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April 18, 2022

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

Re: Blue Cross and Blue Shield of Vermont Q3 2022 Large Group Filing (SERFF # BCVT-133154621) and The Vermont Health Plan Q3 2022 Large Group Filing (SERFF # BCVT-133154563).

The purpose of this letter is to provide a summary and recommendation regarding the proposed Large Group Filings for Blue Cross and Blue Shield of Vermont (BCBSVT) and The Vermont Health Plan (TVHP) (collectively, "the filing") and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides coverage to individuals, small and large group employer, Medicare enrollees Vermont. TVHP is a licensed health maintenance organization (HMO) and for-profit subsidiary of Blue Cross Blue Shield of Vermont. TVHP provides large group coverage to employers 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 filings.

3. This filing addresses BCBSVT and TVHP Insured and Cost Plus large groups. Throughout the filing and this report, BCBSVT and the related company, TVHP, are referred to collectively as BCBSVT, except when specified. There are approximately 3,563 subscribers and 6,396 lives affected across 38 groups for the BCBSVT Q3 2022 Large Group filing and the corresponding TVHP filing.

4. The most important component of any group's premium is their past claims experience. Group-level premiums for coverage years beginning 1Q 2023, for example, will be based on the most current experience available at the time. For this reason, no group's actual premium increase pursuant to this filing is currently known.

5. The previous filing, approved with modification on May 11, 2021, resulted in an average premium change of -1.7%.

6. As initially filed, the average premium change of a manually rated group was approximately 7.9%[1], or roughly $52.41 PMPM, itemized below.

    a. Change to Projected Claims: +**7.3%**
    b. Change from Projected Pharmacy Rebates: **-0.4%**
    c. Change in Administrative Charges: +**0.6%**
    d. Change in Contribution to Reserve: +**0.1%**
    e. Change in Mandate and Assessments: +**0.1%**
    f. Change in Additional Items[2]: +**0.2%**

    It should be noted that the actual rate change, even averaged across all groups, may differ from this level. This is because the filed rating formula incorporates experience which has not yet occurred. If claims are different from current expectations during 2022, this information will flow through to premiums when groups renew their coverage.

7. The actual premium increase experienced by a particular group will vary from the average of +7.9%. Each group's rate increase or rate decrease will consider their recent claims experience, changes in the distribution of members enrolled, and changes in benefits. A newly formed large group would experience 1Q2023 premiums that were approximately 7.9% higher than a similar newly formed large group in 1Q2022.

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 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

BCBSVT provided the proposed methodology used to calculate the Insured and Cost Plus 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, aggregate stop loss and risk charge factors, network changes and large claim factors.

For medical trend development, the Company used claims incurred between September 2017 and August 2021. The data includes claims from BCBSVT Cost Plus groups, BCBSVT Administrative Services Only (ASO) groups with less than 1,001 members, BCBSVT Insured Small and Large Groups including small groups enrolled in Qualified Health Plans, BCBSVT insured AHPs, and The Vermont Health Plan (TVHP) Insured Small and Large 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. Trend for members who have Medicare as their primary coverage was analyzed separately.

Filing Analysis

1. *Updated Experience Base:* For the combined BCBSVT and TVHP block that is used for rate development, the projected claims are expected to decrease 4.0% over what was assumed in the prior

[1] The itemized changes are multiplicative and may not add up to the total.

[2] Additional Items include net cost of reinsurance, Cost Plus stop loss, broker commissions, the OneCare Coordination Fee, and fees paid to outside vendors

filing. The claims used were incurred from November 2020 through October 2021, paid through December 2021.

Total claims were substantially higher than projected during the experience period, resulting in financial losses on this business. However, BCBSVT is choosing not to reflect all of those claims in this filing. The 4% decrease excludes the impact of COVID claims, which were considered one-time events and not included in the development of the manual rate. Additionally catastrophic claims, which fluctuate year-over-year, are replaced by a long-term average "pooling charge" in order to maintain stability in the premiums. This pooling charge was significantly less than the actual catastrophic claims during the base period. So, while the overall claims in 2021 were higher than anticipated, the removal of COVID and catastrophic claims estimates lower claims than what was anticipated.

2. *Medical Trend Development:* Medical trend varies by company and plan type due to contracting differences. For all products combined, the Company is requesting a total allowed[3] medical trend of 7.5% per year. This total allowed medical trend amount is broken down into 7.8% for hospital claims, 14.6% for Mental Health professional claims, 5.6% for other professional claims, and 7.3% for outpatient drugs.[4]

Category	Unit Cost	Utilization	Total
Hospital	5.4%	2.4%	7.8%
Mental Health Professional	4.2%	10.0%	14.6%
Other Professional	4.2%	1.4%	5.6%
Outpatient Drugs	5.4%	1.8%	7.3%
Total	**5.1%**	**2.3%**	**7.5%**

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. To reduce fluctuation and capture only trend, the Company also removed outlier claimants. This data was then analyzed by using exponential regression and other methods. It is important to note that the experience period includes the impact from COVID-19.

The Company chose a utilization trend of 2.4% per year for facility claims and 2.4% for professional and ancillary claims. These average to an overall non-drug medical utilization trend assumption of about 2.4% per year.

L&E reviewed the data and analysis provided by the Company, which includes:

- Year-over-year rolling PMPMs;
- Exponential regressions; and
- Times series analysis.

[3] 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. Paid trends are usually higher because the member's share of the cost is often limited to fixed copays which do not increase with cost trend.

[4] Many specialty drugs, such as certain chemotherapy treatments, are often covered under a policy's medical benefit. These drugs are separate from the Rx experience and trend discussed in the next section but have exhibited similarly high trend in recent years.

BCBSVT has consistently relied on historical utilization changes to project future utilization changes in past filings, using various regression algorithms. However, the disruptions to healthcare provision during COVID-19 lockdowns has resulted in in a unique historical situation that is not likely to be indicative of long-term trends.

Instead, BCBSVT is projecting that the level of facility utilization will return to the pre-pandemic levels observed in the year ending in February 2020. The assumed historical and assumed trends are shown below:

Year Ending	Normalized Facility Claims PMPM	Annualized Trend
February 2019 (Actual)	$306.73	
February 2020 (Actual)	**$299.16**	- 2.5%
August 2021 (Actual)	$283.18	- 3.6%
December 2022 (Projected)	$292.50	+ 2.5%
December 2023 (Projected)	**$299.16**	+ 2.3%

The assumption that hospital utilization will return to pre-pandemic levels appears reasonable. There was a slight reduction in utilization leading up to the COVID lockdowns, so it is possible that there is a more long-term downward trend in utilization that compounds the observed drops during COVID. However, it is reasonable given the uncertainty at this time to assume that facility utilization will return to pre-pandemic levels.

Professional services saw even more extreme disruption due to COVID-19 than facility claims. This has taken two forms. Treatment for mental health issues has risen steadily, and other professional services have fallen sharply. However, both of these patterns were actually more pronounced in the period leading up to the pandemic than during it. Thus, it is difficult to be certain to what extent utilization should be expected to rebound. BCBSVT has assumed that mental health claims will continue to rise at 10% per year, but other professional services will rebound to their pre-pandemic levels. These historical and assumed trends are summarized below:

Year Ending	Normalized MH PMPM	MH Annual Trend	Normalized Other PMPM	Other Annual Trend	Normalized Total PMPM	Total Annual Trend
February 2019 (Actual)	$11.55		$127.25		$138.80	
February 2020 (Actual)	**$13.10**	13.4%	**$122.82**	-3.5%	$135.92	-2.1%
August 2021 (Actual)	$15.21	10.5%	$119.08	-2.0%	$134.29	-0.8%
December 2022 (Assumed)	$17.27	10.0%	$121.26	1.4%	$138.53	2.4%
December 2023 (Assumed)	**$19.00**	10.0%	**$122.82**	1.3%	$141.82	2.4%

There is tension between BCBSVT's assumption that non-mental health professional and facility claims will return to pre-pandemic levels, whereas mental health claims will continue to rise as they have during the pandemic. The demand for mental health services has increased substantially due to COVID

lockdowns and mortality is well documented.[5] Therefore, we have some concern that projecting recent trends in mental health utilization will continue into the future is likely to overstate future mental health costs.

Additionally, due to realities in the supply of qualified providers, it does not seem likely that sustained increases much more than the level assumed would even be possible. As a result, the best estimate should probably fall below the assumed 10%. We recommend changing the assumed mental health professional utilization trend to 5% per year. This would reduce projected premiums by approximately 0.3%.

Unit Cost

The unit cost trend for medical costs is projected to be 5.2% based on an analysis of the hospital budget increases implemented in recent years as well as other providers in the BCBSVT service area. By segment, this increase varies as shown below:

Market Segment	Annual Unit Cost Trend
BCBSVT Managed Care	5.1%
BCBSVT Non-Managed Care	5.2%
TVHP Managed Care	5.2%
Combined	**5.2%**

This projection includes a 5.6% increase for Vermont facilities and providers impacted by the GMCB's hospital budget review and an increase of 4.9% for other facilities and providers. This increase of 5.6% is in line with hospital budget submissions in Fall 2022 and mid-year increase requests filed by some hospitals in early 2022.

Unit cost increases for providers outside the BCBSVT service area were derived from the Blue Trend Survey.[6]

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. L&E does not recommend any changes to the medical unit cost trend assumptions.

Pharmaceuticals Processed through Medical Benefit

Consistent with last year's filing, BCBSVT has isolated claims related to pharmaceuticals covered by the medical benefit (as opposed to pharmaceuticals dispensed in a retail pharmacy setting). These prescriptions are differentiated from others due to their being applicable to medical deductibles and cost sharing rather than the prescription drug benefits. This is often because they are dispensed in an outpatient medical facility. For simplicity, we will refer to these as "outpatient drugs" in this report. These claims are treated as a special carve-out in the determination of medical trend. For unit cost, the overall outpatient cost trend of 5.4% was applied to all outpatient drugs. To determine utilization trend, outpatient drug experience was split into four categories: Injections with a biosimilar option,

[5] https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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

biosimilars, other injections costing at least $1,000, and all other pharmaceuticals. The resulting utilization trend was 1.8%.

Historical utilization of outpatient drugs were provided by incurral month for the last several years and shown to be increasing at a steady rate. The Company assumed an 7.3% increase in cost per year for outpatient drugs. The average increase for recent twelve-month periods is shown below:

Year Ended	Annual Cost Increase – Outpatient Drugs
Feb 2021	13.4%
Feb 2020	8.4%
Feb 2019	15.5%
Feb 2018	5.4%

The assumed 7.3% increase comparable to outpatient Rx trends observed in recent years and is reasonable given the historical variability.

Total Allowed Medical Trend

With the combination of the utilization and intensity trends, the unit cost trend, and the outpatient drugs trend, the total medical allowed trend in the filing is 7.5%. These relationships are shown in the table below:

Medical Cost Type	Cost Trend	Utilization Trend	Total Allowed Trend
Facility	5.4%	2.4%	7.8%
Professional	4.2%	2.4%	6.7%
Total without Outpatient Rx	5.1%	2.4%	7.5%

Medical Cost Type	Total Allowed Trend
Total without Outpatient Rx	7.5%
Outpatient Rx	7.3%
Total	**7.5%**

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 allowed medical trend is 4.9% to 9.7%. 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.

As a result of the recommendation above regarding mental health utilization trend, we recommend that the total medical trend be reduced from 7.5% to 7.4% per year.

3. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend, including the impact of contracting changes with the Pharmacy Benefit Manager, of 9.9%. This aggregate assumption is composed of the following components:

- Non-specialty utilization trend
- Generic cost trend, separately for new and established generics
- Brand cost trend, separately for new and established brands
- Impact of brand drugs going generic
- Specialty trend
- Vaccines, OTC, etc.

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 incorporate the impact of brand drug patent expiration, which results in a decrease in cost as lower-cost generics become available.

The Company modeled separately the total PMPM trends for specialty drugs due to their relatively low utilization and high cost nature. The following table shows the results of the Company's analysis and the requested 9.9% overall allowed pharmacy trend.

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend[7]
Generic	2.8%	1.3%	-1.5%
Brand	10.0%	1.3%	11.5%
Brands Going Generic	-30.3%	1.3%	-29.4%
Total Without Specialty	1.7%	1.3%	3.0%

Pharmacy Trends	Total Annual Trend[8]
Total Without Specialty	3.0%
Specialty	16.9%
Total	9.9%[9]

The Company calculated unit cost trends of 2.8% for generic and 10.0% for brand drugs. Both of these are consistent with recent trends in the observed changes in cost for these categories, as demonstrated in the Company's filing exhibits. Unlike in past filings, generic drugs were adjusted slightly to reflect the change in mix between established generics and new generics, which tend to have different average costs. A similar adjustment was made to brand drugs.

When the patent expires for a brand drug, lower-cost generic alternatives become available. The Company projected the quantity and reduced cost for drugs which will become genericized during the projection period. These drugs are assumed to reduce in price by 30.3% due to the availability of generic alternatives.

[7] The total trend may not equal the combination unit cost and utilization trend due to the additional adjustment for projected mix between new and established generics/brand.

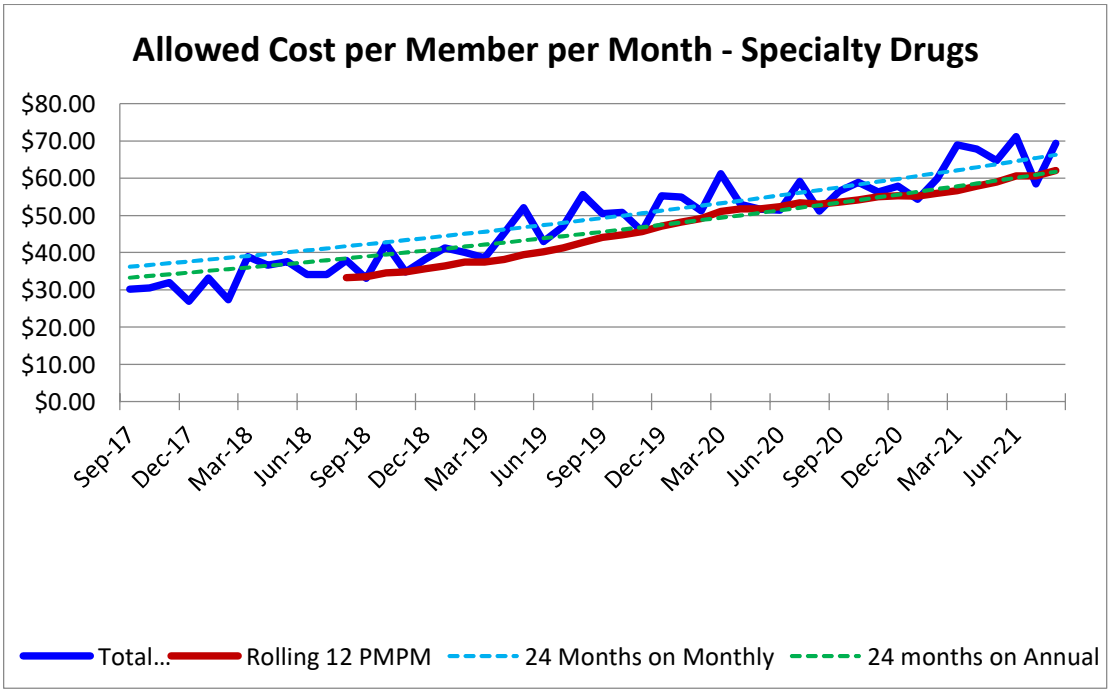
[8] The total trend may not equal the combination unit cost and utilization trend due to the additional adjustment for projected mix between new and established generics/brand.

[9] This figure includes the impact of contracting adjustments in addition to the trends by drug tier.

L&E believes the method of projecting brands going generic is reasonable and appropriate. The assumed unit cost trends for generic, brand, and brand-going-generic are reasonable.

The utilization trend for non-specialty drugs is projected to be 1.3% per year. This is based on historical utilization rising steadily from past levels during 2020 and 2021, even after the one-time effects from COVID-19 are taken into account. The 12-month increase in the year ending in August 2021, adjusted for COVID-19, is 0.5%. The increase in the year ending August 2020 was 3.1%. Due to the consistency between the projected utilization trend and historical utilization trend, we believe the proposed non-specialty utilization trend is reasonable.

Due to their high cost and low frequency, specialty drugs are projected based on their allowed cost, without splitting into unit cost and utilization. We agree with the Company's decision to analyze specialty cost trend this way, as the utilization trend would be difficult to assess given the low frequency and wide variance in unit costs. Unlike in prior filings, the Company has not carved out particular high-cost drugs. The Company explained that the impact of this additional complexity was limited, and they have elected to group all specialty claims into a single category for the purpose of trend development. L&E believes this methodology change is reasonable. Historical specialty trend is shown below:



Historical costs have increased at a steady, high rate for several years. The years ending in August of 2019, 2020, and 2021 exhibited cost increases of 16.7%, 24.2%, and 17.0% respectively. The assumed specialty trend is 16.9%, based on regression analysis of historical claims. The Company's selection of a 16.9% trend assumption is reasonable in light of the historical increases in cost observed.

The Company projects overall pharmacy allowed trend to be about 9.9% per year. This reflects not only unit cost and utilization changes but also contracting changes with the PBM (Pharmacy Benefit Manager). This total pharmacy allowed trend is reasonable in aggregate as well as when analyzed by the components described above.

4. *Total Allowed Trend:* Total allowed costs are projected to increase at 7.9% per year.

Category	Allowed Trend	Approx. Percent of Claims
Medical	7.5%	84%
Rx	9.9%	16%
Total	**7.9%**	**100%**

L&E considered all costs combined and estimated a likely range of annual allowed trends between 4.5% and 10.6%. Both BCBSVT's projected 7.9% trend and L&E's recommended trend 7.6% reflecting a reduction to Mental Health trend fall well within this range.

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends, as this is the clearest way to view changes in cost and utilization. However, plan liability increases at the paid trend rate, not the allowed trend rate. Therefore, an adjustment was made to the calculated allowed trends to reflect expected paid trends given the mix of benefits enrolled in the program.

   The leveraged trend values were determined using the Company's Benefit Relativity models[10] 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	Approx. Percent of Claims
Medical	7.5%	9.0%	83%
Rx	9.9%	10.6%	17%
Total	7.9%	9.3%	100%

   The methodology of using the Benefit Relativity models to estimate the impact on paid claims with and without the allowed trend is consistent with last year's filing. The approach that the Company used to adjust allowed trends to paid trends is reasonable and appropriate.

6. *Administrative Costs:* Administrative costs were projected based on historical administrative costs. The administrative experience period for this filing is January 2020 through December 2020. Those costs are allocated to groups either on a per-account basis, a per-member basis, or a per-contract basis, as appropriate. Transitional costs related to one-time events such as enabling full-time remote work, which will not recur in the future, were removed. The approved administrative charge for 2022 was $50.41 PMPM. The proposed admin charge is $54.94 PMPM. This increase of $4.53 PMPM is attributable to the following factors:
   - *Updated Experience:* The actual 2020 administrative costs differed from anticipated in the prior filing. Reflecting this updated information resulted in a decrease to admin costs of about $1.75 PMPM. This decrease in administrative cost flows through to the projected 2022 and 2023 administrative costs.
   - *Decrease in Total BCBSVT Membership:* BCBSVT has experienced a 13.0% decrease in overall membership across all lines of business between 2020 and 2022. Since fixed expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charges results. While it is not practicable for BCBSVT to reduce staffing as rapidly as enrollment

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

has fallen, BCBSVT has developed the administrative charge as if they did.[11] Under the assumption that 30% of costs are variable costs, this means that the impact on administrative costs is an increase of about 10.4%, or $5.09 PMPM.

- *Administrative Cost Inflation:* The proposed administrative costs will be incurred in 2022 and 2023. The assumed cost inflation reflects the Company's assumption that wages and benefits will increase at 3.0% per year, while other operating costs and membership are expected to remain at current levels. This is consistent with the prior filing. The administrative cost inflation results in an increase to the administrative cost PMPM of about $1.19.

The past few years have exhibited a notable increase in administrative costs for this block. In particular, the 2019 Q3 Large Group administrative charge was $40.85 PMPM. The 34% increase since that time is split about evenly between a 15% increase to total expenses and a 16% change from the reduced enrollment and change in mix of BCBSVT's enrolled membership. According to BCBSVT, the increased expense is driven by the following factors:

- A new operating system for enrollment, billing, and claims processing, which went live in 2019;
- New customer relationship management software;
- Enhancements to the company's IT security program; and
- Inflationary increases in vendor costs.

The process for reflecting the most recent information available is actuarially sound. Additionally, the Company did not reflect the full change in enrollment when calculating the increase in fixed cost per member. That is, a higher increase to administrative costs would be supportable based on the methodology described above.

The premiums will also include allowances for the following state mandates and assessments. Some values are provisional until the relevant agencies announce the final assessment values.

- The Vermont Vaccine Purchasing Program is estimated to cost $10.91 PMPM per child and $1.60 PMPM per adult.
- The New Hampshire Purchasing Program is expected to cost $6.85 PMPM for each child that is a resident of New Hampshire.
- New York State Health Reform Act applies an assessment based on county of residence within New York.
- The Maine Guaranteed Access Reinsurance Association produces an assessment of $4.00 PMPM per Maine resident.
- The Vermont Health Care Claims Tax of 0.999% of claims for all Vermont residents.
- The Health IT-Fund assessment of 0.199% has been routinely extended, so the current rate manual reflects a continued assessment. It will be updated if new information becomes available.
- BCBSVT projects that the total assessments for Vermont Blueprint for Health will be $2.77 PMPM for the Community Health Team and $3.21 for the PCMH team. Actual rates charged will reflect any updates made to the Blueprint Manual in renewals.
- The Green Mountain Care Board assess a billback, projected to be $2.31 PMPM for the coverage period.

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

[11] By rebasing to 2020 costs, BCBSVT is fully reflecting all enrollment changes that occurred prior to 2020. The method they have used in recent years to dampen the effect of enrollment changes on premiums partially delays recognition of enrollment changes for two years.

7. *Federal Fees:* H.R.1865 - Further Consolidated Appropriations Act repealed the ACA's Section 9010 insurer fee for 2021. Therefore, no insurer fee is included in the proposed rates.

   The projected Patient-Centered Outcomes Research Institute (PCORI) fee is approximately $0.25 PMPM. This value is reasonable.

8. *Contribution to Reserves (CTR):* The proposed CTR is 1.5% for BCBSVT Insured Large Groups and 0.375% for Cost Plus Groups. For TVHP insured groups, the proposed CTR is 2.0%. As a result of the Tax Cuts and Jobs Act of 2017, BCBSVT is no longer subject to income tax. Because TVHP is subject to income tax, a higher pre-tax CTR is required to result in equivalent post-tax contributions to reserve.

   The results of the Department of Financial Regulation's Solvency Analysis should be considered in the approval of this assumption.

9. *Other Rate Manual Changes:* Similar to last year's filing, BCBSVT uses factors reflecting the impact of drug benefit design on the generic dispensing rate. Groups with lower generic copays and/or higher brand copays are assumed to have consequently higher generic utilization and lower brand utilization. This change does not have an overall impact on premiums across all groups, but merely attempts to better align premiums between different groups with the benefit value of their different plan designs. This change appears reasonable.

   Costs associated with treating COVID-19 are isolated from the experience and are not included in the manual rate or a group's experience at renewal. This means that any increase to costs from COVID-19 will not be carried forward into premiums for future periods. L&E believes this is a reasonable approach.

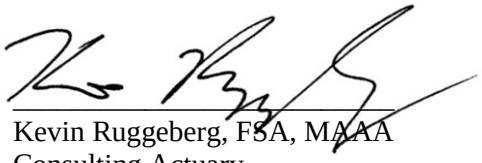
Recommendation

As noted above, L&E recommends that the following change be made to the rates proposed in this filing:

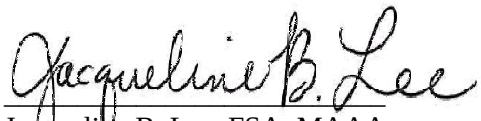
- Reduce the mental health utilization trend from 10% per year to 5% per year. This change will result in a decrease to proposed premiums of approximately 0.3%.

L&E believes that, with the above change, this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing, resulting in an anticipated average premium change of approximately 7.6%.

Sincerely,



Kevin Ruggeberg, FSA, MAAA
Consulting Actuary
Lewis & Ellis, Inc.



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

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[12], 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[13], 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:

- Kevin Ruggeberg, FSA, MAAA, Consulting Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, 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 April 18, 2022. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 18, 2022.

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.

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

Methods, Procedures, Assumptions, and Data

[12] 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.

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

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.