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May 9, 2017

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 2017 Large Group Filing (SERFF # BCVT-130935599)
AMENDED REPORT

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2017 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. This filing includes support for key assumptions for the Large Group rates, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors for large groups. The overall impact of this filing was estimated based on the previously approved factors from the prior Q3 2016 Large Group Filing.

3. This filing addresses BCBSVT Insured and Cost Plus large groups. There are approximately 8,200 subscribers and 15,900 lives affected across 67 groups for the combined BCBSVT and The Vermont Health Plan (TVHP) Q3 2017 Large Group filings.

4. The overall impact of this filing is 10.7%[1] ($50.74 PMPM).[2] This percentage is itemized below and incorporates assumptions and changes from prior filings as well as this filing.
    - Change due to Trend: **6.0%**
    - Change in Contribution to Reserve: **0.2%**
    - Change in Administrative Charges: **1.5%**
    - Changes in Federal Programs: **2.7%**

[1] The four components are multiplicative and therefore do not add up to exactly 10.7%.

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

- Annual Fee on Health Insurance Providers Reimplemented

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 Insured and Cost Plus large group premiums for groups renewing after approval of this filing. 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, 2012 and August 31, 2016, paid through October 31, 2016. Completion factors were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

The data includes claims from BCBSVT Cost Plus groups, BCBSVT Administrative Services Only (ASO) 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.

BCBSVT ASO groups are included in the development of the large claim factors, trend factors, benefit relativity factors, and stop loss 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.

Company's Analysis

1. *Medical Trend Development:* The Company is requesting a total allowed medical trend of 6.0%. This total allowed medical trend amount is broken down into 1.3% for utilization and intensity and 4.7% 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 2016, which resulted in a utilization trend of 1.5%. The Company felt this analysis overstated the utilization trend. Because monthly regressions can be unduly influenced by the beginning and end months in the experience period, the Company tested various end dates for the 24-month regression and calculated utilization trends ranging from 0.3% to 1.7%.

   Alternatively, the Company calculated a year-over-year rolling PMPM utilization trend of 0.9% for the year ending August 2016. The Company selected a 1.0% utilization trend to balance the results from the various calculations and to maintain consistency with the utilization trend in the most recently approved Large Group filing.

   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. 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 4.7% based on an analysis of the hospital budget increases implemented during 2016 as well as other providers in the BCBSVT service area. The Company started with the assumption that the GMCB would approve hospital budgets for October 1, 2017 and October 1, 2018 that support identical commercial increases as the approved increases for October 1, 2016. Then, Provider Contracting provided estimates for specific facilities in 2017 and 2018 that replaced the assumptions noted above.

Similarly, providers within the BCBSVT service area were assumed to have overall 2017 and 2018 budget increases as those implemented during calendar year 2016, except when Provider Contracting provided an estimate for a specific facility. Unit cost increases for providers outside the BCBSVT service area were derived from the Fall 2016 Blue Trend Survey[3].

Total Allowed Medical Trend
The utilization and intensity trend of 1.3% combined with the unit cost trend of 4.7% results in total allowed medical trend of 6.0%.

2. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend of 11.0%. The pharmacy trends are calculated using 24 months of historical data ending September 2016, 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. 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 11.0% overall allowed pharmacy trend.

Pharmacy Trends	Cost	Utilization	Total
Generic	5.1%	2.1%	7.2%
Brand	15.6 %	-8.5%	5.7 %
Specialty	N/A	N/A	19.3%
Total	N/A	N/A	11.0%

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 2016 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 89.0% in the projection period. This is an increase of 0.5% over the prior filing's assumption of 88.5%, 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 increased the 24 month regression trend from 14.9% to 17.3%.

   To project the cost of hepatitis C treatments, the Company reviewed the 2015 and year to date 2016 experience. The Company projected 30 hepatitis C claimants in 2018 based on the ratio of claimants to members in 2015. The distribution amongst the various drugs that are available was projected to be similar to the experience in 2015. The monthly cost based on Company experience is approximately $30,000 and the average treatment is 3.7 months, which results in a total projected cost of $3.3 million in 2018.

   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 16 members that will use a PCSK9 inhibitor in 2018. The annual cost of treatment was indicated to be approximately $14,000 per year, for a projected total cost of $225,000. 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 8 of their large group members will take Orkambi. The annual cost was indicated to be approximately $247,000 per year, for a projected total cost of $2.0 million.

   The table below provides a detailed breakdown of the 19.3% 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	$29,473,842
Claims Removed from the Experience	$2,712,688
Hepatitis C	*$2,393,099*
PCSK9 Inhibitors	*$51,939*
Orkambi	*$267,651*
Pharmacy Specialty Claims without Excluded Drugs	$26,761,154
Projected Specialty Claims using a 17.3% trend for 27 months	$38,313,061
Adding Incremental Cost of Excluded Drugs for the Projection Period	$5,496,992
Hepatitis C	*$3,297,770*
PCSK9 Inhibitors	*$225,344*
Orkambi	*$1,973,878*
Restated Projected Specialty Claims	$43,810,053
Restated Annual Specialty Trend	19.3%[5]

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends 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	6.0%	7.1%
Drug	11.0%	12.2%
Total	6.9%	8.0%

The total allowed trend is responsible for a 6.0% increase in premium.

6. *Administrative Costs:* Three components make up the 25.0%[7] increase to administrative charges, which increases the premiums by 1.5% (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 2016. 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.
   - *Increase in Total BCBSVT Membership (-0.4%):* In 2018, BCBSVT is projecting an increase in overall membership. Fixed expenses will be distributed among a larger pool of members, which results in a decrease in the total PMPM administrative charges.

[5] The annual specialty trend calculation is: ($43,810,053 / $29,473,842) ^ (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 three components are multiplicative and therefore do not add up to exactly 25.0%. In the initial filing, an error was made in the calculation of the projected administrative costs. The Company noted the mistake in a response and that the increase should have been filed as 27.9%. The Company has elected to not correct the filing for this error, keeping the total administrative increase as filed at 25.0%.

- *Updated Cost Allocation, Membership Shifts and Other Administrative Items (22.6%):* During 2015, BCBSVT completed a comprehensive cost accounting study, which increased the proportion of administrative charges that are allocated to large groups. The results were refreshed in 2016 to reflect known operational changes. In prior filings, the administrative costs from Large Group Insureds and Cost Plus groups were combined to calculate the base administrative charges. As of January 2018, a Cost Plus group with over 98% of the membership in this line of business is moving to an ASO arrangement. Therefore, only Insured Groups were used to calculate base administrative costs, which results in a significantly smaller block of business to spread administrative costs specific to Large Groups. Other administrative items are further detailed in the confidential response to the letter dated April 3, 2017.

7. *Federal Fees:* The Consolidated Appropriation Act of 2016 temporarily suspended the collection of the insurer fee for 2017. According to current law, the insurer fee will be collected again starting in 2018, and BCBSVT has estimated that the fee is approximately 2.6% of premium in 2018 and 2019. The insurer fee increases the requested rate increase from 8.0% to 10.7%. Should the current law be repealed and the insurer fee and Patient-Centered Outcomes Research Institute Fee are no longer collected, the rating formula will be modified and the rate increase will be reduced to 8.0%.

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 1.4% is required for the Fully Insured Large Groups to maintain RBC levels at the midpoint of the Company's target RBC range due to the impact of the premium increase. The proposed CTR enables the Company to remain financially strong and manage CTR to an adequate long-term level.

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 5.5%. 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 5.8%.

   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	0.6%	0.3%	0.9%
36 Months	1.2%	0.5%	1.7%
24 Months	1.5%	0.3%	1.8%

   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	4.4%	0.3%	4.7%
36 Months	5.2%	0.5%	5.7%
24 Months	5.5%	0.3%	5.8%

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 3.9% to 7.8%. 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 6.0% 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 6.0% 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 9.7%.

   The estimated range for the actual results is 7.8% to 11.6%. 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. The Company made an error in the specialty drug trend calculation in the original filing (elaborated further in section 4). Correcting this error reduces the specialty trend from 19.3% to 18.4% and reduces the overall allowed pharmacy trend from 11.0% to 10.6%. The overall rate increase is decreased by approximately 0.06%. L&E considers the Company's allowed pharmacy trend of 10.6% 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 January 2015 to December 2016 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 5.7% and 5.9%) is over 30% higher than being near the low end of the range (between 3.9% and 4.1%).

Historical	Rolling 12 Month GDR	Semi-Annual Increase
December 2015	85.9%	
June 2016	86.1%	0.2%
December 2016	86.7%	0.7%

Projected	Rolling 12 Month GDR	Semi-Annual Increase
June 2017	87.3%	0.7%
December 2017	87.9%	0.6%
June 2018	88.5%	0.7%
December 2018	89.0%	0.6%

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 demonstrate a slight acceleration over recent historical months. 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.

   The Company erroneously included members in the projected specialty drugs cost that were not in the experience period. Additionally, certain ICD-10 codes that should have been used in identifying the populations that may utilize specialty drugs were not included. Fixing both of these issues, decreased the cost of the specialty drugs for the projection period from $5,496,992 to $4,813,124 and decreased the specialty trend from 19.3% to 18.4%. The table below outlines the revised assumptions.

Pharmacy Specialty Claims in the Experience	$29,473,842
Claims Removed from the Experience	$2,712,688
Hepatitis C	*$2,393,099*
PCSK9 Inhibitors	*$51,939*
Orkambi	*$267,651*
Pharmacy Specialty Claims without Excluded Drugs	$26,761,154
Projected Specialty Claims using a 17.3% trend for 27 months	$38,313,061
Adding Incremental Cost of Excluded Drugs for the Projection Period	$4,813,124
Hepatitis C	*$3,297,770*
PCSK9 Inhibitors	*$281,680*
Orkambi	*$1,233,674*
Restated Projected Specialty Claims	$43,126,185
Restated Annual Specialty Trend	18.4%[10]

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

[10] The annual specialty trend calculation is: ($43,126,185 / $29,473,842) ^ (12 / 27) - 1

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%	7.1%
Pharmacy	10.6%	11.8%
Total	6.8%	7.9%

6. *Administrative Costs:* The Company has experienced an increase in the administrative costs for the year ending October 2015. The proposed increase of 25.0% to the administrative costs reflect an increase of 1.5% 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 2017 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.
   - *Increase in Total BCBSVT Membership (-0.4%):* The Company used a consistent approach as the prior filing to estimate the impact of a change in the overall membership of the Company.
   - *Updated Cost Allocation, Membership Shifts and Other Administrative Items (22.6%)*: In 2015, the Company conducted a cost accounting study to reassess the allocation of their resources by line of business and the results were refreshed in 2016. The resulting reallocation of expenses increased the administrative expenses attributable to the Large Group business line. Additionally, a large Cost Plus group is moving to an ASO arrangement, which reduces the size of the block of business affected by this filing with which to spread administrative costs specific to Large Groups. Expense allocations are expected to change over time. We reviewed the confidential response to the letter dated April 3, 2017 and consider it to be reasonable and appropriate.

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

7. *Federal Fees:* The Consolidated Appropriation Act of 2016 temporarily suspended the Annual Fee on Health Insurance Providers ("insurer fee") for 2017. The Company estimates that this fee will increase premiums by 2.7% in 2018 when the insurer fee will be reinstated. This change in the premium appears to be reasonable and appropriate.

   Currently, there has been proposed federal regulations that permanently repeal the insurer fee and the Patient-Centered Outcomes Research Institute Fee. If these fees are repealed, the net effect of these changes would reduce the overall average rate increase by 2.7%. The Company noted that these fees will be updated in the rating formula if either is repealed or modified without filing a revised rating formula.

8. *Contribution to Reserves:* A CTR of 1.4% for fully insured groups is required to maintain RBC levels at the midpoint of the Company's target range 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 emergence of new high cost drugs and unforeseen regulatory changes are examples for why they need to set the CTR higher than the minimum needed to cover trend.

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

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 specialty drug trend to 18.4%.

This change does not materially impact the overall rate increase of 10.7%.

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 May 5, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 12, 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.