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July 13, 2015

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

Re: MVP Health Plan 2016 Exchange Filing (SERFF # MVPH-130053210)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2016 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 on January 1, 2016.
2. This filing addresses MVP individual members and small groups. There are approximately 6,400 lives affected with about 10,000 new lives from other non-ACA compliant plans that are expected to enroll in an ACA-compliant plan in 2016.

The overall impact of this filing is a proposed average rate increase of 3.0% or \$13.42 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 2015 VHC filing.

The driving factors of the overall rate increase are discussed in detail in the L&E Analysis section. The highest rate increase is for the Catastrophic plan, which is 27.3%. The primary driver contributing to this plan's rate increase is due to differences in the age/gender distribution of qualified members (< 30 years old) in the 2016 filing versus 2015 filing. The second largest proposed rate increase of 4.2% is for a non-CSR (Cost Sharing Reduction) silver plan.

2016 Proposed Rate Changes

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	27.3%	\$56.96	0.6%
Bronze	2.4%	\$9.21	36.6%
Silver	3.3%	\$15.36	41.2%
Gold	2.1%	\$12.13	8.5%
Platinum	2.8%	\$17.85	13.1%
Overall	3.0%	\$13.42	100.0%

2015 Final Rate Changes after the Board's Decision

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	6.7%	\$13.32	2.1%
Bronze	12.6%	\$58.07	44.6%
Silver	10.0%	\$59.52	35.1%
Gold	11.1%	\$84.62	5.2%
Platinum	8.8%	\$82.00	13.0%
Overall	11.0%	\$62.15	100.0%

- As in previous years, MVP is filing its Exchange products on the HMO license, MVP Health Plan, Inc. In the 2015 filing, MVP assigned no credibility to its small group HMO experience on account of its small size and used manual rates based on its 2013 experience in the individual indemnity and small group HMO and PPO products. In the current 2016 Exchange filing, MVP is using the 2014 experience from its non-ACA compliant and ACA-compliant individual and small group employer data, association group data (including the Agriservices group), and large employer groups with 51-100 employees. MVP anticipates that most of the non-ACA compliant individuals and groups, included in the base period, will migrate to the ACA-compliant plans.
- Anticipated changes attributable to the ACA include the expansion of small groups to those employers with 51-100 employees and the increase to the lower attachment point for transitional reinsurance from \$45,000 to \$90,000.

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 2016 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 2015 and 2016, 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 180,000 total member months from non-ACA compliant and ACA compliant individual and small group employer data, association data, and large groups with 51-100 employees) 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, benefit changes, population morbidity changes, etc.

Exhibit 4 shows the development of the single conversion factor of 1.145, using the distribution by tier and the average contract size by tier derived from the experience period. 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 2015 paid claim cost. MVP provided additional exhibits and quantitative support as requested during the rate review process.

L&E Analysis

The average proposed increase of 3.0% to the 2015 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, we categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Rate Change Drivers

Component ¹	Percentage Change ²	PMPM Change ³
1. 2014 Actual/Projected Claims Experience	-6.8%	-\$30.34
2. Difference in trend from 2014 to 2015	-1.8%	-\$7.33
3. Trend from 2015 to 2016	4.7%	\$18.96
4. Changes to Population Risk Adjustment	-0.8%	-\$3.22
5. Changes to Other Factor	-0.2%	-\$0.96
6. Changes to Risk Adjustment	0.0%	\$0.07
7. Changes to the Federal Transitional Reinsurance Recoveries	1.2%	\$5.06
8. Changes in Administrative Costs	-1.0%	-\$4.43
9. Changes in Contribution to Reserves	-1.1%	-\$4.70
10. Changes in Taxes & Fees	-1.3%	-\$5.62
11. Changes in Single Contract Conversion Factor	4.3%	\$17.65
12. Changes in all Other Factors⁴	6.6%	\$28.41

1. *2014 Actual/Projected Claims Experience:* In this 2016 Exchange filing, MVP combined the experience of ACA-compliant and non-ACA compliant individual and small group data, association group (AgriServices), and large groups with 51-100 employees in developing the experience period claims. Adjustments to the starting point included changes applicable to the 2016 filing, such as using a pooling charge for large claims. In the 2015 Exchange filing, MVP excluded the Agriservices group as these members were not projected to be on VHC for 2015. MVP anticipates that most groups included in the base period experience will migrate to an ACA-compliant plan in 2016.

The claims experience from the 2015 Exchange filing to the 2016 Exchange filing represents a decrease of 6.8% in premiums. Before the application of trend, morbidity, and other factors, the starting claims experience and these adjustments appear to be reasonable and appropriate.

2. *Difference in trend from 2014 to 2015:* The trend from 2014 to 2015 in the 2016 URRT is 4.7%. This trend is lower than the projected trend from 2014 to 2015 utilized in the 2015 URRT by 1.8%. We note that the facility trend factors reflect known and assumed price increases from MVP's provider network. The development of this trend appears to be reasonable and appropriate.
3. *Trend from 2015 to 2016:* The Company requested an allowed medical trend of 3.9% and an allowed Rx trend of 10.6%, which is a combined allowed trend of 4.7%.

¹ The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

² The percentage increases are multiplicative and do not sum to the requested 3.0% premium increase.

³ The PMPM changes do not add up to the overall average PMPM of \$13.42 quoted on Page 1 because the PMPM changes seen in this table incorporate the Single Contract Conversion Factor change.

⁴ Includes Pricing AV changes (cost sharing, induced utilization, network/provider adjustments, etc.), average policy duration, and membership shifts.

- *Medical Trend:*

The Company projected an allowed medical trend of 3.9%. The allowed trend reflects changes in the cost of medical services and changes in utilization of medical services by members. Consistent with prior filings, MVP's utilization trend is 0%; therefore, the allowed trend is based solely on allowed charges (reflecting the total amount of claims paid by the carrier and the policyholder).

MVP computed its allowed trend as a weighted average of the medical claim trends in 2015 and 2016 for inpatient, outpatient, and physician claims based on known and assumed price increases for MVP's provider network.

To evaluate the reasonableness of the Company's allowed medical trend development, we combined all of the allowed medical claims for the prior 36 months and modeled 12-month rolling PMPM claims using an exponential regression. Our analysis resulted in an allowed medical trend of 6.3%, which is higher than the Company's requested allowed medical trend. Our estimated allowed trend range based on regression analysis of the historical experience is 5.8% to 6.8%. Each of the numbers within our estimated range are not equally likely; that is, the trends on the low and high end are not as likely to occur as the trends in the middle of the range.⁵

The Company's proposed allowed medical trend of 3.9% is below the estimated range based on MVP's historical experience and results in lower rate increase than what is supported by the historical analysis. However, a historical trend analysis of the experience period claims is constrained by the limitation that it does not normalize the impact of other causative factors, such as plans shifts (for example, from lower to higher deductible plans), impact of benefit modifications, fluctuations due to large claims, demographic changes, etc. Moreover, actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. MVP used known and assumed contractual increases with providers to derive their requested allowed medical trend consistent with their prior rate filings. This methodology appears to be a reasonable and appropriate to assess the prospective trends.

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 leveraging⁶. The cost share leverage contributes to an additional 0.5% trend, resulting in an annual effective paid medical trend of 4.4%. The medical claims were projected forward to the midpoint of the rating period using the effective paid medical trend of 4.4%. The Company's assumed allowed and effective paid medical trends appear to be reasonable and appropriate.

- *Pharmacy Trend:*

The Company projected an annualized allowed Rx trend of 10.6%. MVP uses the best estimates of pharmacy trend factors, split by drug category (Generic, Brand,

⁵ For example, the probability that the actual trend will be centered on the best estimate (between 6.2% and 6.4%) is over 250% higher than being near the low end of the range (between 5.8% and 6.0%).

⁶ 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

Specialty), as supplied by its pharmacy benefit manager (PBM). The chart below shows that the specialty trend category is driving the total Rx trend up.

Annualized Allowed Rx Trends

Tier	Unit Cost	Utilization	Total
Generic	2.7%	2.7%	5.5%
Brand	12.3%	-8.0%	3.3%
Specialty	13.8%	5.5%	20.0%

After accounting for member cost sharing, the total annualized effective paid Rx trend is 12.6%.

Subsequent to MVP's 3Q 2015 non-Exchange filing submissions⁷, MVP's PBM has lowered its proposed trend forecast relative to the 3Q 2015 filings, resulting in lower rates. The revised trend forecast accounts for drugs coming off patent, changes in average wholesale price, new drugs, and price competitiveness amongst generic and brand drug manufacturers.

As in prior non-Exchange filings, MVP has not used historical pharmacy claim experience to form assumptions for future pharmacy trends as they believe prior experience is not indicative of future trends. We recognize 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. However, the annual trend factors for generic/brand drugs and specialty drugs, as provided by MVP's pharmacy vendor, did not account for MVP's Vermont specific book of business. We consider this to be a limitation on the reasonableness of their trend assumption.

For comparison purposes, we analyzed 36 months of MVP's historical pharmacy trend experience and found it to be volatile. On account of the constantly changing Rx market, we compared the calendar year 2014 Rx allowed claims by category to calendar year 2013 Rx allowed claims by category to reflect the impact of recent high cost specialty drugs. This illustrated a higher allowed trend of 14.2%, compared to the proposed allowed trend of 10.6% reflected in the filing.

While we do not agree with the Company only utilizing the unadjusted trends from their PBM, we believe the historical experience shows higher trends than those recommended by the PBM. This consequently results in lower rates. We considered MVP's historic experience, the PBM's recommendation, and the impact of new high cost specialty drugs, and opine that the requested Rx paid trend of 12.6% is reasonable and appropriate.

⁷ SERFF #: MVPH-129866393, MVPH-129877690, and MVPH-12877747

The Company requested a paid medical trend of 4.4% and a paid Rx trend of 12.6%. The total paid trend is anticipated to be 5.3%. This total trend appears to be reasonable and appropriate.

4. *Changes to Population Risk Adjustment:* The Company is applying a 2.0% morbidity improvement factor (consistent with the Board's decision and order from MVP's 2014 Exchange filing) of its non-ACA compliant products to its projection of experience period data. In absence of statistically credible data to support modifying this assumption, we find using the same factor to be reasonable and appropriate.
5. *Changes to Other Factor:* The Other Change projection factor reflects adjustments to pre-ACA small group experience to account for medical and Rx benefit modifications to meet EHB requirements (such as addition of pediatric dental, pediatric vision, removal of elective abortion and vision exams/hardware), Blueprint payment changes, and anticipated demographics. It also includes an adjustment for the impact of the leap year in 2016. The overall change from the prior filing results in a 0.2% rate decrease.

MVP accounted for the Blueprint payment changes initially in the filing by using the same assumptions as used in prior filings. However, during the course of this review, a decision was made to change how the Blueprint changes were apportioned; therefore, MVP proposed to reduce the premiums by \$1.35 PMPM, which represents a decrease of 0.4%.

We note that the change in demographics between the experience period and the projected rating period was not accounted for in the Other Change projection factors. We find the lack of demographic adjustment to be inappropriate because it does not comply with the definition of index rate as defined in 45 CFR Part 156.80(d)⁸.

Given MVP's 2015 actual enrollment is the basis for the 2016 projected enrollment, we believe it is appropriate to incorporate this information in the development of the index rate. The average age based on March 2015 actual enrollment is 40.4 versus 39.6 in the experience period. We recommend applying a demographic adjustment factor of 2.0%. Please note as a result of this recommendation, the calculation of the single contract conversion factor will also be modified (see #10 below).

We recommend that MVP make modifications for the Blueprint payment changes and the demographic factor, which results in an overall increase of 1.6% to the Other Factor.

6. *Changes to Risk Adjustment:* Consistent with prior Exchange filings, MVP did not make a change to risk adjustment assumption. MVP assumed that there would not be a payment transfer between the carriers in Vermont for 2016. There was a minor change to the risk adjustment user fee, prescribed by CMS. It increased from \$0.08 PMPM to \$0.15 PMPM.

⁸ 45 CFR Part 156.80(d) requires that a health insurance issuer establish an Index Rate for each (or combined) market annually. The Index Rate for a market is based on the total combined claim costs for providing Essential Health Benefits within the single risk pool for that state market. In the URRT, the index rate should reflect the EHB portion of projected allowed claims divided by all *projected* single risk pool lives.

On June 30th, CMS released the first report for the 2014 benefit year payment transfers. Based on the CMS report, MVP will pay Blue Cross Blue Shield of VT (BCBSVT) about \$2.7 million as a result of MVP having a healthier population than BCBSVT in 2014.

MVP is not making an adjustment to their proposed 2016 rates based on the 2014 results. MVP believes that the 2014 population is not statistically credible nor is it representative of their projected 2016 population. Two-thirds of the projected population was not included in the 2014 risk transfer calculation.

If MVP's actual 2016 population turns out to be healthier relative to BCBSVT's actual 2016 population, as it was in 2014, then MVP's contribution to reserves will be lower than anticipated, since MVP has not accounted for this assumption in the 2016 pricing.

7. *Changes to the Federal Transitional Reinsurance Recoveries:* The federal transitional reinsurance parameters for 2016 are anticipated to pay out 50% of all claims between \$90,000 and \$250,000. MVP developed the anticipated payments from the reinsurance pool by analyzing claims in the reinsurance corridor from the calendar years 2012, 2013, and 2014. MVP determined that 50% of the average annual value of claims in the reinsurance corridor to be 4.2% of claims and assumed this average as the 2016 average reinsurance recovery.

The average reinsurance, as percentage of claims, is lower for 2016 due to changes in reinsurance parameters and the assumed percentage of individual enrollment, as illustrated in the table below. Since the Company will only receive reinsurance payments for individual members, the assumed percent of individual members can also affect the reinsurance recovery assumption. As of April 2015, 57.7% of enrollees in ACA-compliant plans were individuals, which is lower than the 61.3% assumed in the 2015 rate development. Based on these two changes, the Company expects the net reinsurance recoveries to decrease in 2016. As a result, the 2016 premiums will increase by 1.2%. The following table illustrates the differences in reinsurance recovery development in 2015 and 2016.

Reinsurance Pool Impact

	2015 Rate Filing	2016 Rate Filing
Lower Attachment Point	\$45,000	\$90,000
Higher Attachment Point	\$250,000	\$250,000
% of claims reinsured between attachment points	50%	50%
Average reinsurance as % of Claims	-7.6%	-4.2%
Projected % of individual membership	61.3%	57.7%
Impact of Reinsurance Recoveries	-4.7%	-2.4%

The development of transitional reinsurance impact appears to be reasonable and appropriate.

8. *Changes in Administrative Costs:* MVP has updated the administrative expense assumption from a percentage of premium basis used in prior filing to a PMPM basis in this filing. The total administrative expenses is equal to \$36.60 PMPM. This includes quality improvement

(QI) expense of 9% of total administrative expense and a \$1.50 PMPM to provide an expanded network to members purchasing exchange products in VT. Since the QI assumption is based on actual 2014 MVP expenses, we find it to be reasonable and appropriate.

The assumed administrative costs assumed in this filing are lower than MVP's 2014 administrative costs of \$40.30 PMPM based on adjusted 2014 Statutory Supplemental Health Care Exhibits (SCHE). The equivalent administrative costs in 2013 SCHE is \$45.58, showing a reduction in costs from 2013 to 2014. In light of the steps taken by MVP in reducing administrative costs over the recent years, the assumed administrative 2016 cost changes appear to be reasonable and appropriate.

9. *Changes in Contribution to Reserves:* MVP's assumed contribution to surplus of 0% in this filing is lower than the 1.0% approved by the Board in the 2015 Exchange filing. MVP's rationale for not building profit/risk charge is to gain competitive position in the VT market, but without producing inadequate rates.

In light MVP not making a modification as a result of CMS' 2014 risk adjustment payments reported and this 0% contribution to reserve assumption, we strongly recommend that no reductions outside of those proposed within this report be made to MVP's rates.

10. *Changes in Taxes & Fees:* The total change for taxes and fees is -1.3%. This decrease is due to the MVP removing the VT paid claim surcharge and HCRA tax (1.25%) from taxes and fees and including it under medical expenses as it is done in the financial statements. No other changes were made in the other taxes and fees. These assumptions appear to be reasonable and appropriate.
11. *Changes in Single Conversion Factor:* The single conversion factor⁹ used in the 2015 rate filing was 9.8%. For this year's filing, MVP utilized 2014 enrollment to calculate the 2016 single conversion factor of 14.5%.

We do not believe that the change in enrollment should be included in the conversion factor calculation. As indicated in #5 above, we believe that the projected demographic change should be included in the index rate calculation. Based on the 2015 actual enrollment, the single conversion factor is 12.6%. The actual 2015 enrollment shows there are less parent/child(ren) and family tier enrollment, when compared to the experience period. The average contract size has reduced from 1.72 in the experience period to 1.64 in the projected period, resulting in a decrease to the single conversion factor. We recommend that the single conversion factor be changed to 12.6%. The net impact of the single conversion factor and the anticipated demographic factor (from #5) is an increase of 0.3%.

⁹ 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.

12. *Changes in All Other factors:* This reflects other Pricing AV changes such as changes in Metal AVs of plans, induced utilization, average policy duration¹⁰ and changes in projected enrollment among plans. The assumed 2016 distribution is more heavily weighted towards richer plans. The weighted Metal AV for the 2016 rate filing is 0.70 versus 0.68 in the 2015 rate filing, constituting a 2.9% rate increase attributable to plan richness. Additionally, this metal AV shift impacts the induced demand, which increases with plan richness and cost sharing subsidies. Since the 2016 plan distribution is based on actual 2015 Exchange enrollment, we find this to be reasonable and appropriate.

The rate development also includes an average policy duration adjustment to account for membership not representing a full 12-month contract over the experience period. With a large proportion of members not enrolling in the Exchange plans until April 2014, compounded by the high share of membership enrolled in high deductible bronze metal plans, MVP made an upward adjustment to the experience period claim costs of ACA-compliant plans to account for membership distribution by contract month. Similar adjustments were independently made for 51-100 large groups, Agriservices, non-ACA compliant individual and small group products depending on the corresponding contract month distribution. The aggregate impact of these adjustments constitute a 2.1% rate increase.

As noted by MVP in its response to our inquiry, the average policy duration factor for the 51-100 large groups needs to be revised to reflect the correct factor for the 51-100 large group factor. This will reduce the single risk pool paid index rate by \$0.36 PMPM, which results in a decrease of 0.1%. With this correction in place, we find the application of average policy duration factors to be reasonable and appropriate.

Recommendation

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

- Increase the projected index rate to account for changes in demographics: +2.0%;
- Adjust for the Blueprint payment changes, reducing rates by \$1.35 PMPM: -0.4%;
- Reduce the single contract conversion factor from 1.145 to 1.126: -1.7%
- Correct the 51-100 large group average policy duration factor to reflect the correct adjustment for large group, reducing rates by \$0.38 PMPM: -0.1%

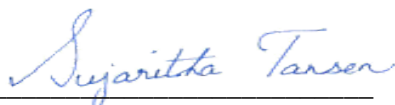
After the modifications, the anticipated overall rate increase will reduce from 3.0% to approximately 2.7%.

¹⁰ The average policy duration factor is an adjustment to account for suppression of paid claims in early months of a member's contract relative to later contract months due to the presence of deductibles.

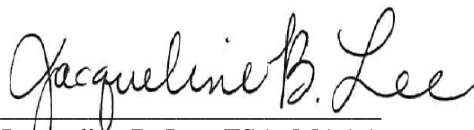
Plan	Proposed Rate Change	Modified Rate Change	Percent of Membership
Catastrophic	27.3%	26.7%	0.6%
Bronze	2.4%	2.0%	36.6%
Silver	3.3%	3.0%	41.2%
Gold	2.1%	1.8%	8.5%
Platinum	2.8%	2.5%	13.1%
Overall	3.0%	2.7%	100.0%

Plan	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	\$56.96	\$55.77	-\$1.19	0.6%
Bronze	\$9.21	\$7.77	-\$1.44	36.6%
Silver	\$15.36	\$13.75	-\$1.61	41.2%
Gold	\$12.13	\$10.32	-\$1.81	8.5%
Platinum	\$17.85	\$15.88	-\$1.97	13.1%
Overall	\$13.42	\$11.81	-\$1.61	100.0%

Sincerely,



Sujaritha Tansen, ASA, MAAA
Consulting Actuary
Lewis & Ellis, Inc.



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



David M. Dillon, FSA, MAAA
Vice President & Principal
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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations¹¹, 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 Conduct¹², 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:

- Sujaritha Tansen, ASA, MAAA, Associate Actuary at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President 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 13, 2015. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is July 7, 2015.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

¹¹ The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

¹² These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- The findings of this report are enclosed herein.

Actuarial Findings

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

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law

This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods

The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.