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July 11, 2016

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 2017 Exchange Filing (SERFF # BCVT-130567350)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2017 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). This filing develops premiums for BCBSVT's Qualified Health Plans (QHPs) to be offered on VHC, beginning January 1, 2017.

2. This filing addresses BCBSVT individual members and small groups. There are approximately 70,000 members currently enrolled and about 7,000 new members from other non-ACA compliant plans that are expected to enroll in an ACA-compliant plan in 2017.

   The overall impact of this filing is a proposed average 8.2% or $37.54 per member per month (PMPM) increase 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	5.2%	$11.94	0.2%
Bronze	9.5%	$34.52	15.3%
Silver	9.4%	$41.10	42.6%
Gold	8.2%	$38.20	22.7%
Platinum	5.5%	$31.58	19.2%
Overall	***8.2%***	***$37.54***	***100.0%***

2016 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	0.5%	$1.17	0.2%
Bronze	6.9%	$23.24	16.3%
Silver	5.9%	$24.23	46.5%
Gold	6.3%	$29.12	16.2%
Platinum	5.2%	$28.26	20.8%
Overall	***5.9%***	***$25.66***	***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 2017 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 70,000 members, who have previously enrolled in a QHP product, and the 7,000 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 4.3%. The unit cost trend for medical trend is projected to be 3.3% based on observations of recent contracting and provider budgetary changes. The utilization and intensity trend is projected to be 1.0%.

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 8.2%.

L&E Analysis

The average proposed increase of 8.2% 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. 2015 Actual/Projected Claims Experience	0.4%	2.26
2. Difference in trend from 2015 to 2016	-1.6%	(8.26)
3. Trend from 2016 to 2017	5.3%	26.49
4. Changes to Population Risk Adjustment	3.6%	19.29
5. Changes to Other Factor	-4.7%	(25.62)
6. Changes to Manual Rating Adjustment	0.0%	0.00
7. Changes to Risk Adjustment	0.6%	2.94
8. Changes to the Federal Transitional Reinsurance Recoveries	2.6%	13.41
9. Changes in Administrative Costs	0.5%	2.79
10. Changes in Contribution to Reserves	1.4%	7.48
11. Changes in Taxes & Fees	-2.9%	(15.83)
12. Changes in Single Contract Conversion Factor	-0.4%	(2.25)
13. Changes in Actuarial Value[4]	3.6%	18.88

1. *2015 Actual/Projected Claims Experience:* The actual 2015 claim experience was 0.4% higher than the projected 2015 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.

2. *Difference in trend from 2015 to 2016:* The trend from 2015 to 2016 in the 2017 URRT of 5.3% results in a 1.6% lower rate increase than the trend from 2015 to 2016 in the prior URRT. The

[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 8.2% premium increase.

[3] The PMPM changes do not add up to the overall average PMPM of $37.78 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.

assumed 5.3% trend assumption is discussed further in the next section.

3. *Trend from 2016 to 2017:* The Company projected an allowed medical trend of 4.3% and an allowed pharmacy trend of 10.2% for a combined allowed trend of 5.3%.

Cost Category	Unit Cost Trend	Utilization Trend	Total Trend
Medical	3.3%	1.0%	4.3%
Drug	9.7%	0.5%	10.2%
Total	4.4%	0.9%	5.3%

- *Medical Trend:* The Company is requesting an allowed medical trend of 4.3%, broken down into 3.3% for unit cost and 1.0% for utilization. The Company analyzed the changes to the provider contracts in the BCBSVT service area and used the Fall 2015 Blue Trend Survey for providers outside the BCBSVT service area to determine the unit cost trend. The Company performed regression analysis over 18 months for the utilization trend.

  Unit Cost
  Future unit cost trends are developed using the most recent round of contract negotiations as a starting point. An adjustment was made to reflect the lower charges from Rutland Regional Medical Center starting May 1, 2016. For providers outside the BCBSVT service area, the Company used the Fall 2015 Blue Trend Survey. This analysis resulted in a unit cost trend of 3.3%, which is lower than recent historical unit cost trends. 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.

  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
18 Month	2.5%
24 Month	3.5%
36 Month	-1.0%

  The Company determined that the difficult start to the Exchange and the option to delay enrollment into a QHP until April 2014 were skewing both the 24-month and 36-month regressions. Therefore, the Company chose the 18-month regression as the starting point.

  The Company adjusted the 18-month regression result of 2.5% downward to remove the impact of changes in induced utilization, the aging population, and the unexpected seasonal patterns in 2014 and potential up-take in 2015, resulting in a utilization trend

of 1.0%. We consider the methodology used to calculate the utilization trend to be reasonable and appropriate.

Total Allowed Medical Trend
Combining the Company's proposed unit cost trend of 3.3% with the utilization trend of 1.0% results in an allowed medical trend of 4.3%. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. Our best estimate of the total allowed medical trend is equal to the Company's estimate of 4.3%, and our estimated range for the actual results is 1.7% to 6.9%. 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]

We consider the allowed medical trend to be reasonable and appropriate.

- *Pharmacy Trend:* The Company is requesting an allowed pharmacy trend of 10.2%.

Multiple methods can be used to determine the reasonableness of these trend assumptions. A typical approach analyzes the historical pharmacy claims costs 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.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	7.0%	1.3%	8.3%
Brand	8.8%	-5.0%	3.3%
Specialty	-	-	18.1%
Total	9.7%	0.5%	10.2%

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 benefits and aging population,
- Cost and utilization trends for Brands, Generics, and Specialty drugs,
- Generic dispensing rates,
- Specialty drugs with very high costs, including hepatitis C, PCSK9 and cystic fibrosis drugs.

Our best estimate of the total allowed medical trend is equal to the Company's estimate of 10.2%, and our estimated range for the actual results is 7.8% to 12.6%. 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 10.2% fits comfortably within our estimated range

[5] For example, the probability that the actual trend will be centered around the best estimate (between 4.2% and 4.4%) is 50% higher than being near the low end of the range (between 1.7% and 1.9%).

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 0.5% lower than the experience period's population. Because the Company is assuming less improvement in their morbidity compared to the 2016 filing, this results in a 3.6% rate increase.

   The decrease of 0.5% from 2015 base period to 2017 projected claims is itemized below:

   - *Changes in pool morbidity*: -1.1%

     The PMPM claims in the base period experience for all members, except those who voluntarily terminated coverage prior to 2016, were 1.1% lower than the PMPM claims for all members in the base period experience. The Company reduced the projected 2017 claims to account for this healthier population that will continue to be covered in 2016.

   - *Impact of the Health Status of the New Members*: +0.9%

     In addition to the continuing population, the Company estimated the health status of the 6,500 projected members who are currently enrolled in Medicaid but are expected to no longer be eligible after the Vermont Department of Health Access requalifies all Medicaid enrollment. Since no claims data was available for the projected members, the Company assumed they would have the same morbidity as their current individual subsidized members. The additional members increase the overall PMPM claims by 0.9%[6].

   - *Change in the Definition of Small Group:* +1.1%

     The Company estimated that the change in the definition of Small Group to include groups with 51-100 employees will increase rates by 1.1%. 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. The majority of this increase is due to groups that have already migrated into a QHP upon their renewal in 2016.

   - *Impact of different benefit plans:* -1.4%

     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 2017 compared to 2015.

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

[6] The overall impact of these projected members is a 0.1% increase in premium due to their impact on risk adjustment and expenses.

5. *Change to Other Factor:* The Company made other various adjustments for changes in provider networks, demographics, impact of plan selection, and other non-system claims. The overall change from the 2016 filing results in a -4.7% rate change.

   The change from the 2015 experience period to the 2017 projected rates is an increase of 1.2%, which has been itemized below:

   - *Changes in provider networks:* -0.1%

     The base period experience includes members from three different networks. Using historical contracted reimbursement schedules, the Company calculated network factors to project the allowed costs using the provider contracts that will be effective in 2017.

   - *Changes in demographics:* +0.6%

     The changes in demographics represent the change in the average age-gender factors between the experience period membership and the projected membership. The impact of the aging population is an increase of 0.6%.

   - *Changes in Pharmacy Contract: -0.9%*

     The new pharmacy contract that the Company has negotiated with its Pharmacy Benefit Manager reduces the premium by 0.9%.

   - *Impact of selection:* +1.0%

     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:* +0.6%

     This includes pharmacy rebates, Blueprint payments, ITS fees, Vaccine payments, net cost of reinsurance, pediatric vision and pediatric dental.

   We reviewed the Company supporting documentation for these adjustments for reasonableness. We consider the Change to the Other Factor to be reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* The Company did not use a manual rate because the experience was considered fully credible. Due to the experience period reflecting 766,083 member months, we consider this to be reasonable and appropriate.

7. *Changes to Risk Adjustment:* At the time of the initial rate filing, the most recent data available on risk adjustment was the interim report for benefit year 2015 that was published on March

18, 2016. The Company estimated that they would receive $1.36 PMPM in 2015 from the risk adjustment program.

Final risk adjustment data for benefit year 2015 was made public by CMS on June 30, 2016. As expected by BCBSVT, the 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 Amounts[7]

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

PMPM Transfer Amounts[7]

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

BCBSVT provided a revised analysis based on the results of the final 2015 risk adjustments and made additional adjustments to be consistent with the projected allowed claims. The revised estimate assumed that BCBSVT would pay $0.73 PMPM for risk adjustment which increased the requested rate increase from 8.2% to 8.6%.

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 had available independently, due to the proprietary nature of this calculation. 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 to BCBSVT from the risk adjustment program will be lower than what was assumed in the original filing. L&E recommends that the assumed risk adjustment receivable be reduced from $1.36 PMPM to $1.04 PMPM. Adopting this change would result in a slight increase in the proposed rate increase from 8.17% to 8.24%.

	Total Risk Adjustment	PMPM Risk Adjustment[7]
BCBSVT Original	-$1,268,182	-$1.36
BCBSVT Revised	$679,984	$0.73
L&E Estimate	-$975,000	-$1.05

[7] The negative risk adjustment payment means that BCBSVT would receive money from the risk adjustment program.

8. *Changes to the Federal Transitional Reinsurance Recoveries:* The subsidy from the Transitional Reinsurance Program, which will be eliminated in 2017, is expected to increase premiums by 2.6%. The Company notes that this is offset by the temporary suspension of the Federal Insurer Fee for 2017.

   The Transitional Reinsurance Program was only a temporary program designed to stabilize premiums in the individual market as the individual shared responsibility payment becomes fully phased in. We consider this to be reasonable and appropriate.

9. *Changes in Administrative Costs:* The change in administrative costs increases premiums from the 2016 rates by 0.5%.

   The 2015 experience period administrative costs increased to account for the following changes:

   - Cost Accounting Study: +0.2%
     The Company completed a comprehensive cost accounting study, which resulted in a 0.2% increase to premiums. Companies conduct cost allocation studies every few years to ensure that costs between lines of business are appropriately allocated

   - Inflation & Cyber Security: +0.2%
     The Company increased the base period administrative costs due to normal inflationary increases, higher than expected spend on new cyber security protocols and timing related to annual technology. These expenses are expected to continue as part of the normal operating budget.

   - Direct Enrollment: -0.1%
     The Company reduced the experience period expenses due to increased enrollment directly through the Company. This resulted in a decrease to premiums of 0.1%. This is consistent with other filings where the Company experienced shifts in enrollment. Generally, increases in enrollment allows the Company to spread the fixed costs across more individuals, meaning that a portion of the expense assumptions can be reduced.

   - Trend: +0.2%
     The Company increased the base administrative costs for trend to project the 2017 administrative costs, using an annualized trend of 2.4%. This trend accounts for a 3% increase to personnel costs which make up 78.4% of administrative costs, while other operating costs are expected to remain flat.

   We consider the revised expense assumption to be reasonable and appropriate.

10. *Changes in Contribution to Reserves (CTR):* The Company's assumed CTR is 2.0% in this rate filing, which is the same as the amount requested and 1.0% higher than the amount approved in the 2016 Exchange filing.

The Company believes that CTR should be managed to an adequate long-term level, rather than fluctuating significantly from year to year with changes in membership and health care cost trend. The Company notes that items, such as, regulatory action, membership growth, and unforeseen events, such as a flu epidemic or new technology, could create a one-time shock to capital.

The Company provided support demonstrating that a 3.8% CTR is needed to maintain RBC levels in light of medical trend and anticipated membership increases resulting from the State's Medicaid eligibility reverification.

Even though the Company believes that additional CTR is required, the Company continues to file a CTR of 2.0% for 2017.

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	2.8%	-1.6%[8]
2015	-2.4%[9]	0.8%
Average	**-0.8%**	**-0.4%**

We believe the proposed CTR is reasonable and allows the Company to offset the impact of trend and other potential adverse events with appropriate consideration given to maintaining the CTR at an adequate long-term level. 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.

Due to the required grace period under the Affordable Care Act, the Company included a risk margin for bad debt of 0.25% to pay for the claims for members for which premiums are never collected. The total amount of non-paid premiums due to the grace period in 2015 was 0.25%.

11. *Changes in Taxes & Fees:* The total taxes and fees decreased from 3.7% in 2016 to 0.9% of premium due to the temporary suspension of the Federal Insurer Fee. The 0.9% tax is made up of the Health Care Claims Tax and the Patient Centered Outcomes Research Institute Fee. We consider this reasonable and appropriate.

[8] 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.

[9] The actual results for 2014 and 2015 include the impacts of the Transitional Reinsurance and Risk Adjustment program in the year they were incurred, not in the year when they were booked.

12. *Changes in Single Contract Conversion Factor:* A conversion factor[10] 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 0.4% from last year's assumption due to the shift in the expected membership from 2016 to 2017. We consider this reasonable and appropriate.

13. *Changes in Actuarial Value:* This reflects other Pricing AV changes such as changes in Metal AVs of plans and changes in projected enrollment among plans. The assumed 2017 distribution is very similar to the 2016 distribution by plan. Since the 2017 plan distribution is based on actual 2016 Exchange enrollment, we find this 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 modification:

- Reduce the projected risk adjustment receivable from $1.36 to $1.05. This change results in a slight increase in the proposed rate increase from 8.17% to 8.24%.

Plan	Proposed Rate Change	Modified Rate Change	Percent of Membership
Catastrophic	5.2%	5.4%	0.2%
Bronze	9.5%	9.6%	15.3%
Silver	9.4%	9.4%	42.6%
Gold	8.2%	8.2%	22.7%
Platinum	5.5%	5.5%	19.2%
Overall	***8.2%***	***8.2%***	***100.0%***

Metal Tier	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	$11.94	$12.29	$0.35	0.2%
Bronze	$34.52	$34.84	$0.32	15.3%
Silver	$41.10	$41.42	$0.32	42.6%
Gold	$38.20	$38.51	$0.31	22.7%
Platinum	$31.58	$31.89	$0.31	19.2%
Overall	**$37.54**	***$37.86***	***$0.32***	***100.0%***

[10] 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.

Sincerely,

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

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

Jacqueline B. Lee, FSA, MAAA
Vice President & Consulting Actuary
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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:

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

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

Identification of Actuarial Documents
The date of this document is 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.

[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 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.