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April 18, 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 Q3 2016 Large Group Filing (SERFF # BCVT-130453174)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2016 Large Group 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 large group coverage to employers in Vermont.

2. This filing establishes the formula, manual rate and accompanying factors that will be used for renewals. Last year, BCBSVT started combining the five filings that have historically been filed separately, including trend, benefit relativities, administrative costs, aggregate stop loss and large claim factors for large groups. By combining these filings, the Company is able to more clearly calculate an average increase in the aggregate factors that impact the rates for large groups. The overall impact of this filing was estimated based on the previously approved factors from the prior Q3 2015 Large Group Filing.

3. This filing addresses BCBSVT Insured and Cost Plus large groups. There are approximately 7,800 subscribers and 15,500 lives affected across 67 groups.

4. The overall impact of this filing is 4.3% ($19.92 PMPM).[1] This percentage is itemized below and incorporates assumptions and changes from prior filings as well as this filing.
    - Change due to Trend: **5.9%**
    - Change in Contribution to Reserve: **0.9%**
    - Change in Administrative Charges: **0.4%**
    - Changes in Federal Programs: **-2.9%**
        - Expiration of Transitional Reinsurance Program

[1] The Company estimated the overall impact for groups renewing in January from their current 2016 rates to the projected 2017 rates.

- Suspension of Annual Fee on Health Insurance Providers

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the proposed methodology used to calculate the 2016 Insured and Cost Plus large group premiums. The Company provided exhibits and support for each component of the premium development, including trend, administrative costs, contribution to reserves, aggregate stop loss and risk charge factors, network changes and large claim factors.

For medical trend development, the Company used claims incurred between November 1, 2011 and August 31, 2015, paid through October 31, 2015. Completion factors were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

The data[2] includes claims from BCBSVT Cost Plus groups, BCBSVT Insured Large Groups and The Vermont Health Plan (TVHP) Insured Large Groups. BCBSVT and TVHP cover substantially similar populations under similar benefit packages. The Company felt that combining these homogeneous populations created greater consistency and credibility within the trend factor development. Adjustments were made to the data to reflect network differences between the two companies.

New in this filing is the inclusion of BCBSVT ASO (Administrative Services Only) groups in the development of the large claim factors, trend factors, and benefit relativity factors. The Company indicated that ASO groups generally have similar benefits and use the same network contracts as the Insured and Cost Plus groups. It was noted that adding this experience increases the credibility of the experience basis for the factor development. ASO experience comprised less than 10% of the total allowed charges.

Company's Analysis

1. *Medical Trend Development:* The Company is requesting a total allowed medical trend of 5.8%. This total allowed medical trend amount is broken down into 1.3% for utilization and intensity and 4.4% for unit cost.

   Utilization and Intensity

   The Company normalized the allowed costs to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. This data was then analyzed by using exponential regression over the 24 month time period ending August 2015 to calculate the utilization trend of 1.0%.

   The Company also demonstrated that the historical utilization and intensity trends have been impacted by large groups buying plans with lower actuarial values over the last several years. This "buy-down" effect reduces the induced utilization for the insured members. Using the Company's induced utilization factors, the average "buy-down" effect impact over the last three years is a reduction of 0.6% in the expected utilization.

[2] The data includes three groups of between 51 and 100 employees, which as of January 1, 2016, are characterized as "small groups" under Vermont law. Based on our discussion with the insurer, it is unclear whether these groups can continue to be rated using the formulas in this filing. We have determined, however, that their inclusion in this filing, even if erroneous, produces no material rate impact.

Consistent with the utilization trend, the Company used a 24-month regression to estimate the impact of the benefit "buy-down" effect of 0.3%, which resulted in an estimated utilization and intensity trend assumption of 1.3%.

Unit Cost Trend
The unit cost trend for medical trend is projected to be 4.4% based on an analysis of the hospital budget increases implemented during 2015 as well as other providers in the BCBSVT service area. The Company assumed that the GMCB would approve hospital budgets for October 1, 2016 and October 1, 2017 that support identical commercial increases as the approved increases for October 1, 2015. Similarly, providers within the BCBSVT service area were assumed to have overall 2016 and 2017 budget increases as those implemented during calendar year 2015. Unit cost increases for providers outside the BCBSVT service area were derived from the Fall 2015 Blue Trend Survey[3].

Total Allowed Medical Trend
The 1.3% utilization and intensity trend combined with the 4.4% unit cost trend results in total allowed medical trend of 5.8%.

2. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend of 10.5%. The pharmacy trends are calculated using 24 months of historical data ending September 2015, which is modeled using an exponential regression. The Company analyzed 24 months of data in order to best capture an adequate amount of the most recent history of drug costs.

   The Company modeled the cost for generic and brand drugs individually. However, to analyze utilization patterns, they combined the data for generic and brand drugs because of several popular brand drugs losing their patents. The combined utilization is projected to increase by 0.6%. A separate adjustment was then made to split the generic and brand utilization based on the projected GDR (elaborated further in section 3). The Company modeled only the total PMPM trends for specialty drugs due to their relatively low utilization and high cost nature (elaborated further in section 4). The following table shows the results of the Company's analysis and the requested 10.5% overall allowed pharmacy trend.

Pharmacy Trends	Cost	Utilization	Total
Generic	6.8%	4.5%	8.9%
Brand	15.5%	-17.8%	5.8%
Specialty	N/A	N/A	17.8%
Total	N/A	N/A	10.5%

3. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The generic dispensing ratio (GDR) is a measure of the percentage of pharmacy utilization attributable to generic drugs. The Company's drug-by-drug analysis shows that the GDR is expected to increase at a similar rate to the projection in the prior filing.

[3] The Fall 2015 Blue Trend Survey is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

Based on the current distribution of days supply and a list of brands expected to move to generic in the projected period, as provided by their Pharmacy Benefit Manager, the Company projected the GDR to reach 88.5% in the projection period. This is an increase of 2.5% over the prior filing's assumption of 86.3%, which was calculated using the same methodology.

4. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* The Company made specific adjustments for specialty drugs that treat hepatitis C, which began in January 2014. In addition, other high-cost or high-utilization drugs have entered the market recently. These include treatments for cystic fibrosis and PCSK9 inhibitors[4] used to treat high cholesterol in patients with familial hypercholesterolemia (FH). First, the Company recalculated the specialty drug trend after excluding the hepatitis C and other new specialty drugs from the historical data. This reduced the 24 month regression trend from 27.8% to 14.1%.

   To project the cost of hepatitis C treatments, the Company used 2015 year to date experience, along with estimates provided by their Pharmacy Benefit Manager, Express Scripts (ESI). Through October 2015, there were 29 large group members who began a hepatitis C treatment with a specialty drug, and the Company projected that 37 members will receive hepatitis C treatments in 2017. The only drug that will be on ESI's formulary in 2017 is Viekira, and the Company indicated that treatments last for an average of 4 months. The monthly cost based on Company experience is almost $30,000, which results in a total projected cost of $4.4 million in 2017.

   To determine the total projected cost of treatments attributed to PCSK9 inhibitors, the Company cited current FH incidence studies, as well as the prevalence of patients who have had a heart attack and then failed two different high-dose statins for 60 days. Based on current membership, this results in an expected 188 members that will use a PCSK9 inhibitor in 2017. The annual cost of treatment was indicated to be $13,750 per year, for a projected total cost of $2.6 million. BCBSVT's policy is to immediately approve PCSK9 inhibitors for patients who have had a heart attack and failed two different high-dose statins.

   Orkambi is a new drug used to treat a specific mutation of the cystic fibrosis that was cited to be found in roughly 50% of those patients. This drug is only prescribed to patients age 12 and older, and BCBSVT indicated that they expect 10 of their large group members will take Orkambi. The annual cost was indicated to be $247,000 per year, for a projected total cost of $2.5 million.

   The final adjustment to the projected specialty claims includes biosimilars. Biosimilars have a lower cost than their equivalent biological drugs. The drug Humira was BCBSVT's highest cost biological drug in 2014. The FDA recently approved a biosimilar for Humira that is expected to be available in the 2017 projection period. The cost is anticipated to be 10% less than Humira, resulting in a reduction in expected claims of approximately $0.4 million.

   The table below provides a detailed breakdown of the 17.8% specialty drug trend development. Note that the pharmacy cost estimates are not adjusted for the expected rebates because the rebates are accounted for in a separate step in the rating methodology.

[4] PCSK9 inhibitors in the formulary include Praluent, which was approved by the FDA on July 24, 2015, and Repatha, which was approved by the FDA on August 27, 2015.

Pharmacy Specialty Claims in the Experience	$28,041,614
Claims Removed from the Experience	$4,608,097
Hepatitis C	*$4,546,314*
PCSK9 Inhibitors	*$0*
Orkambi	*$61,783*
Pharmacy Specialty Claims without Excluded Drugs	$23,433,517
Projected Specialty Claims using a 14.1% trend for 27 months	$31,531,396
Adding Incremental Cost of Excluded Drugs for the Projection Period	$9,415,984
Hepatitis C	*$4,363,471*
PCSK9 Inhibitors	*$2,585,173*
Orkambi	*$2,467,340*
Biosimilar Adjustment	($433,360)
Restated Projected Specialty Claims	$40,514,020
Restated Annual Specialty Trend	17.8%[5]

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends in order to reduce the effect of benefit changes on observed trends. Therefore, adjustments for trend leveraging were made in order to convert the allowed trends into paid trends. The paid trends are what will actually be applied to large group experience to develop premiums. The leveraged trend values were calculated using the Company's Benefit Relativity models[6] by calculating the change in paid claims with and without the allowed trends. The paid trends are summarized in the table below.

	Allowed Trends	**Paid Trends**
Medical	5.8%	6.7%
Drug	10.5%	11.9%
Total	6.6%	7.6%

These trends are responsible for a 7.6% increase in projected claims, which results in a 5.9% increase in premium.

6. *Administrative Costs:* Four components make up the 7.3%[7] increase to administrative charges, which increases the premiums by 0.4% (federal fees are elaborated further in section 7):
   - *Administrative Trend (2.4%):* The proposed administrative costs were developed by trending forward the actual administrative costs for the year ending October 2015. The assumed trend reflects the Company's assumption that wages and benefits will increase at 3.0%, while other operating costs and membership are expected to remain at current levels.
   - *Year over Year Change in Administrative Costs (3.1%):* The Company indicated that the overall administrative charges were higher than the projected charges in the previous filing. The fee for the Vermont Collaborative Care (VCC) program was listed as a separate line item in the previous filing. However, in this filing, the VCC fee was included in the base administrative charge which resulted in a 2.4% increase to the base administrative charge. The remaining increase in

[5] The annual specialty trend calculation is: ($40,514,020 / $28,041,614) ^ (12 / 27) - 1

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

[7] The four components are multiplicative and therefore do not add up to exactly 7.3%.

administrative expenses year over year includes significant upgrades to the Company's cybersecurity protocols as well as business technology projects to maintain and enhance their operating systems.

- *Decrease in Membership (1.1%):* In 2017, BCBSVT is projecting a material decrease in overall membership. Fixed expenses must now be distributed among a smaller pool of members, which results in an increase in the total PMPM administrative charges.
- *Updated Cost Allocation (0.6%):* During 2015, BCBSVT completed a comprehensive cost accounting study, which increased the proportion of administrative charges that are allocated to large groups.

7. *Federal Fees:* Beginning in 2017, the federal reinsurance program will cease to exist. This program was designed as a transitional mechanism to stabilize premiums in the individual market. The program is funded by assessing a fee on insured members in all business lines. In 2016, the transitional reinsurance fees were $27 per member per year. This fee will no longer be collected.

   The Consolidated Appropriation Act of 2016 has temporarily suspended the collection of the insurer fee for 2017. BCBSVT has estimated that the fee is approximately 2.7% of premium in 2016, and is expected to be 2.5% of premium when it returns in 2018.

   The net effect of these two changes in federal programs was indicated to reduce the average rate increase by 2.9%.

8. *Contribution to Reserves (CTR):* The proposed CTR is 2.0% for Insured Large Groups and 0.5% for Cost Plus Groups. The Company demonstrated that a minimum CTR of 1.3% is required for the Fully Insured Large Groups to maintain RBC levels at their current levels due to the impact of the 6.6% total allowed trend. The proposed CTR represents management's judgment of the appropriate margin above the minimum needed to keep pace with trend and ensure stability should a significant adverse event occur. The Company notes that there are many examples of risk to surplus, including regulatory action and unusual events, such as a new specialty drug, that could create a one-time shock to capital.

Lewis & Ellis (L&E) Analysis

1. *Medical Trend Development:* To evaluate the reasonableness of the Company's approach, L&E reviewed the annual change in the total allowed medical claims for the prior 24 months. This analysis resulted in an allowed medical trend of 5.1. An additional 0.3% factor was applied to adjust the historical data which includes a reduction in the induced utilization due to the "buy-down" effect over this time period. Therefore, L&E's best estimate is a total Medical trend of 5.4%.

   Utilization and Intensity

   To review the Company's assumed 1.3% utilization and intensity trend for reasonableness, L&E reviewed both the utilization and the benefit "buy-down" impact using monthly regressions. The results of the analysis are in the table below.

Regression	Utilization Trend	Benefit "Buy-Down"	Utilization Trend Adjusted for "Buy-Down"
46 Months	-0.1%	0.6%	0.5%
36 Months	0.5%	0.6%	1.1%
24 Months	1.0%	0.3%	1.3%

It is evident from the table that the utilization before and after the adjustment for the benefit "buy-down" impact has been trending upward in recent years. Therefore, the Company's projected 1.3% utilization trend is reasonable and appropriate.

Unit Cost
L&E reviewed the confidential support for the unit cost trend that was provided by the Company, and it appears to be reasonable and appropriate.

Total Allowed Medical Trend

Regression	Medical Trend[8]	Benefit "Buy-Down"	Revised Medical Trend
46 Months	4.1%	0.6%	4.8%
36 Months	4.5%	0.6%	5.1%
24 Months	5.1%	0.3%	5.4%

Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. The estimated range for the actual results is 3.4% to 7.5%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.[9]

The Company's revised proposed total allowed medical trend of 5.8% is higher than L&E's best estimate. It is important to note that L&E used the regression analysis to measure the overall reasonableness of BCBSVT's detailed calculations. In addition, BCBSVT's projected trend amount fits comfortably within the estimated range of actual results. Therefore, L&E considers the Company's revised allowed medical trend of 5.8% to be reasonable and appropriate.

2. *Pharmacy Trend Development:* In past filings, reviewing the historical claims data on a total PMPM basis did not produce reasonable results due to the slowing growth of the GDR, drugs losing their patents in the projection period, and the adjustments to the future contract terms with the Company's pharmacy benefit manager. However, in this filing the growth in the GDR is consistent with the experience and the future contract adjustments were moved to a different step in the rating formula. Therefore, L&E reviewed the 24 month regression on the combined pharmacy claims, which produced an estimated trend of 10.4%.

   The estimated range for the actual results is 8.7% to 12.1%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range. L&E considers the Company's allowed pharmacy trend of 10.5% to be reasonable and appropriate.

   Additionally, L&E reviewed the Company's more discrete method to project the pharmacy trend. The adjustments that the Company made are discussed in sections 3 and 4.

3. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The chart below shows the rolling 12 month average GDR from June 2014 to December 2015 as well as the projected GDR for the next 2 years. The projected growth in the GDR is consistent with the recent experience.

[8] Medical trend includes unit cost and utilization.

[9] For example, the probability that the actual trend will be centered around the best estimate (between 5.3% and 5.5%) is over 30% higher than being near the low end of the range (between 3.4% and 3.6%).

Historical	Rolling 12 Month GDR	Semi-Annual Increase
December 2014	85.1%	
June 2015	85.6%	0.6%
December 2015	86.0%	0.5%

Projected	Rolling 12 Month GDR	Semi-Annual Increase
June 2016	86.4%	0.4%
December 2016	87.0%	0.7%
June 2017	87.8%	0.9%
December 2017	88.5%	0.8%

While the chart shows that the historical trends have become relatively stabilized, L&E believes that it is more important to focus on the approach used by the Company to project the GDR. The approach used in the current filing is the same as the approach from last year's filing, which was found to be reasonable and appropriate. The projected GDR would be expected to slow down as the GDR approaches its limit of 100%. The Company projections actually demonstrate a slight acceleration over recent historical months. At this time, L&E considers the approach to project the GDR to be reasonable and appropriate.

4. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* L&E reviewed the cost per treatment for hepatitis C that the Company estimated for the projection period and determined the currently available pricing information to be reasonable. Consistent with last year, ESI has agreed to only include Viekira Pak on their formularies for treatment of hepatitis C.

   L&E also reviewed the cited cost per treatment for the other high profile drugs indicated in the pharmacy specialty drug trend development. The Company cost estimates appear to be consistent with publicly available information on these drugs. Over the past couple of years, several new high-cost drugs have come to market, which has resulted in higher pharmacy trends across the health insurance industry. BCBSVT's indications are consistent with these developments. L&E considers the Company's projections to be reasonable and appropriate.

5. *Leveraged Adjustments to Allowed Trends:* Similar to last year's filing, the Company used their Benefit Relativity models to estimate the impact on paid claims with and without the allowed trend. The approach that the Company used to adjust allowed trends to paid trends is considered to be reasonable and appropriate. The table below shows the Company's revised allowed trends and the paid trends after leverage adjustments were made.

	Allowed Trend	Paid Trend
Medical	5.8%	6.7%
Pharmacy	10.5%	11.9%
Total	6.6%	7.6%

6. *Administrative Costs:* The Company has experienced an increase in the administrative costs for the year ending October 2015. The proposed increase of 7.3% to the administrative costs reflect an increase of

0.4% to the premiums. The Company provided detailed information breaking down each source contributing to the increase in expected administrative expenses.

- *Administrative Trend (2.4%):* Consistent with the prior filing, the Company's budgeted wage increase for 2016 is 3.0%, while other operating costs were assumed to remain flat. The increases due to administrative cost trend and personnel costs did not change materially from last year.
- *Year over Year Change in Administrative Costs (3.1%)*: The primary driver for this increase is that the VCC fee was added into the base administrative charges, rather than being listed as a separate line item expense as it was in the prior filing; this reclassification does impact the total premium. Additionally, the Company upgraded their cybersecurity protocols and operating systems.
- *Decrease in Membership (1.1%):* Several of the largest groups impacted by the prior filing were indicated to have moved to an ASO arrangement, while some of the groups are no longer with BCBSVT. It was also noted that prior estimates regarding which groups would move from "Large Group" to "Small Group" due to the change in definition of Large Groups were incorrect for some groups.[10] Given these considerations, it is reasonable to expect a material reduction in membership and a corresponding increase in administrative expenses.
- *Updated Cost Allocation (0.6%):* In 2015, the Company conducted a cost accounting study to reassess the allocation of their resources by line of business. The resulting reallocation of expenses slightly increased the administrative expenses attributable to the Large Group business line. However, this increase to Large Group administrative costs is offset by decreases to the Company's other lines of business. Expense allocations are expected to change over time.

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

7. *Federal Fees:* For 2017, there are two key changes in ACA programs: the expiration of the federal reinsurance program and the Consolidated Appropriation Act of 2016.

   The federal reinsurance program began in 2014 with the implementation of ACA and has gradually reduced in funding over three years. The program cost for 2016 was $27 per member per year, which will no longer be assessed in 2017.

   The Consolidated Appropriation Act of 2016 has temporarily suspended the Annual Fee on Health Insurance Providers ("insurer fee"). The Company estimates that this fee is approximately 2.7% of premium in 2016.

   The net effect of these changes was noted to reduce the overall average rate increase by 2.9%. This reduction due to the changes in federal programs appears to be reasonable and appropriate.

8. *Contribution to Reserves:* Using the allowed trend of 6.6%, a CTR of 1.3% for fully insured groups is required to maintain RBC levels at their current levels due to the impact of trend. L&E believes the proposed CTR of 2.0% for fully insured groups and 0.5% for Cost Plus groups is reasonable in order to maintain RBC levels in light of medical trend and provide an adequate margin over and above the minimum to keep appropriate RBC levels in the case of an adverse event without being excessive. The Company described the emergence of new high cost drugs and unforeseen regulatory changes as examples for why they need to set the CTR higher than the minimum needed to cover trend.

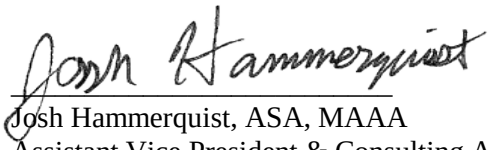
[10] The definition of "Large Group" has been changed from 51+ employees to 101+ employees beginning in 2016.

While L&E believes the proposed CTR of 2.0% for fully insured groups and 0.5% for Cost Plus groups is reasonable, reviewing the Company's current level of reserves is beyond the scope of this review. Therefore, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

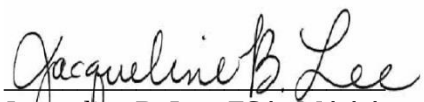
Recommendation

L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing without modification which would result in an overall increase of 4.3% ($19.92 PMPM).

Sincerely,



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



Jacqueline B. Lee, FSA, MAAA
Vice President & Principal
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:

- 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 April 18, 2016. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 8, 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 L&E has not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

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

[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.

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.