LEWIS & ELLIS
Actuaries and Consultants
700 Central Expressway South
Suite 550
Allen, TX 75013
972-850-0850
lewisellis.com

July 10, 2018

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05620

Re: MVP Health Plan 2019 Individual and Small Group Rate Filing (SERFF # MVPH-131497138)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2019 Individual and Small Group 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, 2019.

2. This filing addresses MVP individual members and small groups. As of February 2018, there were approximately 25,223 members enrolled in plans affected by this filing.

3. Beginning in 2019, Vermont will offer "Silver Reflective" plans in addition to the Silver plans offered on Vermont Health Connect. As required by law, VHC must offer Silver plans with cost-sharing reductions (CSRs) to Vermonters at certain income levels who will pay a limited premium as a percentage of their income. So, while the VHC premiums for Silver plans are increasing substantially, most or all members in these plans in 2019 will not have to pay out-of-pocket for the rate increase described below due to an increase in the federal premium subsidies

4. The overall impact of this filing is a proposed average rate increase of 10.9% or $51.98 per member per month (PMPM) in premium, including the large rate increase for VHC Silver plans ("Silver Loaded"). This average increase is broken down by metal level in the first table, below. The second table shows the corresponding information from MVP's 2018 rate increases as approved by the Green Mountain Care Board.

2019 Proposed Rate Changes

Plan Type	Percent Change	PMPM Change	Percent of Membership[1]
Catastrophic	6.1%	$17.83	0.1%
Bronze	5.5%	$22.18	19.8%
Silver Loaded	29.6%	$141.41	20.4%
Silver Reflective	6.0%	$27.63	26.1%
Gold	6.7%	$33.79	24.1%
Platinum	5.8%	$35.98	9.6%
Overall	***10.9%***	***$51.98***	***100.0%***

2018 Proposed and Approved Rate Changes

Plan Type	Proposed Percent Change	Approved Percent Change	Approved PMPM Change	Percent of Membership[2]
Catastrophic	9.5%	6.4%	$17.40	0.3%
Bronze	7.5%	4.2%	$16.18	38.4%
Silver	4.7%	1.4%	$6.28	35.6%
Gold	8.5%	4.9%	$23.72	15.8%
Platinum	8.2%	4.8%	$28.04	9.9%
Overall	***6.7%***	***3.4%***	***$15.21***	***100.0%***

Standard of Review

Pursuant to 8 V.S.A. § 4062, 18 V.S.A. § 9375(6), and 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 2019 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 2018 and 2019, 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 135,000 total member months) from ACA-compliant individual and small group employer data, and adjustments applied in derivation of index rate. These adjustments include application of factors for incurred but not reported (IBNR) claims, pooling charges, paid medical/Rx trend, etc.

[1] Membership projections in the 2019 filing are based on actual February 2018 enrollment.

[2] Membership in the 2018 rate filing was based on actual February 2017 enrollment.

Exhibit 4 shows the development of the single conversion factor of 1.092, using the distribution by tier and the average contract size by tier derived from February 2018. Exhibit 5 shows the retention loads, taxes, assessments, and paid claim surcharges. Exhibit 6 shows the calculations for the load on the On-Exchange Silver Plan to account for the defunding of the Cost Sharing Reductions (CSRs). Exhibit 7 calculates final PMPM premiums from the combination of these assumptions.

The "Loss Ratio Information" section of the Actuarial Memorandum demonstrates that the expected claims and premiums result in a projected traditional loss ratio of 89.2%. After adjusting for taxes, fees, and Quality Initiatives, the Federal MLR is projected to be 90.2%, which exceeds the minimum required 80%.

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

L&E Analysis

The average proposed increase of 10.9% over the 2018 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, L&E categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component[3]	Percentage Change[4]	PMPM Change
1. 2017 Actual/Projected Claims Experience	-8.7%	-$41.70
2. Difference in trend from 2017 to 2018	-0.0%	-$0.16
3. Trend from 2018 to 2019	4.7%	$20.51
4. Changes to Population Morbidity Adjustment	2.1%	$9.64
5. Changes to Other Factor	0.3%	$1.36
6. Changes to Manual Rating Adjustment	0.0%	$0.00
7. Changes to Risk Adjustment	8.9%	$41.64
8. Changes in Administrative Costs	-0.6%	-$2.83
9. Changes in Contribution to Reserves	-0.0%	-$0.06
10. Changes in Taxes & Fees	-1.5%	-$7.82
11. Changes in Single Contract Conversion Factor	0.6%	$3.21
12. Changes in Actuarial Value[5]	5.6%	$28.20
Total Rate Change	10.9%	$51.98

1. *2017 Actual/Projected Claims Experience:* MVP experienced significantly lower than expected claim experience in 2017. The 2018 URRT shows that the 2017 Claim Experience was 8.7% lower than projected in the 2018 Exchange Filing's URRT.

   While the claims were lower than previous expectations, this was due to MVP enrolling a substantially healthier block than they had in earlier years. This can be seen in the offsetting Risk Adjustment related

[3] 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.

[4] The percentage changes are multiplicative and may not sum to the requested 10.9% premium increase.

[5] Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), membership shifts, and Cost Sharing Reduction (CSR) defunding.

increase, which will be discussed further in Section 9 of this report. Through the risk adjustment program, MVP effectively had to cede a substantial portion of collected premium to the other carrier in the market and this filing anticipates it will be doing so again in 2019.

The base period experience has also been adjusted under the assumption that all policies will be active for a full 12 months. Because policies active for less time are less likely to achieve the deductible and/or out-of-pocket maximum, data for partial years tend to show lower utilization and claim costs than data for complete plan years. L&E agrees with MVP's assessment that this adjustment is appropriate for small group plans, which tend to be active for a full 12 months. However, individual plans regularly begin or terminate mid-year due to special enrollment periods, obtaining eligibility through Medicaid or an employer, or voluntary lapsation.

MVP has assumed that there will be no mid-year terminations or enrollments at all, which causes a slight increase in the rates. L&E requested historical enrollment and termination data from MVP, which demonstrated that the pattern of mid-year terminations and enrollments does not appear to have changed drastically in past years among non-employer Exchange policies. MVP has stated that they believe the level of mid-year enrollment and termination will reduce due to the federal repeal of the "Individual Mandate" for 2019. While we agree this could result in lower enrollment overall, we do not believe that the repeal will result in all members remaining enrolled for the full 12-month period. MVP also provided insightful data indicating that the 2018 enrollment experience differs materially from prior years, in that the open enrollment period has been reduced and there has been far less enrollment in February through April than there was in prior years.

L&E recommends that the assumptions regarding mid-year terminations and enrollment for the individual market be modified to reflect the 2019 open enrollment timeline, and historical levels of mid-year terminations and enrollments. Based on L&E's analysis of MVP's data, our best estimate of the 2019 enrollment is that approximately 91.6% of members will enroll in January, with 0.76% of members enrolling in each of the other 11 calendar months. Additionally, we have assumed that approximately 3.8% of all members lapse their coverage in any given month. These assumptions are based on the data provided by MVP. This best estimate of the 2019 enrollment distribution suggests that the adjustment to individual policies should be decreased from 1.013 to 1.007. This change would reduce the overall rate increase by approximately 0.3% and is included in the "Recommendation" section of this report.

2. *Difference in trend from 2017 to 2018:* The 4.5% annual trend from 2017 to 2018 in the 2019 URRT is equal to the trend assumed in the final 2018 URRT. L&E notes that the facility unit cost trend factors reflect known and assumed price increases from MVP's provider network, and our review of these factors confirms that they are consistent with the Vermont hospital budgeting process.

   The trend assumption of 4.5% is discussed further in the next section.

3. *Trend from 2018 to 2019:* The Company requested an allowed medical trend of 3.2% and an allowed Rx trend of 13.3%.

Cost Category	Allowed Trend	Paid Trend[6]
Medical	3.2%	3.6%
Pharmacy	13.3%	14.7%
Total	4.5%	5.0%

- *Medical Trend:*
  The Company projected an annual allowed medical trend of 3.2%. The allowed trend reflects changes in the cost of medical services and changes in utilization of medical services by members.

  Unit Cost Trend
  MVP computed its allowed trend as a weighted average of the medical claim trends in 2018 and 2019 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. These increases reflect the changes to the unit cost increases ordered by the Green Mountain Care Board.

  Since the 2019 hospital budget negotiations are not yet finalized, MVP has assumed that increases by hospital will match 2018 increases. The overall increase for hospital-based charges differs from the Board's Vermont-wide projections for several reasons:

  - MVP's costs are distributed slightly differently from the entire commercial market producing a different average across all facilities.
  - The medical services covered by these plans are not all provided by hospitals subject to the GMCB hospital budgeting process.
  - The hospital budgets are not effective on a calendar year basis, while the rates are being set for calendar year 2019.

  GMCB HOSPITAL BUDGET REVIEW

  The 3.2% unit cost medical trend includes 1.7% for facilities and providers that are impacted by the GMCB's Hospital Budget Review and 5.0% for other facilities and providers that are not subject to the Hospital Budget Review. If all facilities and providers were subject to the 1.7% increase, then the overall rate increase would be reduced by 2.2%.

  The assumed allowed unit cost trend is 3.2% annually. 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 leveraging. The resulting annual effective paid medical unit cost trend is 3.6%. The medical claims were projected forward to the midpoint of the rating period using this effective paid medical trend.

[6] "Allowed trend" reflects the change in the total reimbursement paid to hospitals and other providers. Because copays and deductibles are fixed, the portion paid by the insurer generally increases at a higher rate. This change in the insurer's responsibility, or "Paid Trend", is the trend figure that directly impacts premium rates.

L&E believes the assumed unit cost trends are based on appropriate assumptions and data and are reasonable, and does not recommend any changes at this time.

Utilization Trend and Intensity
In the prior filing, MVP assumed, and the Board approved, a 0.7% annual utilization trend. In this filing, MVP has returned to using a 0.0% utilization trend assumption, which was their standard methodology in most filings up to that point.

We requested recent utilization data from MVP to ensure that it does not show a clear trend which should be reflected in 2019 pricing. We note that other carriers in the market have compiled data purporting to demonstrate substantial positive utilization trends. However, our analysis agrees with MVP's that the data does not support the assumption of any material level of utilization trend. We believe MVP's assumption is reasonable.

Total Allowed Medical Trend
Based on the information available, the best estimate of the total allowed medical trend is 3.2%. Given MVP's assumption of 0% utilization trend, this value represents only unit cost trends and is not likely to vary materially from the assumed value.

If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost in the 2019 premium rate calculations.

- *Pharmacy Trend:* The Company projected an annualized allowed Rx trend of 13.3%.
This trend forecast was provided by MVP's Pharmacy Benefit Manager (PBM) based on MVP's experience by drug class. The chart below shows that the brand and specialty trend categories are driving up the total Rx trend.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	2.1%	2.8%	4.9%
Brand	13.2%	2.1%	15.5%
Specialty	6.8%	7.7%	15.1%
Total	10.2%	2.8%	13.3%

After accounting for member cost sharing, the total annualized effective paid Rx trend is 14.7%.

As in prior non-Exchange filings, MVP has not used historical pharmacy trend analysis to form assumptions for future pharmacy trends as they believe their prior experience is not indicative of future trends. L&E recognizes 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. The proposed allowed Rx trend is higher on an annual basis than the trend assumed by MVP last year. However, MVP provided actual trend experience from the last few years demonstrating that actual trends have consistently and materially exceeded the projections from the PBM. For example, controlling for the healthier group of members MVP enrolled in 2017,

the actual Rx trend in 2017 exceeded 20%. As this methodology is consistent with MVP's other filings, L&E does not propose any change at this time.

L&E considered MVP's historic experience as well as the PBM's recommendation and opines that the requested Rx paid trend of 14.7% appears to be reasonable and appropriate.

The Company requested a paid medical trend of 3.6% and a paid Rx trend of 14.7%, resulting in a projected total paid trend of 5.0% annually. This total trend appears to be reasonable and appropriate, and L&E does not recommend any changes at this time.

If updated information regarding Hospital Budget changes is available at the time of the Board's order regarding this filing, it would be reasonable to require an update to the assumed unit cost trends to mirror actual ordered changes.

4. *Changes to Population Morbidity Adjustment:* In response to the federal repeal of the Individual Mandate for 2019, it is reasonable to expect that some of the healthiest enrollees on the Exchange will terminate their coverage, resulting in the single risk pool population becoming slightly sicker and more expensive on average. Because this effect is market-wide, the risk adjustment program can do nothing to correct for this problem. The Green Mountain Care Board retained L&E to analyze the estimated impact on the single risk pool of the federal repeal and we submitted our findings publicly at that time. Our results indicated that the repeal of the Individual Mandate would increase the single risk pool morbidity by approximately 2.0%. MVP also performed their own analysis based on assuming 5% of low-cost members would terminate coverage, which yielded a similar result of 2.2%. MVP has assumed a 2.0% increase in merged market morbidity, consistent with L&E's analysis. We note that both carriers in the Vermont market, whether they relied on L&E's work or not, arrived at similar conclusions.

   After the initial rate increase was filed, H.696 was signed into law which will enforce the individual mandate in Vermont starting on January 1, 2020. The Company does not expect the 2020 Vermont individual mandate will impact their members' decisions to maintain minimum essential coverage in 2019. These members will have the opportunity to obtain coverage again in 2020 on a guaranteed issue basis to avoid the penalty in 2020.

   Based on L&E's mandate analysis, which considered both financial and non-financial impacts related to the elimination of a mandate, L&E considers MVP's decision to not modify their mandate impact as a result of H.696 as reasonable and appropriate.

5. *Changes to Other Factor:* Last year's factor reduced claims because the base period data was from 2016, a leap year. Leap years have one extra day and therefore experience a slightly higher level of claims per member per month. This year, the "Other" factor has not been used. The removal of the factor normalizing for the leap year has the effect of increasing the rates by 0.3%. This is reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* The Company did not use a manual rate because the 135,424 member months of experience was considered fully credible. L&E considers this to be reasonable and appropriate.

7. *Changes to Risk Adjustment:* In the initial filing, MVP projected the 2019 risk adjustment based on the most recent data available. The most recent data available was the interim report[7] published by CMS in early April and a confirmation of the number of months each carrier had submitted for the interim report.

   In anticipation of the 2019 Exchange filings, L&E requested that both carriers provide their Risk Adjustment Transfer Elements Extract (RATEE) reports from CMS in order to compile them confidentially and provide both carriers with an updated risk adjustment estimate. This calculation indicated that MVP's risk adjustment payment for 2017 would be about 18.5% lower than what MVP assumed in their initial filing. Given the 2017 value, we agree with MVP's methodology of trending forward the market-wide average premium and removing 14% for non-claims expenses per CMS guidelines.

   On July 9th, CMS released the 2017 Summary Report on Permanent Risk Adjustment Transfers[8], which confirmed L&E's calculation of the 2017 risk adjustment amount.

   L&E recommends revising the risk adjustment calculation such that each carrier begins with the same value for calendar year 2017. L&E recommends that each company use a 2017 estimate of $5,700,399 based on the final report from CMS. Updating the merged market starting point from the $7,006,932 calculated from the interim report to the $5,700,399 from the final report, the resulting premium impact is a reduction in projected risk adjustment payable from $50.56 to approximately $41.21 PMPM. Therefore, L&E recommends revising MVP's calculation by updating based on the final report from CMS, resulting in a premium decrease of 1.9%. This is included in the "Recommendation" section of this report.

FUTURE OF RISK ADJUSTMENT

On February 28, 2018, the United States District Court for the District of New Mexico in *New Mexico Health Connections v. United States Department of Health and Human Services* invalidated HHS's risk adjustment formula as "arbitrary and capricious," and on July 7, 2018, the Trump Administration indicated it was suspending payments under the program. It is unclear on the date of this report if the risk adjustment formula will be revised and payments resumed, but if the payments truly do cease, the rates contained in this filing will no longer be actuarially sound. In that event, L&E recommends that the Board allow the carriers to modify their rates, or consider implementing a state program to replace the federal risk adjustment system. However, based on the resolution of the similar case in Massachusetts and the indispensable nature of risk adjustment to the functioning of the Exchange marketplace, we have assumed that risk adjustment will continue as normal after the resolution of NMHC v. HHS and all payments accrued will eventually be paid.

[7] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2017.pdf

[8] https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf

8. *Changes in Administrative Costs:* The rates were decreased by 0.6% due to a reduction in projected administrative costs as a percentage of premium. MVP is projecting general administrative costs to be $39.80 PMPM, which is a slight increase relative to the 2018 Exchange filing. This includes quality improvement (QI) expense of 10% of total administrative expense.

   Because the premium is also increasing from the 2018 Exchange filing, the administrative expenses, as a percentage of premium, are decreasing. The administrative costs assumed in this filing are consistent with MVP's recent individual and small group administrative costs as reported in the last three years of Supplemental Health Care Exhibits (SHCE). These costs have fallen substantially since 2013, when they were $46.57 PMPM. This historical reduction in administrative costs cannot continue indefinitely, and the projected administrative costs appear to be reasonable for this population. We note that while enrollment is increasing and this is a source of downward pressure on administrative costs per member, the effect of membership growth in Vermont is dampened because many administrative functions are shared between Vermont and the much larger block of members in New York. Additionally, MVP has undertaken several projects including modernization of its IT infrastructure and increasing behavioral health management activities that result in a higher investment in administrative costs. In light of the steps taken by MVP in reducing administrative costs over the recent years, the assumed administrative 2019 costs appear to be reasonable and appropriate.

9. *Changes in Contribution to Reserves:* The proposed 2.0% contribution to reserves (CTR) is consistent with the assumptions found in MVP's other recent filings. The projected federal loss ratio using this CTR is 90.2%, which greatly exceeds the statutory minimum of 80% and is reasonably consistent with the other carrier in this market.

   The contribution to reserves assumption appears to be reasonable and appropriate. While L&E does not recommend any changes to the CTR, the results of the Department of Financial Regulation's (DFR) Solvency Analysis should also be considered.

10. *Changes in Taxes & Fees:* The rate change due to changes in taxes and fees is a decrease of 1.5%. This change is driven primarily by the Federal Health Insurer Fee being temporarily suspended for 2019. The fee was projected at $4.60 PMPM in the 2018 filing.

    A small portion of the decrease is due to the expiration of the Patient-Centered Outcomes Research Institute (PCORI) fee, which amounted to $0.21 PMPM in the 2018 filing.

    The taxes and fees also include the 18 VSA 9374(h) Billback, whereby the Company will be required to contribute a portion of the GMCB and HCA's operating costs. The tax and fee assumptions appear to be reasonable and appropriate.

11. *Changes in Single Conversion Factor:* The single conversion factor[9] used in the 2018 rate filing was 1.085. For this year's filing, MVP utilized February 2018 enrollment to calculate the 2019 single conversion factor of 1.092.

    This reduction is the result of a shift towards family coverage since 2017. The impact of this change is an increase of 0.6% in the rates. L&E reviewed the calculation of this adjustment, and the calculations appear to be reasonable and appropriate.

12. *Changes in Actuarial Value:* The Change in Actuarial Value (AV) reflects 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 AVs calculated by MVP.

    Regarding induced utilization, there has been a substantial shift away from bronze coverage. The 2018 URRT assumed that 38% of members would enroll in bronze plans. Based on actual 2018 enrollment, this estimate has changed to 20%, with those members moving into higher cost sharing tiers. One of the impacts of this change is an increase in projected induced utilization, as members with rich coverage (higher metal AV plans) tend to use more medical services. L&E's estimate of the impact of induced utilization on the proposed rate change is approximately 0.9%. The induced utilization assumptions are consistent with the induced utilization factors developed by HHS for use with this population and are reasonable.

    Cost Sharing Reduction (CSR) – Impact of Act 88

    In 2019, there are substantial AV changes resulting from the defunding of the Cost Sharing Reduction (CSR) payments from the federal government. CSRs are "extra savings" for families who earn less than 250% of the Federal Poverty Level, manifested in lower deductibles and copayments for On-Exchange Silver plans. The difference between plan cost sharing and CSR-level cost sharing was reimbursed by the federal government in past years. However, this reimbursement will no longer be paid, and the carrier is responsible for substantially more of the Silver plans' costs than in 2018. The proposed rate increase includes increases to Silver plans on VHC (Silver Loaded plans) to cover these extra costs. These changes combined result in an increase of 5.6% in rates.

    Act 88 (2018) was passed in Vermont in order to allow members who do not receive subsidized coverage to purchase a similar Silver plan off-exchange. This Act allows carriers to increase the rates for subsidized members while keeping the increase largely or wholly funded by the federal government and to keep the premiums affordable for non-subsidized members who elect to keep a Silver plan. We note that many households receive premium subsidies for their coverage that is capped at a certain percentage of their income, including most CSR recipients. As a result, this higher increase will not be paid directly by most of the households who will elect to retain Silver plan coverage in the individual market. The following table summarizes the expected rate increase with and without the Silver on-Exchange members.

[9] 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 for all adults and children. However, the tiered premiums require the base premium to be for a single adult.

Plan Type	Overall Rate Change	Actual Rate Change felt by Vermonters[10]
Catastrophic	6.1%	6.1%
Bronze	5.5%	5.5%
Silver Loaded	29.6%	N/A
Silver Reflective	6.0%	6.0%
Gold	6.7%	6.7%
Platinum	5.8%	5.8%
Overall	***10.9%***	***6.1%***

Additionally, as the premium subsidies available to all metal tiers in the individual market are based on the second-lowest Silver plan premium, the material increase in Silver premiums will result in increased subsidies for many Vermonters. This means that, in the individual market, a substantial portion of the 10.9% increase will be borne by the federal government rather than by policyholders.

L&E reviewed MVP's methodology for normalizing the experience for AV differences and induced utilization, and the projected enrollment by metal tier. These values appear to be reasonable and appropriate.

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:

- *2017 Actual/Projected Claims Experience*: Modify the mid-year enrollment/termination factor to adjust only small-group policies. This results in a decrease in rates of 0.3%.

- *Changes to Risk Adjustment*: Modify the projected risk adjustment payable reflect the most recent data available, resulting in a decrease in rates of 1.9%.

- *Trend from 2018 to 2019*: If updated information regarding unit cost trends are known at the time of the Board order, L&E recommends considering this updated information in the development of the unit cost in the 2019 premium rate calculations.

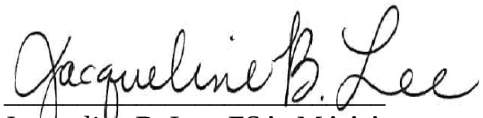
After the modifications, the anticipated overall rate increase will reduce from 10.9% to approximately 8.5% and the rate increase felt by Vermonters will reduce from 6.1% to 3.8%.

[10] This table assumes that no Vermonters ineligible for advanced premium tax credit (APTC) subsidies will purchase the higher priced, on-Exchange Silver plans. While this outcome cannot be guaranteed with absolute certainty, the State of Vermont is undertaking outreach and education efforts to assist Vermonters with choosing their coverage, as non-APTC members will almost uniformly be better off purchasing bronze or gold plans or purchasing Silver coverage off-Exchange.

Metal Tier	MVP Proposed Rate Change	L&E Recommended Overall Rate Change	MVP Proposed Rate Change Felt by Vermonters	L&E Recommended Rate Change Felt by Vermonters	Percent of Membership
Catastrophic	6.1%	4.0%	6.1%	4.0%	0.1%
Bronze	5.5%	3.3%	5.5%	3.3%	19.8%
Silver Loaded	29.6%	27.3%	N/A	N/A	20.4%
Silver Reflective	6.0%	3.7%	6.0%	3.7%	26.1%
Gold	6.7%	4.3%	6.7%	4.3%	24.1%
Platinum	5.8%	3.4%	5.8%	3.4%	9.6%
Overall	***10.9%***	***8.5%***	***6.1%***	***3.8%***	***100.0%***

Sincerely,

Kevin Ruggeberg, 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 organizations[11], 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[12], 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, 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.

Identification of Actuarial Documents

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

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but 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.

Methods, Procedures, Assumptions, and Data

[11] 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.

[12] 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.