

Dallas

Glenn A. Tobleman, F.S.A., F.C.A.S.
 S. Scott Gibson, F.S.A.
 Cabe W. Chadick, F.S.A.
 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.
 Bonnie S. Albritton, F.S.A.
 Brian D. Rankin, F.S.A.
 Wesley R. Campbell, F.C.A.S., F.S.A.
 Jacqueline B. Lee, F.S.A.
 Xiaoxiao (Lisa) Jiang, F.S.A.
 Brian C. Stentz, A.S.A.
 J. Finn Knox-Seith, A.S.A.
 Jennifer M. Allen, A.S.A.
 Josh A. Hammerquist, A.S.A.
 Sujaritha Tansen, A.S.A.
 Sergei Mordovin, A.S.A.
 Johnathan L. O'Dell, A.S.A.
 Clint Prater, A.S.A.
 Larry Choi, 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 H. Davis, F.S.A.
 Karen E. Elsom, F.S.A.
 Jill J. Humes, F.S.A.
 Christopher J. Merkel, F.S.A.
 Kimberly S. Shores, F.S.A.
 Michael A. Brown, F.S.A.
 Naomi Kloepersmith, F.S.A.
 Stephanie Crownhart, F.S.A.
 Thomas L. Handley, F.S.A. (Of Counsel)

London / Kansas City

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

Baltimore

David A. Palmer, C.F.E.

Denver

Mark Stukowski, F.S.A.

July 14, 2015

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

Re: Blue Cross and Blue Shield of Vermont 2016 Exchange Filing (SERFF # BCVT-130082559)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2016 Exchange Filing for Blue Cross and Blue Shield of Vermont (BCBSVT) 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 individual and small group coverage to be sold on Vermont Health Connect (VHC).
2. This filing develops premiums to be used in VHC beginning January 1, 2016.
3. This filing addresses BCBSVT individual members and small groups. There are approximately 70,000 lives affected with about 6,500 new lives from other non-ACA compliant plans that are expected to enroll in an ACA-compliant plan in 2016.
4. The overall impact of this filing is a proposed average 8.6% or \$37.54 per member per month (PMPM) increase in premiums. This average increase broken down by metal level is:

2016 Proposed Rate Changes

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	5.2%	\$11.92	0.2%
Bronze	9.9%	\$33.44	16.3%
Silver	8.7%	\$35.77	46.5%
Gold	8.9%	\$41.44	16.2%
Platinum	7.7%	\$41.89	20.8%
Overall	8.6%	\$37.54	100.0%

2015 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	6.8%	\$12.95	0.2%
Bronze	7.1%	\$22.34	16.6%
Silver	7.9%	\$29.43	44.3%
Gold	8.5%	\$36.95	16.9%
Platinum	7.1%	\$36.81	22.1%
Overall	7.7%	\$31.13	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

BCBSVT provided the methodology used to calculate the proposed 2016 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees.

The changes to the morbidity assumptions and the population based factors are calculated using the 63,500 members, who have previously enrolled in a QHP product, and the 6,500 new members.

Exhibit 3 provided support for the proposed pharmacy and medical trend factors. The historical claims costs are provided for the prior three years.

For pharmacy trend, the combined utilization for generic and brand drugs are projected and then split by the projection of the generic dispensing rate (GDR) based on the brand drugs that are scheduled to lose patent in the next few years.

For medical trend, the total allowed amount is 7.4%. The utilization and intensity trend is projected to be 2.0%. The unit cost trend for medical trend is projected to be 5.3% based on an analysis of the budget increases implemented during 2014 for hospital budgets as well as other providers in the BCBSVT service area.

Exhibit 5 demonstrated the development of the Market Adjusted Index Rate beginning with the experience period Index Rate. Adjustments were made for population risk morbidity, other factors (such as changes in provider networks), unit cost trend, utilization trend, non-system claims, and market wide adjustments.

Exhibit 9 showed the proposed premiums, the requested rate increase by plan, and the calculation of the average rate increase of 8.6%.

In the initial filing, Exhibit 9 showed an increase of 8.4%, but during the course of the review, legislation was passed that impacted the Blueprint program. These changes were not incorporated into the rate increase of 8.4%. The Company amended the rate increase to reflect the Blueprint adjustments in SERFF on June 26th, 2015, which resulted in an increase of 8.6%.

L&E Analysis

The average proposed 8.6% increase to the 2015 premiums is attributed to several factors including trend, updated membership assumptions, and changes to state and federal programs. 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. 2014 Actual/Projected Claims Experience	-1.8%	(8.63)
2. Difference in trend from 2014 to 2015	2.1%	9.96
3. Trend from 2015 to 2016	7.3%	35.30
4. Changes to Population Risk Adjustment	2.7%	14.05
5. Changes to Other Factor	-4.8%	(25.88)
6. Changes to Risk Adjustment	0.0%	\$0.07
7. Changes to the Federal Transitional Reinsurance Recoveries	1.7%	8.61
8. Changes in Administrative Costs	0.1%	0.50
9. Changes in Contribution to Reserves	1.1%	5.65
10. Changes in Taxes & Fees	0.0%	0.14
11. Changes in Single Contract Conversion Factor	-0.8%	(4.40)
12. Changes in All Other Factors⁴	1.2%	6.39

- 2014 Actual/Projected Claims Experience:* The actual 2014 claim experience was 1.8% lower than the projected 2014 costs. For the purposes of this report, we allocated two year trends evenly between both years. Since this change is driven by actual experience, this rate component appears to be reasonable and appropriate.
- Difference in trend from 2014 to 2015:* The trend from 2014 to 2015 in the 2016 URRT of 7.3% results in a 2.1% higher rate increase than the trend from 2014 to 2015 in the prior URRT. The assumed 7.3% trend assumption is discussed further in the next section.
- Trend from 2015 to 2016:* The Company projected an allowed medical trend of 7.4% and an allowed pharmacy trend of 6.5% for a combined trend of 7.3%.
 - Medical Trend:* The Company is requesting an allowed medical trend of 7.4%, broken down into 5.3% for unit cost and 2.0% for utilization. The Company analyzed the changes to the provider contracts in the BCBSVT service area and used the Fall 2014 Blue Trend Survey for providers

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 changes are multiplicative and do not sum to the requested 8.6% premium increase.

³ The PMPM changes do not add up to the overall average PMPM of \$37.54 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.), average policy duration, and membership shifts

outside the BCBSVT service area to determine the unit cost trend and performed regression analysis over 24 months for the utilization trend.

Unit Cost

The Company assumed providers within the BCBSVT service area would have overall 2015 and 2016 budget increases identical to those implemented during 2014. For providers outside the BCBSVT service area, the Company used the Fall 2014 Blue Trend Survey. This analysis resulted in a unit cost trend of 5.3%. After confidential correspondence that adequately supported the change, the Company agreed that it would be more appropriate to use a unit cost trend of 5.1%.

Utilization and Intensity

The Company normalized the allowed costs for the past 48 months to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. The average trend was then analyzed by using exponential regression over three different time periods.

Regression Time Period	Average Trend
12 Month	18.8%
24 Month	6.1%
36 Month	6.7%

The Company determined that the trend based on the 12 month regression was significantly impacted by seasonality and was not appropriate. Therefore, the Company chose the 24 month regression because the population was more stable over this time period due to a large association group that was included in the data beginning January 1, 2012, which increased membership by approximately 50%.

The Company analyzed utilization using a closed block of members that were active on December 31, 2014 and had at least two years of enrollment. Since a closed block of business was used in the analysis, the Company adjusted the 6.1% downward to remove the impact of changes in induced utilization and the aging population, resulting in a utilization trend of 2.0%. We consider the methodology used to calculate the utilization trend to be reasonable and appropriate.

Total Allowed Medical Trend

Combining the Company's proposed revised unit cost trend of 5.1% with the utilization trend of 2.0% results in an allowed medical trend of 7.2%, which is lower than the Company's originally requested allowed medical trend of 7.4%. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. Our estimated range for the actual results is 4.5% to 10.0%. 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.⁵

The Company's originally proposed allowed medical trend of 7.4% was unintentionally inflated due to the methodology used. With the Company's proposed revision, we consider the allowed medical trend to be reasonable and appropriate. Therefore, we recommend modifying the allowed medical trend to 7.2%.

⁵ For example, the probability that the actual trend will be centered around the best estimate (between 7.1% and 7.3%) is 50% higher than being near the low end of the range (between 4.5% and 4.7%).

- *Pharmacy Trend:* The Company is requesting an allowed pharmacy trend of 6.5%.

We attempted to analyze the historical claims costs of the pharmacy claims by modeling the total claims on a per member per month basis; however, this does not account for other factors such as the slowing growth of the generic dispensing rate, drugs losing their patents in the projection period, as well as the adjustments to the future contract terms with the Company's pharmacy benefit manager. Therefore, we mirrored the Company's approach to calculate the pharmacy trends. The Company's approach utilized a complex analysis to account for the ever-changing pharmacy environment, including:

- Adjusted historical experience for changes in their PBM contractual provisions, changes in benefits, and aging population,
- Cost and utilization trends for Brands, Generics, and Specialty drugs,
- Generic dispensing rates,
- Specialty drugs with very high costs, including the Hepatitis C and PCSK9 drugs.

Our estimated range for the actual results is 5.5% to 7.6%. 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 value of 6.5% fits comfortably within our estimated range of actual results. We consider the Company's requested allowed pharmacy trend to be reasonable and appropriate.

4. *Change to Population Risk Adjustment:* The Company is estimating that the projected population's morbidity will be 4.0% lower than the experience period's population. This assumption results in a rate increase of 2.7% from the 2015 premiums, meaning that the Company expects less improvement to the morbidity for the 2016 population.

The 4.0% decrease from 2014 base period to 2016 projected claims is itemized below:

- *Changes in pool morbidity:* -2.8%

The PMPM claims in the base period experience for all members, except those who voluntarily terminated coverage prior to 2015, were 2.8% lower than the PMPM claims for all members in the base period experience. The Company reduced the projected 2016 claims to account for this healthier population that will continue to be covered in 2015.

- *Impact of the Health Status of the newly insured:* -0.9%

In addition to the continuing population, the Company estimated the health status of newly insured members. Since no claims data was available for new members, the demographics of the actual 2015 enrollees were used to estimate that the young, new members that enrolled in 2015 would reduce the overall PMPM claims by 0.9%.

- *Change in the Definition of Small Group: +0.2%*

The Company estimated that the change in the definition of Small Group to include groups with 51-100 employees in 2016 will increase rates by 0.2%. The Company assumed that only groups that would realize lower premiums by choosing QHPs would join the risk pool, while the other groups would move to a self-funded plan.

- *Impact of different benefit plans: -0.5%*

The Company estimated the change in the average utilization of services due to the change in the average cost sharing in QHP products compared to the experience period products. This accounts for an anticipated reduction in induced utilization because members are expected to choose plans with higher cost sharing in 2016 compared to 2014.

We consider the morbidity adjustments that the Company made to be reasonable and appropriate.

5. *Change to Other Factor:* The Company made other various adjustments for changes in provider networks, demographic changes, impact of plan selection, and other non-system claims. The overall change from the 2015 filing results in a -4.8% rate change. The change from the 2014 experience to the 2016 projected rates is an increase of 6.2%, which has been itemized below:

- *Changes in provider networks: +1.1%*

The base period experience includes members from four different networks. In the 2015 filing, this factor was +10.4%. The large reduction in this factor is due to the membership in the Catamount Network only being reflected in the first few months of the base period. The Catamount network had significant discounts that are not present in the EPO network which is used for all plans in this filing.

- *Changes in demographics: +1.4%*

The changes in demographics represent the aging of the current population. With a growing block of business, the Company also estimated the health status of newly insured members which was described in the previous section under the Population Risk Adjustment. The impact of the aging population is an increase of 1.4% and is mostly offset by the newly insured members, as discussed in the *Impact of the Health Status of the newly insured* section above.

- *Impact of selection: +2.0%*

Healthy members generally select low cost plans, while less healthy members tend to choose plans with the richest benefits. The Affordable Care Act does not allow carriers to reflect selection at the plan level; therefore, the Company has included the impact of selection equally to all plans.

- *Non System Claims: +1.6%*

This includes pharmacy rebates, Blueprint payments, ITS fees, Vaccine payments, net cost of reinsurance, pediatric vision and pediatric dental. The Company revised the filing on June 26th, 2015 to incorporate the impact of changes to the Blueprint program; these changes are included in the 1.6% impact.

We consider the Change to the Other Factor to be reasonable and appropriate.

6. *Changes to Risk Adjustment:* Consistent with prior Exchange filings, BCBSVT did not make a change to the risk adjustment assumption. BCBSVT assumed that there would not be a payment transfer between the carriers in Vermont for 2016. There was a minor change to the risk adjustment user fee, prescribed by HHS. It increased from \$0.08 PMPM to \$0.15 PMPM.

On June 30th, HHS released the first report for the 2014 benefit year payment transfers. In this report, MVP Health Plan (MVP) will pay BCBSVT about \$2.7 million. The Company assumed that market share, average risk score and distribution of membership among metal levels relative to the market would be unchanged for each carrier in 2016 because no credible, publicly available information existed that would allow them to make a more refined projection for these assumptions.

After the release of the HHS report, the Company chose to modify its rates to account for this updated information. The Company used the average 16.3% premium increase between the actual 2014 premiums and the proposed 2016 premiums to project the 2016 risk adjustment transfer. This resulted in a proposed decrease of 0.8% to the originally requested rate increase. We consider the proposed decrease to be reasonable and appropriate.

7. *Changes to the Federal Transitional Reinsurance Recoveries:* The Company expects the net reinsurance recoveries to decrease in 2016 by \$8.01 PMPM due to updated experience, the change in individual enrollment based on actual 2015 enrollment, official 2016 reinsurance parameters, and 2016 reinsurance contribution rates.

The Company based the reinsurance recoveries on the 2016 parameters from the Final Notice of Benefits and Payment Parameters for 2016 rule (80 F.R. 10750). The Company used 2014 experience and applied the updated reinsurance parameters to determine the expected claims that would be included in the reinsurance program. Since only individuals are covered by the transitional reinsurance program, the percentage of individuals in the total eligible QHP population was used to reduce the PMPM applied to all members.

	2015 Rate Filing	2016 Rate Filing
Lower Attachment Point	\$45,000	\$90,000
Higher Attachment Point	\$250,000	\$250,000
Reinsurance Recoveries (PMPM)	(\$54.92)	(\$28.70)
Projected % of individual membership	40.4%	44.5%
Reinsurance Recoveries across all members (PMPM)	(\$22.20)	(\$12.77)
Reinsurance Contribution Rate (PMPM)	\$3.67	\$2.25
Net Reinsurance Recoveries (PMPM)	(\$18.53)	(\$10.52)

As proposed by the Company, the 2016 premiums will increase by 1.7%. We consider the use of the proposed parameters and the calculation of the net reinsurance recoveries to be reasonable and appropriate.

8. *Changes in Administrative Costs:* The Company started with the calendar year 2014 expenses for members who were enrolled in a QHP plan in 2015. The Company reduced the experience period expenses of \$28.40 PMPM by \$0.82 PMPM (2.9%) due to one-time expenses related to resource augmentation of certain enrollment functions in 2014 that are not expected to occur going forward in 2016. The remaining costs of \$27.58 PMPM are projected to 2016 using a 2.2% annual trend. This accounts for a 3% increase to personnel costs which make up 74.9% of administrative costs, while other operating costs are expected to remain flat.

The resulting administrative costs of \$28.83 PMPM (6.4%) represent a 0.1% increase as a percentage of premiums compared to the 2015 assumptions. However, the Company's calculation does not account for an increase in membership compared to the 2014 experience period. After discussions with the Company, they provided a revised projection that takes into account the increased membership. They noted that variable costs are approximately half of administrative costs resulting in a decrease of \$0.40 PMPM.

We consider the revised expense assumption to be reasonable and appropriate. Therefore, we recommend modifying the administrative costs to \$28.43 PMPM.

9. *Changes in Contribution to Reserves (CTR):* The Company's assumed CTR is 2.0% in this rate filing, which is higher than the 1.0% requested and approved in the 2015 Exchange filing. The Company provided support demonstrating that a 1.5% CTR is needed to maintain RBC levels in light of medical trend, and the 2.0% CTR provides appropriate margin above the minimum to help ensure continued financial stability should a significant adverse event occur. The Company notes that regulatory action, membership growth, unusual events, such as a flu epidemic or new technology, may create a one-time shock to capital. The Company notes that their decision to assume that PCSK9 inhibitors will only be used to treat Familial Hypercholesterolemia (FH) in 2016 is an example of a potential one-time shock to capital.

The table below shows the actual historical CTR and the expected CTR based on the Company's forecasting model, which incorporates final premiums including amendments ordered by regulators.

Year	Actual	Expected
2011	1.9%	-0.3%
2012	-3.4%	0.9%
2013	-2.0%	-2.0%
2014	-0.5%	-1.6% ⁶
Average	-1.0%	-0.8%

The actual 2014 CTR of -0.5% does not include the impact of the increased reinsurance recoveries due to the decision by HHS on June 17th to increase the coinsurance for 2014 reinsurance recoveries from 80% to 100%. Additionally, HHS released the report for the 2014 benefit year payment transfers which results in BCBSVT receiving a payment of \$2.7 million from MVP. With the impact of HHS' decision to increase the coinsurance and the risk transfer payment, the Company has estimated that the revised margin will be 1.9% for 2014. At this time, HHS has not updated or proposed updates to their guidance for the 2016 reinsurance recoveries; therefore, we do not expect this to impact the projected rates for 2016.

We believe the proposed CTR is reasonable and allows the Company to offset the impact of trend and other potential adverse events. While we do not recommend any changes to the CTR, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

10. *Changes in Taxes & Fees:* The total taxes and fees remained approximately the same at 3.7% of premium, which remains unchanged from the 2015 filing. This is broken down into State and Federal assessments and State taxes of 0.9% and health insurer fee of 2.7%.

The total insurer fee collected nationwide will increase by 41.25% from \$8 billion in 2014 to \$11.3 billion in 2016. The Company increased the required charge as a percentage of total 2014 premium by 41.25% from 1.9% to 2.7%. However, we noted that increasing the percentage of premium by 41.25% would overestimate the 2016 insurer fee.

The Company proposed an alternative calculation that assumed BCBSVT would be responsible for 0.1% of the total nationwide insurer fee in 2016, which is the same portion that they paid for 2014. This results in an estimated \$14,074,814 (2.6% of premium) needed to be collected for 2016.

The proposed alternative calculation is reasonable and appropriate. Therefore, we recommend modifying the insurer fee to 2.6% of premium, which would reduce the overall taxes and fees to approximately 3.6%.

11. *Changes in Single Contract Conversion Factor:* A conversion factor⁷ adjustment is essential to convert and allocate the gross claim costs to a premium based on the state-mandated tier factors. The single conversion factor decreased about 0.8% from last year's assumption due to the shift in the expected membership from 2015 to 2016. The projected 2016 membership is based on actual 2015 enrollment with a portion of the Company's current enrollment in groups with 51-100 employees expected to purchase the QHP plan most similar to their current plan. We consider this reasonable and appropriate.

⁶ The expected 2014 CTR includes the impact of the decision to allow individuals and small groups to continue in their 2013 plan through the first quarter of 2014.

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, Vermont's tiered premiums require the base premium to be for a single adult.

12. *Changes in All Other Factors:* This reflects other Pricing AV changes such as changes in Metal AVs of plans and changes in projected enrollment among plans. The assumed 2016 distribution is very similar to the 2015 distribution by plan. Since the 2016 plan distribution is based on actual 2015 Exchange enrollment, we find this to be reasonable and appropriate.

The Changes in Family Tiering factor reduces the base premium to account for the difference between the state-mandated tier factors and the actual cost⁸ of providing coverage to each tier.

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:

- Reducing the total allowed trend to 7.2%: -0.3%;
- Reducing the administrative costs to \$28.43: -0.1%;
- Use the proposed alternative method to calculate the insurer fee to 2.6%: -0.1%; and
- Increase the projected risk transfer payment to \$3.70 PMPM: -0.8%.

After the modifications, the anticipated overall rate increase will reduce from 8.6% to 7.3% (\$31.66 PMPM).

Plan	Proposed Rate Change	Modified Rate Change	Percent of Membership
Catastrophic	5.2%	3.1%	0.2%
Bronze	9.9%	8.3%	16.3%
Silver	8.7%	7.3%	46.5%
Gold	8.9%	7.7%	16.2%
Platinum	7.7%	6.6%	20.8%
Overall	8.6%	7.3%	100.0%

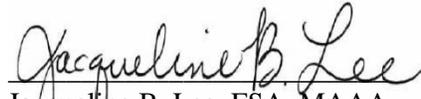
⁸ Without this adjustment, the Company would receive 3.7% more premium than necessary.

Plan	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	\$11.92	\$7.08	-\$4.84	0.2%
Bronze	\$33.44	\$27.97	-\$5.47	16.3%
Silver	\$35.77	\$29.90	-\$5.87	46.5%
Gold	\$41.44	\$35.51	-\$5.93	16.2%
Platinum	\$41.89	\$35.68	-\$6.21	20.8%
Overall	\$37.54	\$31.66	-\$5.88	100.0%

Sincerely,



Josh Hammerquist, ASA, MAAA
 Assistant Vice President & Consulting 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:

- Joshua A. Hammerquist, ASA, MAAA, Assistant Vice President at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President 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 14, 2015. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is July 8, 2015.

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.
- 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.

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.

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.