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April 22, 2019

Green Mountain Care Board
State of Vermont
144 State Street
Montpelier, VT 05602

Re: Blue Cross and Blue Shield of Vermont 2020 Association Health Plan Filing (SERFF # BCVT-131835459)

The purpose of this letter is to provide a summary and recommendation regarding the proposed Association Health Plan (AHP) Filing for Blue Cross and Blue Shield of Vermont (BCBSVT) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides individual coverage, small and large group coverage to employers, and Medicare Supplement coverage in Vermont.

   This filing establishes the formula, manual rate and accompanying factors that will be used for Association Health Plan renewals. This filing includes support for key assumptions, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors.

2. This is the first filing since new federal Department of Labor rules permitting a broader range of associations to offer group coverage were released. We note that the U.S. District Court for the District of Columbia issued a ruling vacating key provisions of this rule during the review of this filing. We do not believe this ruling modifies the scope of our review, and we have not considered the implications of such a stay on the proposed rates.

3. BCBSVT currently provides coverage to two AHP groups in Vermont. Those groups will be subject to this filing, but will both be rated with consideration of their group-specific experience. At this time, insufficient data is available to quantify the impact of this filing on those groups' renewal rates. The manual rate applied, where applicable, was previously based on the large group manual rate, rather than a separate manual rate for AHPs. The proposed AHP manual rate for those groups compared to the prior manual rate reflects a 12.0% increase. This increase is roughly consistent with the recently filed increase on large group products.

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 AHP group premiums for groups issued or renewing after approval of this filing. The Company provided exhibits and support for each component of the premium development, including trend and administrative costs.

For medical trend development, the Company used claims incurred between July 1, 2014 and June 30, 2018. Completion factors[1] were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

Company's Analysis

1. *Manual Rate Development:* If there is association-specific experience available, the projected claims will be based on the claims for that association. However, if the group is too small to have fully credible data, or if no such data is available, the projected claims will be based on a manual rate which reflects the Company's expectation of average associations during the projection period. The manual rate was developed from historical data. The specific experience used is from claims incurred between October 2017 and September 2018 from BCBSVT small groups who do not have their entire enrollment on a platinum plan. This population was selected as the Company believes it is analogous to the health and demographic characteristics of associations in 2020. This data is adjusted for pharmacy contracting and trended forward to 2020 based on the trend assumptions described below.

2. *Medical Trend Development:* The Company is requesting a total allowed[2] medical trend of 6.4% per year. This total allowed medical trend amount is broken down into 3.5% for utilization and intensity and 2.8% 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. To reduce fluctuation and capture only trend, the Company removed claims over $500,000. This data was then analyzed by using exponential regression over the 24-month and 36-month time periods ending June 2018, which resulted in utilization trend estimates of 4.2% and 3.2%, respectively.

   In addition to their standard approaches, the Company performed time series analyses using the data that excludes the large claims. The Company used six different times series methods and calculated each of them over 24, 36 and 48 months of historical data. The results range from a minimum utilization trend of 0.4% to a maximum of 6.1%.

   After an evaluation of the different trend estimates, the Company selected a 3.5% utilization trend. This estimate is consistent with the trends calculated using their standard methodologies and is in the range of trends produced by the alternative methods.

   Given the recent increase in the utilization trends, the Company identified the following contextual information for the 3.5% increase:

[1] Settling claims with providers often takes enough time that not all claims from the experience period are known with certainty. Completion factors are used to estimate the ultimate incurred claims based on the historical pattern of paid claims.

[2] Allowed cost trends are based on charges that reflect the total amount of claims paid by both the carrier and the policyholder. Paid trends reflect the actual claim payment made by the carrier only and are shown in section 5. Paid trends are usually higher because the member's share of the cost is often limited to fixed copays which do not increase with cost trend.

- Professional Services: Utilization trend is being driven by significant increases in professional services, including increases in primary care services, mental health and substance abuse services, and lab and radiology services.
- Inpatient cost per admit: Inpatient cost per admission has increased by 6%. This is due to more expensive drugs and injectables being administered during inpatient stays. BCBSVT anticipates that these drugs will continue to drive high inpatient trends.
- Consistent Statewide: The Company also noted that Cigna, in their large group filing, developed a utilization/mix trend of 3.9% in their most recent large group filing.
- Unit Costs: Finally, unit cost increases for Vermont hospitals have reached historical lows in part due to budget overages caused by excess utilization.

Unit Cost Trend
The unit cost trend for medical trend is projected to be 2.8% based on an analysis of the hospital budget increases implemented during 2018 as well as other providers in the BCBSVT service area.

This projection includes a 2.6% increase for Vermont facilities and providers impacted by the GMCB's hospital budget review and a 3.0% for other facilities and providers. The Company started with the assumption that the GMCB would approve hospital budgets for October 1, 2019 and October 1, 2020 that support identical commercial increases as the approved increases for October 1, 2018. Then, BCBSVT's Provider Contracting department provided estimates for specific facilities in 2019 and 2020 that replaced the assumptions noted above.

Providers within the BCBSVT service area were assumed to have overall 2019 and 2020 budget increases similar to those implemented during calendar year 2018, except when the Provider Contracting department provided an estimate for a specific facility. Unit cost increases for providers outside the BCBSVT service area were derived from the Fall 2018 Blue Trend Survey.[3]

Total Allowed Medical Trend
The utilization and intensity trend of 3.5% combined with the unit cost trend of 2.8% results in total allowed medical trend of 6.4%.

3. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend of 7.8%. The pharmacy trends are calculated using 24 months of historical data ending June 2018, which is modeled using an exponential regression.

   The Company modeled the costs for generic and brand drugs separately; however, they did combine the data to analyze utilization patterns. A separate adjustment was then made to incorporate the impact of brand drug patent expiration, which results in a decrease in cost as lower-cost generics become available.

   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 7.8% overall allowed specialty trend.

3 The Fall 2018 Blue Trend Survey is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend	With Contracting Adjustments
Generic	3.5%	0.0%	3.5%	N/A
Brand	5.9%	0.0%	5.9%	N/A
Brands Going Generic	-43.4%	0.0%	-43.4%	N/A
Specialty	N/A	N/A	18.0%	N/A
Total	N/A	N/A	9.1%	7.8%

4. *Pharmacy Trend Adjustment – Brands Going Generic:* When the patent expires for a brand drug, lower-cost generic alternatives become available. The Company projected the quantity and reduced cost for drugs which will become genericized during the projection period.

   In the past, BCBSVT has projected the Generic Dispensing Ratio (GDR) and used this projection to split brand and generic drugs into separate categories. This change does not affect manual rates.

5. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* The Company made specific adjustments for several high-cost specialty drugs:

   - Orkambi, which is used to treat cystic fibrosis;
   - PCSK9 inhibitors[4], which are used to treat high cholesterol in patients with familial hypercholesterolemia (FH); and
   - Ocrevus which is used to treat multiple sclerosis (MS).

   The Company recalculated the specialty drug trend after excluding these new specialty drugs from the historical data. This decreased the 24-month specialty trend from 18.5% to 18.4%. Then, the Company added in the projected costs of these expensive specialty drugs and recalculated the specialty drug trend to be 18.0%.

   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, the Company expects 19 members to use a PCSK9 inhibitor in 2020. The annual cost of treatment was indicated to be approximately $14,000 per year, for a projected total cost of about $270,000. 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 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 only had one member in the experience period that had claims for Orkambi. Given the length and time the drug has been available, they do not expect to see a change in utilization and added in the projected total cost for one member of approximately $390,000.

   Ocrevus is a drug used to treat MS. The Company estimated that 15% of their current members currently taking medicine for MS would switch to taking Ocrevus.

[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.

The table below provides a detailed breakdown of the 18.0% 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.

Pharmacy Specialty Claims in the Experience	$29,744,082
Claims Removed from the Experience	$1,197,776
PCSK9 Inhibitors	*$160,676*
Orkambi	*$388,607*
Multiple Sclerosis Drugs, Anticipated to Move to Ocrevus	*$648,493*
Pharmacy Specialty Claims without Excluded Drugs	$28,546,306
Projected Specialty Claims using a 18.4% trend for 30 months	$43,525,331
Adding Incremental Cost of Excluded Drugs for the Projection Period	$1,455,958
PCSK9 Inhibitors	*$269,351*
Orkambi	*$388,607*
Ocrevus	*$798,000*
Restated Projected Specialty Claims	$44,981,289
Restated Annual Specialty Trend	18.0%

6. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends, as this is the clearest way to view changes in cost and utilization. However, plan liability increases at the paid trend rate, not the allowed trend rate. Therefore, an adjustment was made to the calculated allowed trends to reflect expected paid trends given the mix of benefits enrolled in the program.

   The leveraged trend values were calculated using the Company's Benefit Relativity models[5] 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	6.4%	7.2%
Drug	7.8%	8.6%
Total	6.6%	7.5%

7. *Administrative Costs:* Administrative costs are projected based on past administrative costs. The administrative experience period for this filing is November 2017 through October 2018. As this is a new block of business, the source data is from BCBSVT and TVHP large group business, as the size of the covered AHPs will be most similar to large groups. Those costs are allocated to groups either on a per-account basis, a per-member basis, or a per-contract basis, as appropriate. Several components make up the administrative charges:
   - *Administrative Trend (2.5%):* The proposed administrative costs were developed by trending forward the actual administrative costs for the year ending October 2018. 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.

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

- *Removing Transitional Costs (-2.0%):* The base period expenses include the one-time costs of converting to a new technology platform. Because these costs will not be repeated in the future, they were removed from the projection.
- *Updated Experience Base and Allocation (16.3%):* The large group line of business experienced an 11.7% decrease in member months, which reduced variable administrative costs, but resulted in the fixed costs being distributed over a smaller population.
- *Decrease in Total BCBSVT Membership (0.7%):* BCBSVT is projecting a decrease in overall membership for 2020, across all lines of business. Since fixed expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charges results.
- *Net Cost of Reinsurance:* BCBSVT purchases reinsurance for amounts exceeding $800,000 per member for 2019, and expects to enter a similar arrangement for 2020. The expected retention on this reinsurance is included in the expense projections, equal to $1.71 PMPM for policies issued in Q1 of 2020.

8. *Federal Fees:* H.R. 195 temporarily suspended the collection of the insurer fee for 2019. According to current law, the insurer fee will be collected again starting in 2020, and the Company has estimated that the fee is approximately $13.53 PMPM in 2020. The insurer fee increases the requested rate increase by approximately 2.2%.

9. *Contribution to Reserves (CTR):* The proposed CTR is 1.5%. This is consistent with the Company's requested CTR for insured large groups.

Lewis & Ellis (L&E) Analysis

1. *Manual Rate Development*: The manual rate is based on small group experience. While AHPs will generally have more members than small groups, they can be formed by multiple smaller employers grouping together for the purposes of obtaining health coverage. The choice of whether to join the AHP is a decision very similar to the existing choice of whether to BCBSVT chose to exclude small groups with exclusively Platinum plans, which we believe is reasonable given the underwriting efforts to control anti-selection that should be in place in most AHPs.

   We note that the existing AHPs have previously used the large group manual rate where applicable, rather than small group data. However, we believe this change is appropriate for several reasons. First, changes to the regulatory environment making it easier for multi-employer AHPs to form can reasonably be expected to result in changes in the covered population. Second, the manual-to-manual rate increase resulting from this filing is 12.0%, slightly less than the increase being experienced in the current large group block. Third, of the two existing AHPs, both have significant statistical credibility, and one of the two is fully experience-rated. Therefore, the impact of changes to the manual rate on existing AHPs is limited.

   We believe the proposed manual rate development is reasonable and appropriate for the population to be covered by this filing.

2. *Medical Trend Development:* The Company is requesting a total allowed medical trend of 6.4%. This total allowed medical trend amount is broken down into 3.5% for utilization and intensity and 2.8% for unit cost. L&E reviewed each of these components separately.

   Utilization and Intensity

   L&E reviewed the data and analysis provided by the Company, which includes:

   - Exponential regression with and without high claimants;

- Year-over-year rolling PMPMs with and without high claimants; and
- Times series analysis.

Each of the different methods produced varied results, which indicates uncertainty in the projected utilization trends. The Company also provided extensive qualitative support their utilization trend assumption.

BCBSVT has consistently relied on historical utilization changes to project future utilization changes in past filings, using various regression algorithms. Regression on 24 rolling 12-month datapoints, the historical utilization trend is 4.2% per year. Using 36 rolling 12-month periods, the trend is 3.2%. The most recent 12 months showed utilization at 3.9% higher than the prior 12 months. In consideration of these and other numbers, BCBSVT assumed a 3.5% per year utilization trend. We note that BCBSVT could plausibly have assumed a higher number based on historical experience alone.

We have reviewed the regression analysis and considered the possibility of random fluctuation in the results. The data suggests that the underlying trend over the last 4 years has variability such that a 90% confidence interval would be from 1.8% to 5.2% per year.[6] We believe BCBSVT's trend assumption is reasonable and do not recommend any changes at this time.

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. An extremely minor error was discovered during our review, but the Company noted that a change needed to be made, but there was no impact to the rates due to this correction.

Total Allowed Medical Trend

Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. L&E's estimated range for the total allowed trend is 4.7% to 8.1%. 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.

BCBSVT's assumed total allowed medical trend of 6.4% is reasonable in light of the known and likely hospital budget increases, as well as the consistent pattern of increasing utilization in recent years. We do not recommend any changes to the medical trend assumptions in this filing.

3. *Pharmacy Trend Development:* The Company's method of projected pharmacy trends has been updated since the prior filing. In this filing, a utilization trend is developed separately for brand and generic drugs, with separate unit cost trends. There is a third category of drugs, referred to as "Brands Going Generic", which represent the particular drugs which are assumed to be replaced by generic equivalents between the base period and projection period. These drugs have projected unit costs based on the Company's estimate of the generic cost of the particular drugs being shifted over, which is much lower than their current brand cost.

   The Company calculated unit cost trends of 3.5% for generic and 5.9% for brand drugs. As noted below in Section 4, there was a calculation error in the generic unit cost trend. Otherwise, the non-specialty unit cost trends appear reasonable.

[6] Values near the middle of the range are expected to occur more often. For instance, the regression suggests that the likelihood trend is between 1.8% and 1.9% is about 3.5 times lower than that trend is between 3.5% and 3.6%.

The utilization trend for non-specialty drugs is projected to be zero. We believe that utilization trend methodologies for medical and drug costs should be developed in a consistent manner. The most recent drug utilization data suggests a negative trend. However, the Company has illustrated that, unlike the medical trend, the drug utilization trend is not part of a long-term shift in utilization. The utilization trend was positive until a rather sudden, one-time drop around January 2017. We also note that the medical trend assumed was lower than could be supported based on historical data. Therefore, we believe it is reasonable that zero utilization trend for non-specialty drugs be assumed in this filing. However, we recommend this assumption be monitored closely to ensure that any developing long-term trend be reflected in future filings.

Due to their high cost and low frequency, specialty drugs are projected based on their allowed cost, without splitting into unit cost and utilization. We agree with the Company's decision to analyze specialty cost trend this way, as the utilization trend would be virtually impossible to assess given the low frequency and wide variance in unit costs. Before adjusting for a handful of unique specialty drugs, the calculated specialty drug trend is 18.5% per year. Detail on the adjustment for high-cost drugs is described in Section 4 below.

The initial filing projected overall pharmacy allowed trend to be 7.8% per year. This reflects not only unit cost and utilization changes, but also contracting changes with the PBM (Pharmacy Benefit Manager) that reduced the trend from 8.5% to 7.8%.

4. *Pharmacy Trend Adjustment – Brands Going Generic*: The projected generic drugs are made up of two categories. The first are those that were generic during the base period. The second category includes drugs which are under patent during the base period but will have generic replacements during the projection period. This latter category has high unit costs, as competitive manufacturers begin to develop the newly generic drug alternatives. This means that the movement from brand into the generic increases the generic unit cost.

   The movement of drugs from brand to generics has occurred historically and is, therefore, reflected in the historical generic unit cost trend calculated by the Company. This resulted in a slight double-counting in the original filing. When this overstatement of trend was discovered by L&E, the Company agreed that the generic unit cost trend study should be revised to ignore this impact on historical costs. This updated study reduced the projected unit cost trend for generics from 3.5% per year to 0.0% per year. This reduces overall pharmacy trend from 7.8% to 7.2%.

   With this revision, L&E believes the method of projecting brands going generic is reasonable and appropriate.

5. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* L&E reviewed the cited cost per treatment for the expensive drugs indicated in the pharmacy specialty drug trend development. The Company's unit cost estimates appear to be consistent with publicly available information on these drugs, and the utilization estimates are reasonable and consistent with their experience. 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.
6. *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 reasonable and appropriate. The table below

shows the Company's revised allowed trends, the paid trends after leverage adjustments were made, and the impact of projected pharmacy contract changes.

	Allowed Trends	Paid Trends
Medical	6.4%	7.2%
Drug	7.8%	8.6%
Total	6.6%	7.5%

7. *Administrative Costs:* The Company has experienced an increase in the administrative costs in 2018. The Company provided detailed information breaking down each source contributing to the increase in expected administrative expenses.

   - *Administrative Trend (2.5%):* 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.
   - *Updated Experience Base and Allocation (16.3%):* The large group line of business experienced a significant decrease in member months, which results in the fixed costs being spread over a smaller population. Additionally, the large rate increase in this filing results in a higher percentage of administrative costs being allocated to large groups.
   - *Decrease in Total BCBSVT Membership (0.7%):* The Company used a consistent approach as the prior filing to estimate the impact of a change in the overall membership of the Company.
   - *Other Adjustments (0.1%):* The 62 large groups that are expected to renew in 2019 have higher administrative costs than the average across all large groups.

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

8. *Federal Fees:* H.R. 195 temporarily suspended the Annual Fee on Health Insurance Providers ("insurer fee") for 2019. The Company estimates that this fee will increase premiums by 2.2% in 2020. This projected cost appears to be reasonable and appropriate.

9. *Contribution to Reserves:* L&E believes the proposed CTR of 1.5% 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.

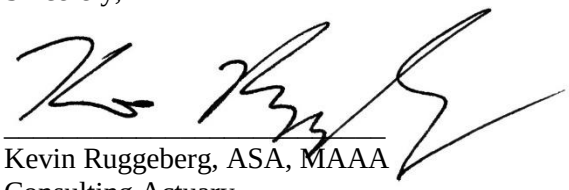
   While L&E believes the proposed CTR is reasonable, reviewing the Company's current level of capital and surplus is beyond the scope of this review. Therefore, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

Recommendation

L&E believes that this filing, modified to address the errors referenced above, does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing with the modifications described below. We estimate that this change will reduce the overall manual rate impact for the existing AHP groups from 12.0% to approximately 11.7%.

- Change the non-specialty drug unit cost trend from 3.5% to 0.0% per year.

Sincerely,



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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[7], 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[8], 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, Consulting 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 April 22, 2019. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 22, 2019.

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.

[7] 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.

[8] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

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.