

Dallas

Cabe W. Chadick, F.S.A.
 S. Scott Gibson, F.S.A.
 Glenn A. Tobleman, F.S.A., F.C.A.S.
 Michael A. Mayberry, F.S.A.
 David M. Dillon, F.S.A.
 Gregory S. Wilson, F.C.A.S.
 Steven D. Bryson, F.S.A.
 Brian D. Rankin, F.S.A.
 Bonnie S. Albritton, F.S.A.
 Jacqueline B. Lee, F.S.A.
 Wesley R. Campbell, F.C.A.S., F.S.A.
 Xiaoxiao (Lisa) Jiang, F.S.A.
 Brian C. Stentz, A.S.A.
 Jennifer M. Allen, A.S.A.
 Josh A. Hammerquist, A.S.A.
 Johnathan L. O'Dell, A.S.A.
 Clint Prater, A.S.A.
 Larry Choi, A.S.A.
 Kevin Rugeberg, A.S.A.
 Traci Hughes, A.S.A.

**Kansas City**

Gary L. Rose, F.S.A.
 Terry M. Long, F.S.A.
 Leon L. Langlitz, F.S.A.
 D. Patrick Glenn, A.S.A., A.C.A.S.
 Christopher J. Merkel, F.S.A.
 Christopher H. Davis, F.S.A.
 Karen E. Elsom, F.S.A.
 Jill J. Humes, F.S.A.
 Kimberly S. Shores, F.S.A.
 Michael A. Brown, F.S.A.
 Naomi J. Kloepersmith, F.S.A.
 Stephanie T. Crownhart, F.S.A.
 Mark W. Birdsall, F.S.A.

London/Kansas City

Timothy A. DeMars, F.S.A., F.I.A.
 Scott E. Morrow, F.S.A., F.I.A.

Denver

Mark P. Stukowski, F.S.A.
 William J. Gorski, F.S.A.

Indianapolis

Kathryn R. Koch, A.C.A.S.

Baltimore

David A. Palmer, C.F.E.

July 11, 2016

Green Mountain Care Board
 State of Vermont
 89 Main Street, Third Floor, City Center
 Montpelier, VT 05620

Re: MVP Health Plan 2017 Exchange Filing (SERFF # MVPH-130558905)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2017 Exchange Filing for MVP Health Plan, Inc. (MVP) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP provides individual and small group coverage to be sold on Vermont Health Connect (VHC). This filing develops premiums for MVP's Qualified Health Plans (QHPs) to be offered on VHC, beginning January 1, 2017.
2. This filing addresses MVP individual members and small groups. As of March 2016, there are approximately 6,600 members affected by this filing.
3. The overall impact of this filing is a proposed average rate increase of 8.8% or \$37.57 per member per month (PMPM) in premiums. This average increase is broken down by metal level in the table below. The second table illustrates the final premium rate changes after last year's 2016 VHC filing.

2017 Proposed Rate Changes

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	9.0%	\$23.72	0.5%
Bronze	10.4%	\$38.75	34.9%
Silver	8.0%	\$35.69	22.0%
Gold	8.3%	\$39.09	31.0%
Platinum	7.0%	\$39.83	11.5%
Overall	8.8%	\$38.23	100.0%

2016 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	21.8%	\$45.57	0.6%
Bronze	1.9%	\$7.37	36.6%
Silver	2.6%	\$12.29	41.2%
Gold	1.7%	\$9.70	8.5%
Platinum	2.2%	\$14.28	13.1%
Overall	2.4%	\$10.73	100.0%

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

MVP provided the methodology used to calculate the proposed 2017 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including the index rate development with adjustments for trend, administrative costs, and taxes and fees.

Exhibit 2a illustrates the assumed allowed medical cost trend by benefit category for 2016 and 2017, annual paid trend that accounts for leveraging impact, and the utilization/unit cost trends for prescription drugs by drug category. Exhibit 2b illustrates the application of pharmacy trends by drug category to experience period paid PMPM in development of the projected pharmacy paid PMPM.

Exhibit 3 shows the index rate development starting from MVP's experience period claims (encompassing about 125,000 total member months from non-ACA compliant and ACA compliant individual and small group employer data, association data, and large groups with 51-100 employees) and adjustments applied in derivation of index rate. These adjustments include application of factors for incurred but not reported claims, pooling charge, paid medical/Rx trend, benefit changes, demographic changes, etc.

Exhibit 4 shows the development of the single conversion factor of 1.118, using the distribution by tier and the average contract size by tier derived from the experience period. Exhibit 5 shows the retention loads, taxes, assessments, and paid claim surcharges. Exhibit 6 shows the development of the contract tier rates from the adjusted 2016 paid claim cost.

MVP also provided a report from an actuarial consulting firm with pricing for minor changes to required EHB's, including couples' therapy and private duty nursing.

MVP provided additional exhibits and quantitative support as requested during the rate review process.

L&E Analysis

The average proposed increase of 8.8% to the 2016 premiums is attributed to several factors, including trend, contract tier distribution assumptions, and changes to federal programs, as illustrated in the table below. To create a consistent comparison for both companies filing VHC products, we categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component ¹	Percentage Change ²	PMPM Change ³
1. 2015 Actual/Projected Claims Experience	10.8%	\$51.82
2. Difference in trend from 2015 to 2016	-1.1%	-\$6.10
3. Trend from 2016 to 2017	3.4%	\$17.70
4. Changes to Population Risk Adjustment	0.0%	\$0.09
5. Changes to Other Factor	0.3%	\$1.57
6. Changes to Manual Rating Adjustment	-3.2%	-\$17.58
7. Changes to Risk Adjustment	7.5%	\$39.58
8. Changes to the Federal Transitional Reinsurance Program	1.9%	\$10.72
9. Changes in Administrative Costs	-1.1%	-\$6.37
10. Changes in Contribution to Reserves	1.3%	\$7.59
11. Changes in Taxes & Fees	-2.2%	-\$12.79
12. Changes in Single Contract Conversion Factor	-2.4%	-\$13.39
13. Changes in Actuarial Value⁴	-5.5%	-\$30.63

1. *2015 Actual/Projected Claims Experience*: MVP experienced worse than expected claim experience in 2015. The 2017 URRT shows that the 2015 Claim Experience was 10.8% higher than projected in the 2016 Exchange Filing's URRT.

Since this change is driven by actual experience, this rate component appears to be reasonable and appropriate.

2. *Difference in trend from 2016 to 2017*: The annual trend in the 2017 URRT is 3.4%. This trend is lower than the projected trend from 2016 to 2017 utilized in the 2016 URRT by 1.1%. We note that the facility trend factors reflect known and assumed price increases from MVP's provider network.

The assumed 3.4% trend assumption is discussed further in the next section.

¹ The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

² The percentage increases are multiplicative and do not sum to the requested 8.8% premium increase.

³ The PMPM changes do not add up to the overall average PMPM quoted on Page 1 because the PMPM changes seen in this table incorporate the Single Contract Conversion Factor change.

⁴ Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), and membership shifts.

3. *Trend from 2016 to 2017:* The Company requested an allowed medical trend of 2.5% and an allowed Rx trend of 11.6%. The cost for capitated services is projected to decrease, resulting in an overall increase in medical costs of 2.1% annually.

Cost Category	Allowed Trend	Paid Trend
Medical	2.5%	2.8%
Drug	11.6%	12.2%
Total	3.5%	3.9%

The total combined allowed trend is 3.4% annually.

- *Medical Trend:*

The Company projected an annual allowed medical trend of 2.5%. The allowed trend reflects changes in the cost of medical services and changes in utilization of medical services by members. Consistent with prior filings, MVP's utilization trend is 0%; therefore, the allowed trend is based solely on allowed charges (reflecting the total amount of claims paid by the carrier and the policyholder).

Unit Cost Trend

MVP computed its allowed trend as a weighted average of the medical claim trends in 2016 and 2017 for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network. MVP used known and assumed contractual increases with providers to derive their requested allowed medical trend consistent with their prior rate filings. Based on our preliminary and limited review of the proposed hospital budget submissions, significant investments are expected to reduce commercial rates in 2017 for facilities and providers that are impacted by the GMCB's Hospital Budget Review. This methodology appears to be a reasonable and appropriate and should be more effective at predicting future trends than considering historical data alone. This resulted in a unit cost trend of 2.5%.

The effective paid medical trend reflects the actual claim payment made only by the carrier and is derived from the proposed allowed cost trend rates, adjusted for the impact of cost share leveraging⁵. The resulting annual effective paid medical trend is 2.8%. The medical claims were projected forward to the midpoint of the rating period using this effective paid medical trend. The Company's assumed allowed and effective paid medical trends appear to be reasonable and appropriate.

Utilization Trend and Intensity

As previously stated, MVP has consistently used an assumption of 0% for utilization trend. As a result of our inquiry, MVP provided historical utilization data by month since the beginning of 2014. This data reasonably demonstrates that while there was a brief period of high utilization in early 2014, utilization has been quite flat since that time. The outlier utilization in early 2014 is most likely due to pent-up demand associated with the implementation of the ACA. That one-time event will not repeat in 2017. The continued

⁵ Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation.

use of 0% utilization trends appears to be reasonable and appropriate in light of historical claims patterns.

Total Allowed Medical Trend

To evaluate the reasonableness of the Company's allowed medical trend development, we combined all of the allowed medical claims for the prior 24 months and modeled PMPM claims, normalized for changes in demographics, using an exponential regression. This analysis resulted in an allowed medical trend of 2.1%, which is consistent with the Company's proposed trend, when capitated services are taken into account. Our estimated allowed trend range based on regression analysis of the historical experience is 1.5% to 2.6%. Each of the numbers within our 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 2.5% (non-capitated) is within our estimated range based on MVP's historical experience.

- *Pharmacy Trend:* The Company projected an annualized allowed Rx trend of 11.6%.

This trend forecast was provided by MVP's Pharmacy Benefit Manager (PBM), based on MVP's experience by drug class. This forecast was performed separately for large group and for individual/small group combined. The chart below shows that the specialty trend category is driving the total Rx trend up.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	-7.8%	3.3%	-4.8%
Brand	14.6%	-2.5%	11.7%
Specialty	10.5%	9.0%	20.5%
Total	8.7%	2.7%	11.6%

After accounting for member cost sharing, the total annualized effective paid Rx trend is 12.2%.

This is the first filing in which the Rx trends are based on MVP's own data, rather than the PBM's nationwide trend estimates. As a result, we believe that these trends will be more representative of future trend experience than in previous filings. The large group trend estimates are applied to the large group experience in the base period, while the individual and small group trend estimates are applied to the remainder. This results in a very granular projection of Rx trends.

As in prior non-Exchange filings, MVP has not used historical pharmacy trend analysis evaluating the PMPM changes over time to form assumptions for future pharmacy trends as they believe prior experience is not indicative of future trends. We recognize that historical trends may not be indicative of future trends for all underlying factors, such as shifts in generic dispensing rates, drugs losing patents, introduction of new

drugs, (such as high cost Hepatitis-C drugs) and changes in pharmacy vendors. For comparison purposes, we analyzed 24 months of MVP's historical pharmacy trend experience and found it to be volatile. Looking at rolling 6 month averages, the annualized paid Rx trend has consistently been above 35% over the last two years. If historical drug trends were used, instead of the PBM's prospective analysis, to estimate future trends, the result would be trend assumptions materially higher. We agree with MVP's assessment that the PBM's projections are more reliable than historical trends at this time.

We considered MVP's historic experience as well as the PBM's recommendation and opine that the requested Rx paid trend of 12.2% appears to be reasonable and appropriate.

The Company requested a paid medical trend of 2.8% and a paid Rx trend of 12.2%. The total paid trend is anticipated to be 3.9% annually. This total trend appears to be reasonable and appropriate.

4. *Changes to Population Risk Adjustment:* No changes to the risk profile of the covered population were assumed in this filing. MVP used claim experience from the Exchange members as well as members outside the Exchange population to project the 2017 claim costs (elaborated further in section 6 below). MVP considered potential differences in the risk profiles of these added populations and the Exchange population, but both groups had similar allowed costs. It was determined that this was a strong indicator that the risk profiles of each cohort was materially similar. L&E evaluated the claim detail for each cohort included in the projected rates and agreed that the allowed costs between the various cohort were similar. The population risk adjustment appears to be reasonable and appropriate.
5. *Changes to Other Factor:* The Other Change projection factor reflects several adjustments to pre-ACA small group experience. The overall change from the prior filing results in a 0.3% rate increase. These adjustments are:
 - A factor to reflect the seasonal impact of mid-year terminations and renewals
 - A factor to adjust for anticipated changes to the member age distribution since the base period

Anticipated demographic changes are incorporated by comparing the change in average HHS Age Factor between the experience period and March 2016. Given MVP's 2016 actual enrollment is the basis for the 2017 projected enrollment, we agree with MVP's decision to incorporate this information in the development of the index rate. The ACA compliant small group members have become slightly younger on average than in the experience period. All other cohorts have become slightly older on average in that time.

We note that the HHS age factors understate the true difference in cost between young and old members. Due to the minimal change in the population age since the base period, this difference would not have a material effect on the premiums proposed in this filing. However, we suggest that MVP consider using a data-driven age curve to adjust for age changes in future filings.

The Other Factor change of 0.3% appears to be reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* Changes to the manual rate experience caused a 3.2% decrease in the rates. In this 2017 Exchange filing, MVP combined the experience of ACA-compliant and non-ACA compliant individual and small group data, association group (AgriServices), and large groups with 51-100 employees in developing the experience period claims. Adjustments to the starting point included changes applicable to the 2016 filing, such as using a pooling charge for large claims. This methodology is consistent with last year's filing. MVP anticipates that most groups included in the base period experience will migrate to an ACA-compliant plan in 2017.

To increase non-ACA experience for EHB's that are currently captured by MVP's ACA compliant data (such as pediatric dental), MVP applied observed costs for ACA members to the non-ACA blocks. In cases where non-EHB's are reflected in the base period, such as vision hardware and elective abortion, the cost of these benefits was removed from the non-ACA experience.

At this time, the Exchange experience is fully credible by almost any common credibility measure. However, the methodology of blending experience with other blocks of business assigns the Exchange experience only 51% credibility. It is common practice to map particular groups to ACA-compliant plans that are anticipated to migrate based on a consistent methodology. However, based on the past 3 years, it is clear that assuming all groups will migrate is not a likely assumption. MVP has illustrated that the ACA and non-ACA experience has similar allowed costs between both of them, suggesting similar risk profiles and minimizes the impact of this methodology.

In future VHC filings, we believe an alternate reasonable approach would be to assign reduced weight to the transitional experience, acknowledging the fact that not all members will transition over in any given year. Additionally, while the allowed claim costs were similar among the cohorts for this filing, L&E recommends that MVP consider adjusting for differences in risk profiles when combining different cohorts for claim projections.

7. *Changes to Risk Adjustment:* At the time of the initial filing, the most recent data available on risk adjustment was the interim report for benefit year 2015 that was published on March 18, 2016. Due to data quality concerns in the interim report, MVP's assumption was based on the risk adjustment payments/receivables for benefit year 2014. The PMPM risk adjustment assumed in the URRT is equal to 2/3 of MVP's PMPM risk adjustment paid into the risk adjustment program for benefit year 2014.

Final risk adjustment data for benefit year 2015 was made public by CMS on June 30, 2016. As predicted by MVP, these final results were different from the interim data; however, the report did show that risk adjustment in Vermont has changed significantly since 2014. The tables below show the aggregate payables and receivables and the corresponding PMPM values for both carriers in each benefit year.

Aggregate Transfer Amounts⁶

Benefit Year	BCBSVT	MVP
2014	-\$2,670,249	\$2,670,249
2015	-\$581,288	\$581,288

PMPM Transfer Amounts⁶

Benefit Year	BCBSVT	MVP
2014	-\$4.57	\$44.13
2015	-\$0.82	\$9.55

MVP indicated that they wished to continue using the assumption based on 2014 experience after 2015 data was available.

L&E gathered risk adjustment data for benefit year 2015 from both carriers and developed an independent projection of future results using more information than either carrier has available, due to the proprietary nature of this data. L&E's projection is based on known changes to premium levels and Exchange eligibility, as well as other shifts in the Vermont healthcare market. Our projections indicate that the payments made from MVP into the risk adjustment program will be substantially lower than what is assumed in the URRT. L&E recommends that MVP's assumed risk adjustment payment be \$9.75 PMPM. Adopting this change would result in a 4.2% decrease in the proposed rates.

Additionally, L&E noted that the projected members in the URRT appear to be overly optimistic. L&E recommends that the projected population be changed to be more reflective of realistic assumptions. Given an assumed 2017 enrollment of 100,000 member months, MVP's total projected 2017 risk adjustment payment would be \$975,000.

	Total Risk Adjustment	PMPM Risk Adjustment ⁶
MVP Original	\$2,942,000	\$29.42
L&E Estimate	\$975,000	\$9.75

8. *Changes to the Federal Transitional Reinsurance Program:* The rates were increased 1.9% to account for the phase-out of the transition reinsurance program. Since the base period experience reflects reinsurance cash flows, these receipts were removed to increase the ACA-compliant experience period paid claims. Conversely, experience period claims were reduced for other blocks of business to reflect the termination of contributions into the reinsurance program. The net result of an increase of 1.9% due to the phase-out appears to be reasonable and appropriate.

⁶ The positive risk adjustment payment means that MVP would pay money to the risk adjustment program.

9. *Changes in Administrative Costs:* The rates were decreased by 1.1% due to a reduction in projected administrative costs as a percentage of premium. MVP is projecting general administrative costs to be \$36.60 PMPM, which remains unchanged from the 2016 Exchange filing. This includes quality improvement (QI) expense of 10% of total administrative expense and a \$1.50 PMPM to provide an expanded network to members purchasing exchange products in Vermont. Since the QI assumption is based on actual 2015 MVP expenses, we find it to be reasonable and appropriate.

Because the premium is increasing from the 2016 Exchange filing, the admin expenses as a percentage of premium are decreasing. The assumed administrative costs assumed in this filing are slightly higher than MVP's 2015 individual and small group administrative costs of \$35.15 PMPM based on the 2015 Supplemental Health Care Exhibits (SCHE). These costs have fallen substantially since 2013, when they were \$46.57 PMPM. This historical reduction in admin costs could not continue indefinitely, and the projected admin costs appears reasonable. In light of the steps taken by MVP in reducing administrative costs over the recent years, the assumed administrative 2017 costs appear to be reasonable and appropriate.

10. *Changes in Contribution to Reserves:* The rates were increased 1.3% to reflect the increase in the contribution to reserves. MVP's assumed contribution to reserves of 1% in this filing is higher than the -0.2% approved by the Board in the 2016 Exchange filing. The proposed 1% contribution to reserves, while higher than approved last year, is more consistent with the assumptions found in MVP's other previous filings. We note that a 0% margin is not sustainable in the long run and believe the contribution to reserves appears to be reasonable and appropriate.
11. *Changes in Taxes & Fees:* The rate change due to changes in taxes and fees is a decrease of 2.2%. This change is driven primarily by the moratorium on the Health Insurer Fee for coverage year 2017. Other changes in the taxes and fees include a slight reduction in the Risk Adjustment User Fee and the addition of the Health Care Advocate (HCA) assessment. As dictated by House Bill 873, the Company will be required to contribute a portion of the HCA's operating costs, resulting in an increase in premiums of approximately \$0.49 PMPM. These assumptions appear to be reasonable and appropriate.
12. *Changes in Single Conversion Factor:* The single conversion factor⁷ used in the 2016 rate filing was 1.145. For this year's filing, MVP utilized March 2016 enrollment to calculate the 2017 single conversion factor of 1.118.

This reduction is the result of a shift towards single coverage since 2014. The impact of this change is a decrease of 2.4% in the rates. L&E reviewed the calculation of this adjustment, and the calculations appears to be reasonable and appropriate.

⁷ The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, the tiered premiums require the base premium to be for a single adult.

13. *Changes in AV Factors:* This reflects other Pricing AV changes such as changes in Metal AVs of plans, induced utilization, cost sharing changes, and changes in projected enrollment among plans. This also reflects any changes to the pricing AV's calculated by MVP. These changes combined cause a 5.5% decrease in rates.

To project membership by plan, MVP considered the March 2016 benefit richness of all members included in the base period experience, including those that are not currently enrolled in ACA compliant plans. Non-ACA members tend to be enrolled in richer plans (i.e. Gold and Platinum) than members who enroll in ACA compliant plans. For this reason, the projected index rate assumes higher induced utilization than is currently present. This is based on an implicit assumption that members who transition from non-ACA plans to ACA plans will keep similar metal tiers. This method also assumes that all members in non-ACA, non-large group plans will transition to ACA plans in 2017.

The assumed 2017 distribution is more heavily weighted towards gold plans than the assumed 2016 distribution. However, pricing AV values for all plans dropped noticeably. The projected paid to allowed ratio has decreased from 0.805 to 0.775, despite the projected increase in Gold enrollment. That is, MVP projects that the gold plan benefits will be less rich than was previously expected. Additionally, this metal AV shift impacts the induced demand, which increases with plan richness and cost sharing subsidies.

While we have some concerns about this methodology, we note that the Exchange enrollment distribution has shifted noticeably towards gold plans between 2015 and 2016, which is consistent with MVP's assumptions regarding transitioning members. We do not recommend any changes to the assumed metal tier distribution at this time.

In normalizing the experience for AV differences and induced utilization, MVP used a calculation method that inadvertently created a slight upward bias in final premiums. The order of operations in calculating the weighted average AV/induced utilization factor understated the impact of induced utilization on the base period experience.

After discussing the issue, MVP agreed that the calculation should be revised. This modification to the calculation methodology results in a decrease in proposed premiums of approximately 0.5%. We recommend this change be made to the filing.

Recommendation

After modifications, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modifications:

- Modify the normalization for AV and induced utilization to be the weighted average of the combined factor (rather than combined impact of the weighted averages). This change results in a decrease in the proposed rates of 0.5%.
- Reduce the projected risk adjustment payment from \$29.42 to \$9.75. This change results in a decrease in the proposed rates of 4.2%.

After the modifications, the anticipated overall rate increase will reduce from 8.8% to approximately 3.7%.⁸

⁸ Due to rounding, the change of 0.5% reduces the overall rate increase from 8.8% to 8.2%, even though this appears to be a 0.6% change.

Metal Tier	Proposed Rate Change	Modified Rate Change	Percent of Membership (March 2016)
Catastrophic	9.0%	4.3%	0.7%
Bronze	10.4%	5.4%	43.8%
Silver	8.0%	3.0%	28.4%
Gold	8.3%	3.3%	14.5%
Platinum	7.0%	1.9%	12.6%
Overall	8.8%	3.7%	100.0%

Metal Tier	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	\$23.72	\$11.40	-\$12.32	0.7%
Bronze	\$37.62	\$19.50	-\$18.12	43.8%
Silver	\$35.31	\$13.18	-\$22.13	28.4%
Gold	\$39.70	\$15.57	-\$24.13	14.5%
Platinum	\$40.85	\$11.29	-\$29.56	12.6%
Overall	\$37.57	\$16.04	-\$21.53	100.0%

Sincerely,



Kevin Rugeberg, ASA, MAAA
Associate Actuary
Lewis & Ellis, Inc.



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



David M. Dillon, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations⁹, 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 Conduct¹⁰, 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 Ruggenberg, ASA, MAAA, Associate Actuary 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 July 11, 2016. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is July 11, 2016.

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 we have 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.
- We are 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.

⁹ 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.

¹⁰ These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- 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

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.