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July 11, 2017

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

Re: MVP Health Plan 2018 Exchange Filing (SERFF # MVPH-131034103)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2018 Exchange Filing for MVP Health Plan, Inc. (MVP) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP provides individual and small group coverage to be sold on Vermont Health Connect (VHC). This filing develops premiums for MVP's Qualified Health Plans (QHPs) to be offered on VHC, beginning January 1, 2018.

2. This filing addresses MVP individual members and small groups. As of February 2017, there are approximately 10,305 members affected by this filing.

3. The overall impact of this filing is a proposed average rate increase of 6.7% or $29.98 per member per month (PMPM) 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 2017 VHC filing.

2018 Proposed Rate Changes

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	9.5%	$26.10	0.3%
Bronze	7.5%	$28.73	38.4%
Silver	4.7%	$21.36	35.6%
Gold	8.5%	$41.06	15.8%
Platinum	8.2%	$48.30	9.9%
Overall	***6.7%***	***$29.98***	***100.0%***

2017 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	4.3%	$11.40	0.7%
Bronze	5.4%	$19.50	43.8%
Silver	3.0%	$13.18	28.4%
Gold	3.3%	$15.57	14.5%
Platinum	1.9%	$11.29	12.6%
Overall	***3.7%***	***$16.04***	***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
MVP provided the methodology used to calculate the proposed 2018 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including the index rate development with adjustments for trend, administrative costs, and taxes and fees.

Exhibit 2a illustrates the assumed allowed medical cost trend by benefit category for 2017 and 2018, annual paid trend that accounts for leveraging impact, and the utilization/unit cost trends for prescription drugs by drug category. Exhibit 2b illustrates the application of pharmacy trends by drug category to experience period paid PMPM in development of the projected pharmacy paid PMPM.

Exhibit 3 shows the index rate development starting from MVP's experience period claims (encompassing about 82,000 total member months) from ACA compliant individual and small group employer data, and adjustments applied in derivation of index rate. These adjustments include application of factors for incurred but not reported claims, pooling charge, paid medical/Rx trend, etc.

Exhibit 4 shows the development of the single conversion factor of 1.085, using the distribution by tier and the average contract size by tier derived from February 2017. Exhibit 5 shows the retention loads, taxes, assessments, and paid claim surcharges. Exhibit 6 shows the development of the contract tier rates from the adjusted 2016 paid claim cost.

The "Loss Ratio Information" section of the Actuarial Memorandum demonstrates that the expected claims and premiums result in a projected traditional loss ratio of 88.3%. After adjusting for taxes, fees, and Quality Initiatives, the Federal MLR is projected to be 89.6%, which exceeds the minimum required 80%.

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

L&E Analysis

The average proposed increase of 6.7% to the 2017 premiums is attributed to several factors, including trend, contract tier distribution assumptions, and changes to federal programs, as illustrated in the table below. To create a consistent comparison for both companies filing VHC products, L&E categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component[1]	Percentage Change	PMPM Change
1. 2016 Actual/Projected Claims Experience	0.3%	$1.37
2. Difference in trend from 2016 to 2017	1.6%	$7.16
3. Trend from 2017 to 2018	5.4%	$24.29
4. Changes to Population Morbidity Adjustment	0.0%	$0.00
5. Changes to Other Factor	-0.9%	-$4.15
6. Changes to Manual Rating Adjustment	-0.7%	-$3.23
7. Changes to Risk Adjustment	1.5%	$7.15
8. Changes in Administrative Costs	-0.2%	-$1.15
9. Changes in Contribution to Reserves	1.1%	$5.30
10. Changes in Taxes & Fees	1.0%	$4.90
11. Changes in Single Contract Conversion Factor	-3.0%	-$14.37
12. Changes in Actuarial Value[2]	0.6%	2.71

1. *2016 Actual/Projected Claims Experience:* MVP experienced slightly worse than expected claim experience in 2016. The 2018 URRT shows that the 2016 Claim Experience was 0.3% higher than projected in the 2017 Exchange Filing's URRT.

   This 0.3% corresponds approximately to the amount payable by MVP for the 18 VSA 9374(h) Billback. This amount has been treated as a claim expense in this filing. L&E does not believe it is appropriate to refer to this expense as a claim expense. However, were it to be removed from claims, it would need to be added to the non-benefit expenses. Therefore, the inclusion of the billback amount in the claims experience does not have a material rate impact.

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

   L&E requested historical enrollment and termination data from MVP, which demonstrated that the pattern of mid-year terminations and enrollments does not appear to be change drastically among

[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] Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), and membership shifts.

non-employer Exchange policies. MVP has stated that they believe the level of mid-year enrollment and termination has been due to one-time events in the Vermont healthcare market, such as changes to the open enrollment timeline and to Vermont's Medicaid system.

L&E recommends that the factor be modified to reflect the modified open enrollment timeline, special enrollment periods, and mid-year terminations. Based on L&E's analysis of MVP's data, the best estimate of the 2018 enrollment distribution suggests that the adjustment to individual policies should be decreased from 1.014 to 1.007. This change would reduce the overall rate increase by approximately 0.3%.

2. *Difference in trend from 2016 to 2017:* The 5.4% annual trend from 2016 to 2017 in the 2018 URRT is higher than the trend assumed in the prior URRT by 1.6%. L&E notes that the facility unit cost trend factors reflect known and assumed price increases from MVP's provider network. The change in 2017 trend is also caused by utilization trend, discussed below.

   The assumed trend assumption of 5.4% is discussed further in the next section.

3. *Trend from 2017 to 2018:* The Company requested an allowed medical trend of 4.2% and an allowed Rx trend of 11.9%.

Cost Category	Allowed Trend	Paid Trend
Medical	4.2%	4.7%
Drug	11.9%	12.7%
Total	5.4%	5.8%

- *Medical Trend:*
  The Company projected an annual allowed medical trend of 4.2%. The allowed trend reflects changes in the cost of medical services and changes in utilization of medical services by members.

  Unit Cost Trend
  MVP computed its allowed trend as a weighted average of the medical claim trends in 2017 and 2018 for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network. MVP used known and assumed contractual increases with providers to derive their requested allowed medical trend consistent with their prior rate filings. These increases reflect the changes to the unit cost increases ordered by the Green Mountain Care Board.

  Since the 2018 hospital budget negotiations are not yet finalized, MVP has assumed that increases by hospital will match 2017 increases. The only exception to this is that facilities which had negative changes in 2017 were assumed to return to normal rate increases in 2018. That is, hospitals cannot maintain cost decreases in the long run. The overall increase

for hospital-based charges differs from the Board's Vermont-wide projections for several reasons:

- MVP's costs are distributed slightly differently from the entire commercial market producing a different average across all facilities.
- The medical services covered by these plans are not all provided by hospitals subject to the GMCB hospital budgeting process.
- MVP uncovered two mistakes in the 2017 and 2018 trend assumptions which, when corrected, would result in a decrease in the filed rates of approximately 0.5%.

The assumed allowed unit cost trend is 3.5% annually. The effective paid medical trend reflects the actual claim payment made only by the carrier and is derived from the proposed allowed cost trend rates, adjusted for the impact of cost share leveraging[3]. The resulting annual effective paid medical trend is 3.9%. The medical claims were projected forward to the midpoint of the rating period using this effective paid medical trend.

L&E recommends that MVP correct the mistakes in the trend assumptions, as outlined above. This change results in a decrease in the rates of 0.5%. After modification, the Company's assumed allowed and effective paid medical trends appear to be reasonable and appropriate.

Utilization Trend and Intensity

In prior filings, MVP has consistently used an assumption of 0% for utilization trend. In this filing, MVP is assuming average annual utilization increases of 0.7%. This assumed increase reflects an observed increase in outpatient and physician services.

In this filing, MVP has provided historical utilization data that shows utilization of all major service categories increased noticeably between 2015 and 2016, even after normalizing for changes in member age. MVP chose to use a logarithmic regression, which implicitly assumes that trend will normalize to zero over time. This methodology resulted in an assumed 0.7% annual utilization trend on average.

In addition, market data available from other filings indicates that an increase in medical utilization is being observed across the individual and small group market. Based on all information available at this time, the utilization trend included in this filing appears to be reasonable and appropriate.

Total Allowed Medical Trend

Based on the information available, the best estimate of the total allowed medical trend is 3.9%. L&E estimates that the actual results could ultimately range from 2.1% to 5.1%. Each of the results 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. Correction for the Company's mistakes in the unit cost trend makes the allowed medical trend equal to 3.9%, which falls within the estimated range.

[3] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation.

When the 2018 hospital budgets are finalized and made available to the carriers prior to the Board's order on this filing, it may be that the unit cost increases differ from current assumptions. If this occurs, the unit cost changes should be updated to reflect the actual cost increases.

- *Pharmacy Trend:* The Company projected an annualized allowed Rx trend of 11.9%. This trend forecast was provided by MVP's Pharmacy Benefit Manager (PBM), based on MVP's experience by drug class. The chart below shows that the brand and specialty trend categories are driving the total Rx trend up.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	-1.4%	3.1%	1.6%
Brand	13.8%	0.3%	14.1%
Specialty	7.7%	7.0%	15.2%
Total	8.8%	2.8%	11.9%

After accounting for member cost sharing, the total annualized effective paid Rx trend is 13.4%.

As in prior non-Exchange filings, MVP has not used historical pharmacy trend analysis to form assumptions for future pharmacy trends as they believe prior experience is not indicative of future trends. L&E recognizes that historical trends may not be indicative of future trends for all underlying factors, such as shifts in generic dispensing rates, drugs losing patents, introduction of new drugs (such as high cost Hepatitis-C drugs), and changes in pharmacy vendors. The proposed allowed Rx trend is lower on an annual basis than recent trends experienced by MVP over the last few years. Also, the trend assumptions are from MVP's PBM, which has on average understated cumulative trend slightly over the last two years. The proposed trend is likely on the lower end of what L&E would consider reasonable given these facts. As this methodology is consistent with MVP's other filings, L&E does not propose any change at this time.

L&E considered MVP's historic experience as well as the PBM's recommendation and opines that the requested Rx paid trend of 12.7% appears to be reasonable and appropriate.

The Company requested a paid medical trend of 4.7% and a paid Rx trend of 12.7%. The total paid trend was projected to be 5.8% annually. As noted above, L&E's recommended changes to the medical unit cost assumptions results in a decrease in the total paid trend to approximately 5.5% annually.

4. *Changes to Population Morbidity Adjustment:* No changes to the risk profile of the covered population were assumed in this filing. MVP used claim experience from the Exchange to project the 2018 claim costs (elaborated further in section 6 below).

5. *Changes to Other Factor:* The Other Change projection factor reflects a reduction due to the base period, 2016, being a leap year. An adjustment of approximately 0.997 was applied to projected claims to account for 2018 being shorter by one day than 2016. Last year's factor included other increases to reflect population differences, e.g. changing age distributions between the base period experience and the projection period. As this filing uses only Exchange data, these adjustments were removed. The overall change from the prior filing results in a 0.9% rate decrease.

   The Other Factor change of -0.9% appears to be reasonable and appropriate.

6. *Changes to Manual Rating Adjustment:* MVP is no longer using a manual rate to project costs for this program. Because the Exchange population is large enough to suppress random fluctuations, the Vermont Health Connect experience is being assigned 100% statistical credibility. This methodology appears to be reasonable and appropriate.

7. *Changes to Risk Adjustment:* In the initial filing, MVP projected 2018 risk adjustment based on the most recent data available. At the time, the most recent data was the interim report[4] published by CMS in early April and a confirmation of the number of months each carrier had submitted for the interim report. The interim report was based on incomplete data, which meant that MVP had to adjust the results to reflect their anticipation of the projected final results, which were released in the final report[5] on June 30th. The initial projection resulted in an estimated risk adjustment payable of approximately 4% of claims, or about $1.4 million. MVP's methodology was reasonable based on the information they had at the time of the filing. However, since the actual results for benefit year 2016 were materially different from MVP's expectation, MVP revised their calculation.

   The Final 2016 Risk Adjustment report showed that MVP owed $300,153 to the risk adjustment program. The Final Notice of Benefit and Payment Parameters for 2018[6] published by HHS stated that the 2018 risk adjustment payments will be reduced by 14% to prevent risk adjusting administrative costs. MVP decreased the 2016 figure to $258,132 for this reason. Using base period enrollment, this amounts to $3.13 PMPM, or 0.7% of claims. However, MVP does not believe that their risk score relative to the market will be as high in 2018 as in 2016 due to membership shifts. MVP anticipates gaining membership in 2018, and new members cause disruptions to risk adjustment efforts, as MVP will have less diagnosis data on these new members than on their renewing members. MVP provided experience data on new enrollees demonstrating that this effect has a measurable impact on risk scores that exceeds the impact on claims. An adjustment was made to reflect these new members, increasing the relative risk assumption from 0.7% to 2.7%.

[4] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2016_5CR_033117.pdf

[5] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[6] https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html

L&E has reviewed MVP's proposed calculation, and it appears that MVP's methodology reasonably projects 2018 risk adjustment. L&E does not propose any changes to MVP's modified calculation. Relative to the initial filing, MVP's modified calculation reduces the proposed rate increase by approximately 0.9%. The revised estimate assumes that MVP would pay $1,382,986, or $11.18 PMPM. Note that this figure reflects MVP's assumption that 2018 enrollment will be nearly 50% higher than 2016 enrollment.

8. *Changes in Administrative Costs:* The rates were decreased by 0.2% due to a reduction in projected administrative costs as a percentage of premium. MVP is projecting general administrative costs to be $38.10 PMPM, which is a slight increase over the 2017 Exchange filing. This includes quality improvement (QI) expense of 10% of total administrative expense. Since the QI assumption is based on actual 2016 MVP expenses, L&E finds it to be reasonable and appropriate.

   Because the premium is increasing from the 2017 Exchange filing, the administrative expenses, as a percentage of premium, are decreasing. The assumed administrative costs assumed in this filing are slightly lower than MVP's 2016 individual and small group administrative costs of $40.51 PMPM based on the 2016 Supplemental Health Care Exhibits (SHCE). These costs have fallen substantially since 2013, when they were $46.57 PMPM. This historical reduction in administrative costs cannot continue indefinitely, and the projected administrative costs appear to be reasonable. In light of the steps taken by MVP in reducing administrative costs over the recent years, the assumed administrative 2017 costs appear to be reasonable and appropriate.

9. *Changes in Contribution to Reserves:* The rates were increased 1.1% to reflect the increase in the contribution to reserves. MVP's assumed contribution to reserves of 2.0% in this filing is higher than the 1.0% approved by the Board in the 2017 Exchange filing. The proposed 2.0% contribution to reserves, while higher than approved last year, is consistent with the assumptions found in MVP's other recent filings. The contribution to reserves assumption appears to be reasonable and appropriate.

   While L&E does not recommend any changes to the CTR, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

10. *Changes in Taxes & Fees:* The rate change due to changes in taxes and fees is an increase of 1.0%. This change is driven primarily by the return of the Health Insurer Fee for coverage year 2018. This federal fee was waived for 2017, resulting in a temporary decrease in rates for which the rates must now be corrected. The projected Health Insurer Fee is based on MVP's projected share of the $14.3 billion to be collected nationwide for 2018 and appropriately reflects the impact of MVPHP's non-profit status.

    As noted in Section 1 above, the true taxes and fees also include the 18 VSA 9374(h) Billback and the HCA billback, whereby the Company will be required to contribute a portion of the HCA's operating costs. These costs were included in the claims by MVP. Because the projected loss ratio is above the required minimum, there is no material rate impact of reflecting these costs in claims. The tax and fee assumptions appear to be reasonable and appropriate.

11. *Changes in Single Conversion Factor:* The single conversion factor[7] used in the 2017 rate filing was 1.118. For this year's filing, MVP utilized February 2017 enrollment to calculate the 2018 single conversion factor of 1.085.

    This reduction is the result of a shift towards single coverage since 2016. The impact of this change is a decrease of 3.0% in the rates. L&E reviewed the calculation of this adjustment, and the calculations appear to be reasonable and appropriate.

12. *Changes in Actuarial Value:* This change reflects other Pricing AV changes, such as changes in Metal AVs of plans, induced utilization, cost sharing changes, and changes in projected enrollment among plans. This also reflects any changes to the Pricing AV's calculated by MVP. These changes combined result in an increase of 0.6% in rates.

    To project membership by plan, MVP considered the February 2017 enrollment of all Exchange members. The assumed 2018 distribution is more heavily weighted towards silver and bronze plans than the 2017 distribution. However, Pricing AV values for these bronze and catastrophic plans have increased materially since 2017. This means that while the AV calculator values high deductibles differently from MVP's data, which is used to set pricing AV's.

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

Cost Sharing Reduction (CSR) – Defunding Scenarios

CSRs are "extra savings" for families who earn less than 250% of the Federal Poverty Level. These savings, which are fully subsidized by the federal government, help people with their out-of-pocket costs, like deductibles, coinsurance, and copayments.

Per a current legal challenge at the federal level, it is possible that these federal subsidies will not be available for 2018. If this were to occur, MVP would be responsible for funding the previously subsidized additional benefits; however, the proposed premiums would be materially insufficient to offset the shortfall created by the revocation of the federal subsidies.

If the CSR is ultimately defunded for 2018, L&E recommends that the Board should permit carriers to increase their rates. This could be accomplished in either of two methods:

1. First, premiums could be increased on Silver plans only, as only Silver plans are eligible for CSR. This approach would create a situation where Silver plans are nearly as expensive as gold plans. However, it should be noted that this approach would increase After Tax Premium Credits, since APTCs are based on the premium for the second lowest cost Silver

[7] The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, the tiered premiums require the base premium to be for a single adult.

plan. Under this approach, it would be expected that non-CSR eligible persons who currently purchase Silver plans, would change to either a Bronze or Gold plan due to the increased cost of the Silver plans. This approach maximizes the subsidies that are provided by the federal government.

2. Second, premiums could be increased for all plans, maintaining an appropriate benefit relativity between the metal tiers. This approach produces rates that are less disruptive to the market but results in lower subsidies provided by the federal government.

Regardless of the approach selected, L&E recommends that the Board require that all market participants to use the same method. Otherwise, it is anticipated that significant volatility and instability would be introduced the marketplace.

MVP has provided their analysis of the impact of both methods. Under the first method, MVP's Silver premiums would increase by 8.7%. Under the second method, all of MVP's rates would increase by 3.1%. L&E believes both of these figures appear to be reasonable.

Should the CSR be defunded, L&E believes the Board should consult with the carriers and other stakeholders to arrive at a decision regarding the proper method for the market as a whole. Regardless of the approach selected, L&E recommends that the Board requires that all market participants use the same method. Otherwise, it is anticipated that significant volatility and instability would be introduced into the marketplace.

Recommendation

After modifications, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modifications:

- *2016 Actual/Projected Claims Experience*: Modify the mid-year enrollment/termination factor to adjust only small-group policies. This results in a decrease in rates of 0.3%.

- *Trend from 2017 to 2018*: Correct the mistake found in MVP's 2017 unit cost trend calculation. This results in a decrease in rates of 0.5%.

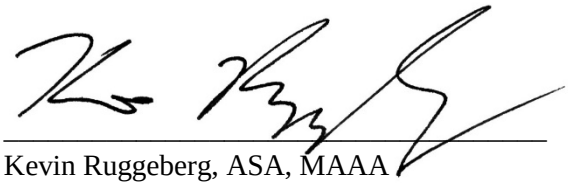
- *Trend from 2017 to 2018*: This report considers the information available to the carriers as of the time of this report. L&E recommends that the Board consider the impact of 2018 hospital budgets on unit cost trends once the 2018 budgets become publicly available.

- *Changes to Risk Adjustment*: Reduce the projected risk adjustment payment to reflect MVP's new best estimate assumption. This results in a decrease in rates of 1.1%.

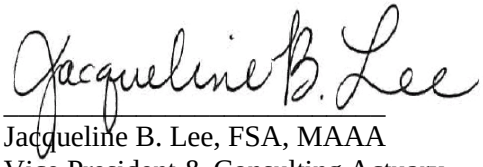
After the modifications, the anticipated overall rate increase will reduce from 6.7% to approximately 4.8%.

Metal Tier	Proposed Rate Change	Modified Rate Change	Percent of Membership
Catastrophic	9.5%	7.7%	0.3%
Bronze	7.5%	5.6%	38.4%
Silver	4.7%	2.8%	35.6%
Gold	8.5%	6.5%	15.8%
Platinum	8.2%	6.2%	9.9%
Overall	***6.7%***	***4.8%***	***100.0%***

Sincerely,



Kevin Ruggeberg, ASA, MAAA
Associate Actuary
Lewis & Ellis, Inc.



Jacqueline B. Lee, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

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

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[8], 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[9], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Kevin Ruggeberg, ASA, MAAA, Associate Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

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

Identification of Actuarial Documents

The date of this document is July 11, 2017. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 9, 2017.

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.

[8] 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.

[9] 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.