced the assumptions noted above.

Providers within the TVHP service area were assumed to have overall 2017 and 2018 budget increases similar to those implemented during calendar year 2016, except when the Provider Contracting department provided an estimate for a specific facility. Unit cost increases for providers outside the TVHP service area were derived from the Fall 2017 Blue Trend Survey.[6]

Total Allowed Medical Trend
The utilization and intensity trend of 3.0% combined with the unit cost trend of 2.8% results in total allowed medical trend of 5.9%.

2. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend of 9.7%. The pharmacy trends are calculated using 24 months of historical data ending September 2017, which is modeled using an exponential regression. The Company analyzed 24 months of data to best capture an adequate amount of the most recent history of drug costs.

   The Company modeled the costs for generic and brand drugs separately; however, they did combine the data to analyze utilization patterns. A separate adjustment was then made to split the generic and brand utilization based on the projected GDR (elaborated further in section 3).

   The Company modeled only the total PMPM trends for specialty drugs due to their relatively low utilization and high cost nature (elaborated further in section 4). The following table shows the results of the Company's analysis and the requested 9.7% overall allowed pharmacy trend.

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend
Generic	3.7%	0.9%	4.7%
Brand	9.8%	-7.9%	1.2%
Specialty	N/A	N/A	19.2%
Total	N/A	N/A	9.7%

3. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The generic dispensing ratio (GDR) is a measure of the percentage of pharmacy utilization attributable to generic drugs. The Company's drug-by-drug analysis shows that the GDR is expected to increase at a similar rate to the projection in the prior filing.

   Based on the current distribution of days' supply and a list of brands expected to move to generic in the projected period, as provided by their Pharmacy Benefit Manager, the Company projected the GDR to reach 90.6% in the projection period. This is an increase of 1.6% over the prior filing's assumption of 89.0%, which was calculated using the same methodology.

4. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* The Company made specific adjustments for several high-cost specialty drugs:

6 The Fall 2017 Blue Trend Survey is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

- Orkambi, which is used to treat cystic fibrosis;
- PCSK9 inhibitors[7], which are used to treat high cholesterol in patients with familial hypercholesterolemia (FH); and
- Ocrevus which is used to treat multiple sclerosis (MS).

The Company recalculated the specialty drug trend after excluding these new specialty drugs from the historical data. This decreased the 24-month regression trend from 20.6% to 19.8%. Then, the Company added in the projected costs of these expensive specialty drugs and recalculated the specialty drug trend to be 19.2%.

To determine the total projected cost of treatments attributed to PCSK9 inhibitors, the Company cited current FH incidence studies, as well as the prevalence of patients who have had a heart attack and then failed two different high-dose statins for 60 days. Based on current membership, the Company expects 18 members to use a PCSK9 inhibitor in 2018. The annual cost of treatment was indicated to be approximately $13,000 per year, for a projected total cost of about $230,000. TVHP's policy is to immediately approve PCSK9 inhibitors for patients who have had a heart attack and failed two different high-dose statins.

Orkambi is a drug used to treat a specific mutation of the cystic fibrosis that was cited to be found in roughly 50% of those patients. This drug is only prescribed to patients age 12 and older, and TVHP indicated that they only had one member in the experience period that had claims for Orkambi. Given the length and time the drug has been available, they do not expect to see a change in utilization and added in the projected total cost for one member of approximately $249,000.

Ocrevus is a drug used to treat MS. The Company estimated that 15% of their current members currently taking medicine for MS would switch to taking Ocrevus.

The table below provides a detailed breakdown of the 19.2% specialty drug trend development. Note that the pharmacy cost estimates are not adjusted for the expected rebates because the rebates are accounted for in a separate step in the rating methodology.

[7] PCSK9 inhibitors in the formulary include Praluent, which was approved by the FDA on July 24, 2015, and Repatha, which was approved by the FDA on August 27, 2015.

Pharmacy Specialty Claims in the Experience	$30,465,793
Claims Removed from the Experience	$1,308,576
PCSK9 Inhibitors	*$127,886*
Orkambi	*$374,233*
Multiple Sclerosis Drugs, Anticipated to Move to Ocrevus	*$806,457*
Pharmacy Specialty Claims without Excluded Drugs	$29,157,218
Projected Specialty Claims using a 19.8% trend for 27 months	$43,814,127
Adding Incremental Cost of Excluded Drugs for the Projection Period	$1,434,809
PCSK9 Inhibitors	*$230,108*
Orkambi	*$249,202*
Ocrevus	*$955,500*
Restated Projected Specialty Claims	$45,248,936
Restated Annual Specialty Trend	19.2%[8]

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends to reduce the effect of benefit changes on observed trends. Therefore, adjustments for trend leveraging were made in order to convert the allowed trends into paid trends. Paid trends are what are applied to large group experience to develop premiums.

   The leveraged trend values were calculated using the Company's Benefit Relativity models[9] by calculating the change in paid claims with and without the allowed trends. The paid trends are summarized in the table below.

	Allowed Trends	Paid Trends	Paid Trends after Pharmacy Contract Changes
Medical	5.9%	7.0%	7.0%
Drug	9.7%	10.6%	8.1%
Total	6.5%	7.7%	7.2%

   The total medical and drug trend is responsible for a 6.0%[10] increase in premium.

6. *Administrative Costs:* Several components make up the 16.6% increase to administrative charges, which increases the premiums by 1.2% (federal fees are explained further in section 7):
   - *Administrative Trend (2.5%):* The proposed administrative costs were developed by trending forward the actual administrative costs for the year ending September 2017. The assumed trend reflects the Company's assumption that wages and benefits will increase at 3.0%, while other operating costs and membership are expected to remain at current levels.
   - *Correct Trend Application (2.4%):* During the actuarial review of the Q3 2017 filing, the Company discovered that the trend factor was not being applied correctly which resulted in an understatement of the administrative charges. The Company decided to not file a correction at the time, but it is being corrected for the filing this year.

[8] The annual specialty trend calculation is: ($45,248,936 / $30,465,793) ^ (12 / 27) - 1

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

[10] This does not equal to the total paid trend of 7.7%, because the trend only impacts paid claims and not administrative expenses.

- *Updated Experience Base and Allocation (10.3%):* The large group line of business experienced a 15.9% decrease in member months, which reduced variable administrative costs, but resulted in the fixed costs being distributed over a smaller population. This also includes a higher percentage of administrative expenses allocated to large groups due to the increase in expected claims because of underpricing in the prior filing.
- *Decrease in Total TVHP Membership (0.8%):* TVHP is projecting a decrease in overall membership for 2019. Since fixed expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charges results.
- *Other Adjustments: (0.6%):* This includes the impact of estimating the increase for the 64 specific large groups that are expected to renew in 2019, which have slightly higher administrative costs than the average across all large groups.

7. *Federal Fees:* H.R. 195 temporarily suspended the collection of the insurer fee for 2019. According to current law, the insurer fee will be collected again starting in 2020, and TVHP has estimated that the fee is approximately 2.1% of premium in 2018. The insurer fee decreases the requested rate increase from 13.7% to 11.2%.

8. *Contribution to Reserves (CTR):* The proposed CTR is 1.5% for Insured Large Groups and 0.375% for Cost Plus Groups. The proposed CTR was reduced from 2.0% and 0.5% in the prior filing because of the Tax Cuts and Jobs Bill of 2017 that is expected to reduce the tax rate to 0% for 2018.

   The Company demonstrated that a minimum CTR of 1.8% is required for the Fully Insured Large Groups to maintain Risk Based Capital (RBC) levels at the midpoint of the Company's target RBC range due to the impact of the projected claims increase. The proposed CTR enables the Company to remain financially strong and manage CTR to an adequate long-term level.

9. *Worse than Expected Experience:* For the combined BCBSVT and TVHP large group block that is used for rate development, the Company experienced a 5.3% loss in 2017. This contrasts with the proposed CTR of 2.0% in the prior filing. As a result, the premiums in this filing were increased by 7.1% to account for the deterioration in expected claims experience.

   The Company demonstrated that the impact was largely driven by an issue with the development of the benefit relativity factor and the difference between the expected manual and experience claims. The Company has revised their process as a result to more accurately project the claims for the large group line of business.

Lewis & Ellis (L&E) Analysis

1. *Medical Trend Development:* The Company is requesting a total allowed medical trend of 5.9%. This total allowed medical trend amount is broken down into 3.0% for utilization and intensity and 2.8% for unit cost. L&E reviewed each of these components separately.

   Utilization and Intensity

   L&E reviewed the data and analysis provided by the Company, which includes:
   - Exponential regression with and without high claimants;
   - Year-over-year rolling PMPMs with and without high claimants; and
   - Times series analysis.

Each of the different methods produced varied results, which indicates uncertainty in the projected utilization trends. The Company also provided extensive qualitative support their utilization trend assumption.

To review the Company's assumed 3.0% utilization and intensity trend for reasonableness, L&E reviewed the year-over-year rolling PMPM utilization trends, with and without high claimants included over one, two and three-year periods. The results of the analysis are in the table below:

High Claimants	1 Year	2 Years	3 Years[11]
Included	7.1%	2.3%	1.7%
Excluded	3.6%	1.5%	1.3%

It is evident from the table that utilization has been trending upward in recent years. L&E expects that the 1-year trend of 7.1% is likely an anomaly rather than a trend that will continue; however, L&E does believe that the trends in this table support a substantial, non-zero utilization trend. L&E's best estimate for the projected trend is 2.25%, and L&E's estimated range for the utilization trend is 1.5% to 3.0%. The Company's projected 3.0% utilization trend is on the high side of our estimated range. Since the Company's utilization is within L&E's range, L&E considers it be reasonable and appropriate.

Unit Cost
L&E reviewed the confidential support for the unit cost trend that was provided by the Company, and it appears to be reasonable and appropriate.

Total Allowed Medical Trend
Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. L&E's estimated range for the total trend is 4.1% to 6.1%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.

The Company's proposed total allowed medical trend of 5.9% is on the high side of L&E's estimated range, and L&E considers it to be reasonable and appropriate.

2. *Pharmacy Trend Development:* In past filings, reviewing the historical claims data on a total PMPM basis did not produce reasonable results due to the slowing growth of the GDR, drugs losing their patents in the projection period, and the adjustments to the future contract terms with the Company's pharmacy benefit manager. However, in this filing the growth in the GDR is consistent with the experience and the future contract adjustments were moved to a different step in the rating formula. Therefore, L&E reviewed the 24-month regression on the combined pharmacy claims, which produced an estimated trend of 7.8%.

   The estimated range for the actual results is 5.2% to 10.5%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the

[11] For the 2-Year and 3-Year analyses, an adjustment upwards of 0.1% to 0.2% should be applied to the numbers in this table to offset the impact of benefit buy downs during this period.

middle of the range.[12] L&E considers the Company's allowed pharmacy trend of 9.7% to be reasonable and appropriate.

Additionally, L&E reviewed the Company's more discrete method to project the pharmacy trend. The adjustments that the Company made are discussed in sections 3 and 4.

3. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The chart below shows the rolling 12-month average GDR from January 2015 to December 2016 as well as the projected GDR for the next 2 years. The projected growth in the GDR is consistent with the recent experience.

Historical	Rolling 12 Month GDR	Semi-Annual Increase
December 2016	88.0%	
June 2017	88.5%	0.6%
December 2017	88.8%	0.3%

Projected	Rolling 12 Month GDR	Semi-Annual Increase
June 2018	89.0%	0.3%
December 2018	89.4%	0.4%
June 2019	90.1%	0.7%
December 2019	90.6%	0.6%

While the chart shows that the historical trends have become relatively stabilized, L&E believes that it is more important to focus on the approach used by the Company to project the GDR. The approach used in the current filing is the same as the approach from last year's filing, which was found to be reasonable and appropriate. The projected GDR would be expected to slow down as the GDR approaches its limit of 100%. The Company projections demonstrate a slight acceleration over recent historical months. L&E considers the approach to project the GDR to be reasonable and appropriate.

4. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* L&E reviewed the cited cost per treatment for the expensive drugs indicated in the pharmacy specialty drug trend development. The Company's unit cost estimates appear to be consistent with publicly available information on these drugs and the utilization estimates are reasonable and consistent with their experience. Over the past couple of years, several new high-cost drugs have come to market, which has resulted in higher pharmacy trends across the health insurance industry. TVHP's indications are consistent with these developments. L&E considers the Company's projections to be reasonable and appropriate.

5. *Leveraged Adjustments to Allowed Trends:* Similar to last year's filing, the Company used their Benefit Relativity models to estimate the impact on paid claims with and without the allowed trend. The approach that the Company used to adjust allowed trends to paid trends is reasonable and appropriate. The table below shows the Company's revised allowed trends, the paid trends after leverage adjustments were made, and the impact of projected pharmacy contract changes.

[12] For example, the probability that the actual trend will be centered around the best estimate (between 7.7% and 7.9%) is over 50% higher than being near the low end of the range (between 5.2% and 5.4%).

	Allowed Trends	Paid Trends	Paid Trends after Pharmacy Contract Changes
Medical	5.9%	7.0%	7.0%
Drug	9.7%	10.6%	8.1%
Total	6.5%	7.7%	7.2%

6. *Administrative Costs:* The Company has experienced an increase in the administrative costs for the year ending September 2017. The proposed increase of 16.6% to the administrative costs reflect an increase of 1.2% to the premiums. The Company provided detailed information breaking down each source contributing to the increase in expected administrative expenses.

    - *Administrative Trend (2.5%):* Consistent with the prior filing, the Company's budgeted wage increase for 2017 is 3.0%, while other operating costs were assumed to remain flat. The increases due to administrative cost trend and personnel costs did not change materially from last year.
    - *Correct Trend Application (2.4%):* During our prior review, the Company discovered that the trend factor was not correctly being applied and are correcting the issue during this filing.
    - *Updated Experience Base and Allocation (10.3%):* The large group line of business experienced a significant decrease in member months, which results in the fixed costs being spread over a smaller population. Additionally, the large rate increase in this filing results in a higher percentage of administrative costs being allocated to large groups.
    - *Decrease in Total TVHP Membership (0.8%):* The Company used a consistent approach as the prior filing to estimate the impact of a change in the overall membership of the Company.
    - *Other Adjustments (0.6%):* The 64 large groups that are expected to renew in 2019 have higher administrative costs than the average across all large groups.

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

7. *Federal Fees:* H.R. 195 temporarily suspended the Annual Fee on Health Insurance Providers ("insurer fee") for 2019. The Company estimates that this fee will decrease premiums by 2.1% in 2019. This change in the premium appears to be reasonable and appropriate.

8. *Contribution to Reserves:* A CTR of 1.8% for fully insured groups is required to maintain Risk Based Capital (RBC) levels at the midpoint of the Company's target range due to the impact of the projected claims increase. L&E believes the proposed CTR of 1.5% for fully insured groups and 0.375% for Cost Plus groups is reasonable in order to maintain RBC levels in light of medical trend and provide an adequate margin over and above the minimum to keep appropriate RBC levels in the case of an adverse event without being excessive.

    While L&E believes the proposed CTR of 1.5% for fully insured groups and 0.375% for Cost Plus groups is reasonable, reviewing the Company's current level of capital and surplus is beyond the scope of this review. Therefore, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

9. *Worse than Expected Experience:* The Company experienced a 5.3% loss in 2017 for the large group line of business, which contrasts with the proposed CTR of 2.0% in the prior filing. The Company revised the premiums to be reasonable and adequate for 2019; therefore, this change appears to be reasonable and appropriate.

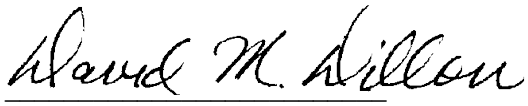
Recommendation

L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing without modification which would result in an overall increase of 11.2% ($55.68 PMPM).

Sincerely,

Josh Hammerquist, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

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



David M. Dillon, FSA, MAAA
Vice President & Principal
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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[13], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[14], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Joshua A. Hammerquist, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

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

Identification of Actuarial Documents
The date of this document is May 14, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is May 10, 2018.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but L&E has not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

[13] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

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

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

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.