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October 4, 2023

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

Re: MVP Health Plan, Inc.
2024 Large Group HMO Rate Filing
SERFF #: MVPH-133767802

The purpose of this letter is to provide a summary and recommendation regarding the large group filing submitted by MVP Health Plan (MVP or MVPHP) for its existing HMO products for coverage year 2024 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. MVP is a non-profit health benefit plan provider. MVP provides large group coverage to employers in Vermont as well as individual and small group coverage sold on Vermont Health Connect (VHC).

2. This filing demonstrates the premium rate development of MVP's large group HMO product portfolio and includes proposed rates for all four quarters of 2024. This product portfolio is comprised of base major medical high deductible health plans (HDHP) and non-high deductible plans (Non-HDHP), and benefit riders. The example below demonstrates a 1st quarter 2024 manual rate calculation for a group with a base major medical health plan, a medical benefit rider, a pharmacy benefit rider, and a point-of-service (POS) rider (i.e., adds out-of-network coverage):

a) Base Major Medical Health Plan VT4HMO087ZLAN	$705.21	
b) Medical Rider MV3HMB305L	$8.20	
c) Rx Rider RXVT3HMB500ZL	$94.32	
d) Combined In-Network Manual Base Rate[1]	$807.73	= a) + b) + c)
e) POS Rider SV3HMB101L	3.57%	
f) Combined Manual Base Rate w/ POS Rider	$836.57	= d) * [1 + e)]

3. As of April 2023, there were approximately 1,667 members enrolled in MVP large group plans in Vermont. Approximately 75% have renewal dates during 1st quarter.

[1] Base Rate refers to the premium rate prior to the application of rating factors (ex. age/gender) and retention.

Below is the rate change for the first quarter 2024 as initially filed:

Reason for Change	1Q '24 Manual Rate Change
Base Rate Change	-0.2%
Age/Gender Factor Changes	0.0%
Change in Retention	1.3%
Total Manual Rate Change	***1.1%***

For accounts that renew in the first quarter of 2024, the requested annual average rate increase is 7.5%. This is comprised of the previously approved quarterly rate changes for 2Q23 through 4Q23 combined with the proposed 1Q24 manual rate change and membership distribution shift. These quarterly rate changes are outlined as follows:

Quarter	1Q '24 Annual Total Rate Change
2Q '23 / 1Q '23	1.9%
3Q '23 / 2Q '23	1.9%
4Q '23 / 3Q '23	1.9%
1Q '24 / 4Q '23	1.1%
Membership Distribution Shift[2]	0.5%
Total Annual Rate Change	***7.5%***

The quarterly manual rate changes through the remainder of calendar year 2024 are all equal to 2.4%, representing the assumed quarterly trend.

Quarter	Quarterly Rate Change
2Q '24 / 1Q '24	2.4%
3Q '24 / 2Q '24	2.4%
4Q '24 / 3Q '24	2.4%

The following table outlines the proposed total manual rate changes for each quarter in 2024.

Quarter	Membership as of Apr '23	Filed Annual Total Rate Change
1Q23	1,245	7.5%
2Q23	0	8.0%
3Q23	285	8.6%
4Q23	137	9.1%

The proposed rate changes discussed above reflect the revenue increase for a manually rated group. This is used for groups without any past coverage experience or for groups that are too small for the experience to be used entirely. In practice, the large groups represented in this filing have premium rates based on an average blend of their own claims experience at approximately 22% and the manual rate at approximately 78%. Therefore, some groups will experience higher increases, and some will experience lower increases. If a group experiences a higher rate increase, it is because their claims

[2] The difference in the membership between the experience period and April 2023, which was the current membership at the time of rate development.

experience deteriorated relative to the other large groups in this block. All groups will experience the effect of changes in retention, as these components of the rate are added to the projected claims, whether those claims came from the manual rate or the group's experience.

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 in premium rate development (Exhibit 2a-2b and Exhibit 3a-3b) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim data and the membership, pricing trend assumptions, experience rating formula (Appendices A-C), and additional supporting exhibits, as requested during review of the filing.

L&E Analysis

1. *Rate Development:* MVP utilized large group claim data (constituting HDHP and non-HDHP products) for the period from May 2022 through April 2023 and paid through May 2023 as the base period experience. Incurred but not reported (IBNR) estimates were updated through June 2023. The base period data is considered 100% credible.

   Exhibit 3a illustrates both the claim projection from the experience period to the rating period and the accompanying adjustments applied in deriving the rates for 1Q24.

   MVP uses a pooling charge to mitigate the impact of catastrophic claims (i.e., those exceeding $250,000 per member per year). The purpose of this adjustment is to prevent major swings in premium resulting from a small number of cases. Regardless of the actual value of catastrophic claims, the claims are removed and replaced by a flat percentage. Pooling claims is a typical industry practice.

   From the historical medical experience, claims in excess of $250,000 were replaced with a pooling charge. The pooling charge reflects the average cost of claims in excess of $250,000 and is based on historical experience for MVP's New York large group population, which is much larger and more stable than Vermont's population. The pooling charge filed is equal to 4.95% of claims below the pooling limit. By comparison, recent claims in excess of $250,000 based on Vermont historical experience range from 3% to 10%, with an average of approximately 7%. This practice is consistent with prior filing and is considered reasonable and appropriate.

   The adjusted claims were projected forward to the midpoint of the 1Q24 rating period using an annual paid medical trend assumption of 11.2% (elaborated further in item 3 below). MVP's paid medical trend is derived from its proposed allowed cost trend and the impact of cost share leveraging[3]. The prescription (Rx) claims were projected forward to the midpoint of the 1Q24 rating period using an annual paid Rx trend of 8.3% (elaborated further in item 4 below).

[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.

The trended medical and Rx claim cost was further adjusted to develop the projected claim costs as of 1Q24. These adjustments included projected cost of capitation, non-FFS claim expenses, Rx rebates, newly added benefits, adjustments for COVID-19 (elaborated further in item 5 below), and a leap year adjustment. Reflecting these adjustments, the quarterly base rate change suggested by the data was -0.2% for 1Q24 compared to 4Q23.

MVP developed the remaining quarterly manual rates by applying additional trend to the experience period claims. This results in quarterly manual rate increases of 2.4% in each quarter of 2024. The 2.4% quarterly rate increases are based on a 2025 trend assumption that is consistent with the 2024 trend assumption. That is, groups renewing in April will be charged premiums based on manual rates 2.4% higher than groups renewing in January. As noted above, approximately 75% of groups have 1st quarter renewal dates.

2. *Age/Gender and Industry Factor Changes:* There were no changes to the age/gender factors proposed in this filing. The industry factor for SIC Code 8021 (Offices and Clinics of Dentists) decreased from 1.15 in the prior filing to 1.0 in this filing. MVP explains that the prior 1.15 factor appeared high in the market when quoting NY groups, and due to the lack of experience in VT for this industry, assumed dentists behave the same in both states. The change to this industry factor does not have a material impact on the overall average rate increase. All other industry factors are unchanged from the prior filing.

3. *Medical Trend:* MVP is requesting a utilization trend of 1.0% and a unit cost trend of 10.1% for 2023. This represents a total allowed trend of 11.2%[4] for 2023. Below are the allowed and paid medical trends:

Medical Trend	Unit Cost	Utilization	Total Allowed Trend	Paid Trend
2023/2022	10.1%	1.0%	11.2%	12.5%
2024/2023	7.9%	1.0%	9.0%	10.3%
Total[5]	8.8%	1.0%	9.9%	11.2%

The allowed cost trends are based on the allowed charges (reflecting total amount of claims cost paid by the carrier and the policyholder) while paid trends reflect the actual claim payments made by the carrier. Using the paid trends for each year as shown in the table above, MVP derived a total average annual paid medical trend factor of 11.2%, which was applied for 20 months to trend the experience forward to 1Q24.

Utilization Trend

MVP analyzed historical medical utilization trends for its total Vermont block of business and the data was too volatile in recent years to use for medical utilization trend purposes. MVP used an exponential smoothing forecasting method for analyzing historical utilization patterns and projecting them to the rating period. MVP notes that the rapid membership growth in this block of business in the recent past may influence the results of historical trend methodologies. This approach produces a wide range of forecasted total utilization trends with a 10th percentile of -1.2%, a mean trend of 1.2%, and a 90th percentile of 3.5%. Since the

[4] [(1.101)*(1.01)]-1=11.2%

[5] A weighted average is calculated by applying 8 months of 2023 trend and 12 months of 2024 trend based on the experience period end date of April 30, 2023.

simulation produced a wide range, MVP assumed a 1.0% utilization trend, consistent with utilization trend used in the prior three QHP filings. L&E notes the following:

- MVP has historically performed analysis producing a much wider range in utilization (e.g., last year's filing indicated a historical utilization range of -29% to 25%). The range for the 2024 filing analysis is only about 5 percentage points between the 10th and 90th percentiles.
- While MVP explained why recent historical data may not be ideal (e.g., membership growth) and that the range forecasted is too large to have confidence in the result, the mean trend of 1.2% does appear to support the chosen 1.0% utilization trend.

Based on all information available at this time, the utilization trend of 1.0% is reasonable and appropriate.

Unit Cost Trend

The assumed unit cost trends reflect a combination of known and assumed price increases from MVP's provider network. Since the filing was submitted, the Green Mountain Care Board has made final decisions regarding 2024 hospital budgets. The budgeted unit cost increases are lower than anticipated at the time of the filing. Therefore, we recommend that MVP modify the filing to reflect the ordered hospital budget amounts[6]. This reduces the average annual allowed unit cost trend from 8.8% to 6.5%, which reduces the total average annual paid medical trend from 11.2% to 8.6%. The impact of this change to the rate increases in each quarter is as follows:

Manual Rate Change	1Q '24 / 4Q '23	2Q '24 / 1Q '24	3Q '24 / 2Q '24	4Q '24 / 3Q '24
Initially Requested Rate Increases	7.5%	2.4%	2.4%	2.4%
Rate Increases Reflecting Hospital Budget Orders	3.8%	1.6%	1.6%	1.6%

4. *Rx Trend:* MVP analyzes its pharmacy data by drug category (Generic, Brand, Specialty). MVP is requesting the annual allowed trends illustrated in the chart below, split by calendar year and by drug tier:

	2023 Trend		2024 Trend	
Tier	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Generic	4.5%	2.2%	-12.7%	3.0%
Brand	3.1%	8.7%	3.4%	0.2%
Specialty	2.1%	8.8%	4.4%	8.1%

The total allowed trends in each year are as follows:

Year	Assumed Trend
2023	10.5%
2024	6.2%
Total[5]	7.9%

[6] https://gmcboard.vermont.gov/FY2024hospitalbudgets

The average annual allowed trend of 7.9% is composed of a utilization trend of 2.8% and a unit cost trend of 4.9%.

The annualized effective paid trend is 8.3%, which is shown in Exhibit 2b of the filing. The Rx paid trend, which adjusts the allowed trends to account for cost sharing by the insured (by modeling deductible, copay and coinsurance), is used to trend the experience period claim costs to the projection period.
The following table shows the actual pharmacy allowed trends for the last 5 years:

Year	Actual Trend
2018/2017	0.6%
2019/2018	7.1%
2020/2019	53.9%
2021/2020	3.4%
2022/2021	7.0%

Annual allowed trend factors by drug category were supplied by MVP's pharmacy benefit manager (PBM), reflecting MVP's business in the state of Vermont. The table below shows the comparison of the historical PBM expected trends to the actual allowed trends.

Year	Actual Trend	Expected Trend	Actual-to-Expected Ratio
2018/2017	0.6%	11.6%	0.05
2019/2018	7.1%	8.2%	0.87
2020/2019	53.9%	5.6%	9.63
2021/2020	3.4%	11.9%	0.29
2022/2021	7.0%	5.9%	1.19
5-year Average	14.4%	8.6%	1.67
5-year Average Excluding Outliers	5.8%	8.7%	0.67

L&E notes that there were outlier trends observed in 2018 and 2020. In 2018, specialty drug trends were unusually negative, and in 2020, specialty drug trends were unusually high. L&E does not believe it would be reasonable to include these when analyzing historical trends for the purpose of informing future trend assumptions. L&E recognizes that historical trends do not represent prospective trends. However, the actual-to-expected analysis shows that, outside of one outlier year and prior to 2022, the Company's PBM has a history of over-projecting prospective Rx trends.

L&E observes the following:

- The historical 5-year average actual allowed Rx trend, excluding outlier years, is 5.8%.
- The filed prospective total allowed trend based on information from the PBM is 7.9%. The initially filed total allowed Rx trend assumption reduced by 33%, based on the Actual to Expected ratio from the chart above, results in an allowed Rx trend of 5.3%.
- The emerging Rx trend from January through June 2023/2022 is lower than average at 1.6%.
- In two out of the three historical non-outlier years the observed Rx trend was approximately 7.0%.

MVP has stated that their Vermont large group experience is volatile and not credible. While L&E understands the concern around volatility, the methodology used of relying on the PBM for the Rx trend assumption has not been accurate historically. L&E also notes that the Vermont large group block of business has more than 20,000 members, and approximately over 250,000 member months each year, in recent history. Objectively, a block of business that size would meet most standard credibility thresholds for being fully credible.

Based on the above observations, L&E recommends an allowed pharmacy trend of 5.8%, or a paid pharmacy trend of 6.2% to be in line with the 5-year historical average, excluding outliers, and more consistent with the Actual to Expected analysis. L&E's pharmacy trend recommendation decreases the 2024 first quarter rates by approximately 0.3%.

5. *Other Rate Adjustments:*

The manual rates are adjusted for the following items for the 2024 rating period:

COVID-19 Cost Sharing

Costs are reduced for COVID-19 cost sharing changes. Where cost-sharing was being waived for COVID-19 services in the experience period, cost sharing is not expected to be waived for the rating period due to the unwinding of the public health emergency. This results in a $1.37 PMPM reduction that includes treatment, visits, and testing. This is considered reasonable and appropriate.

COVID-19 Testing Utilization

As a result of the increased cost sharing for COVID-19 testing, MVP assumed testing utilization would decrease and applied a 10% reduction in COVID-19 testing costs in the projection period compared to the experience period. This is a $0.26 PMPM decrease for COVID-19 testing.

MVP provided COVID-19 testing claims counts for January 2021 through June of 2023, using paid claims data through June 2023. L&E notes that there was a particular spike in COVID-19 claims counts August 2023 through January 2022, and January 2022 is included in the experience period. Using more recent data such as April 2022 through March 2023, acknowledging that April 2023 through June 2023 is not fully developed, the decline in COVID-19 testing compared to the 2022 experience period is approximately 40%. Therefore, L&E recommends that the assumed reduction in COVID-19 testing be increased to a 40% reduction. This would result in a 0.1% decrease to the filed premium rates.

COVID-19 Vaccinations

In addition to the ending of the PHE, the Biden Administration announced that it no longer had funding[7], absent further Congressional action, to make additional vaccine purchases and it began preparing for the full transition of COVID-19 vaccine costs to the commercial market. Therefore, MVP assumed that commercial payers will be responsible for paying the full ingredient cost of COVID-19 vaccines by 2024.

MVP currently pays $40 per vaccine for the administration of the vaccine only. MVP expects to pay $130

[7] https://www.whitehouse.gov/omb/briefing-room/2022/09/02/meeting-critical-needs-for-the-american-people-in-the-new-fiscal-year/

per vaccine in 2024 for both the ingredient cost and administration of the vaccine, based information gathered and published by KFF[8]. MVP reduced the additional cost by 40% to reflect COVID-19 vaccines that are covered by the Vermont Vaccine Purchasing Program (VVPP) in 2024, based on review of members receiving influenza vaccines covered through the VVPP. The 40% reduction is only applied to the change in vaccine cost from 2022 to 2024, as MVP is still responsible for paying the administration fee for the vaccine under the VVPP. MVP estimates the impact of the increase in COVID-19 vaccine cost to be $0.74 PMPM. This is considered reasonable and appropriate.

Additional Benefits

Vision coverage was added to all plans in 2023 and vision claims reflected in the base period are limited. MVP estimates the impact of vision coverage to be $1.45 PMPM based on review of three years of historical claims for members with vision riders.

Hearing aid coverage is being added as an Essential Health Benefit (EHB) in 2024. MVP estimates the impact of hearing aids as an EHB to be $0.34 PMPM based on review of its New York experience.

Vermont has mandated coverage of abortions without cost sharing before the deductible on HDHPs. MVP estimates the impact of this coverage to be $0.03 PMPM based on review of historical Vermont experience.

Telemedicine is covered in full for 2024, before the deductible and including for HDHPs. The expansion of telemedicine for all HDHPs is accounted for in the pricing Actuarial Value (AV) for the plans. MVP estimates the impact of cost sharing for Telemedicine to be $0.02 PMPM.

Leap Year

MVP adjusts the experience period claims upward by $1.51 PMPM[9] to account for the additional day in the projection period, as 2024 is a leap year.

6. *Retention:* As in the prior approved filing, retention charges are added to the blended pure premium in deriving the group required premium. The 13.4% total retention load is composed of the following:

Retention Item	Approved 2023 Retention	Proposed 2024 Retention
Administrative Expenses	7.8%	7.6%
Other Expenses	3.5%	3.8%
Contribution to Reserves (CTR)	1.0%	2.0%
Total Retention	**12.3%**	**13.4%**

[8] https://www.kff.org/coronavirus-Covid-19/issue-brief/how-much-could-Covid-19-vaccines-cost-the-u-s-after-commercialization/

[9] Equivalent to 0.3% of premium, or 366 divided by 365, minus one.

Administrative Expenses

The projected administrative expense of 7.6% of premium is consistent with the average expense for the last three years. The following table summarizes data taken from the Supplemental Health Care Exhibits in recent years:

Administrative Expense Summary for Large Group Products				
	Member Months	**Premium PMPM**	**Admin PMPM**	**Expense Ratio**
2018	26,765	$484.55	$48.67	10.00%
2019	22,511	$499.97	$46.35	9.30%
2020	23,424	$540.97	$38.45	7.10%
2021	25,201	$568.90	$47.93	8.40%
2022	22,029	$584.72	$43.89	7.50%

The administrative load appears to be reasonable and appropriate.

Other Expenses

The breakdown of the other expenses is as follows:

Other Expenses	Approved 2023 Retention	Proposed 2024 Retention
Broker Load	2.6%	2.4%
VT Vaccine Pilot	0.4%	0.6%
Bad Debt	0.3%	0.3%
Comparative Effectiveness Research Fee	0.0%	0.0%
18 VSA 9374(h) Billback	0.2%	0.5%
Total Other Expenses[10]	**3.5%**	**3.8%**

Contribution to Reserves (CTR)

The proposed contribution to reserves (CTR) is 2.0%, which is consistent with historically proposed CTR. In past orders, the Board has reduced the proposed CTR.

The target loss ratio is decreasing from the approved 87.7% 1Q 2023 to 86.6% for 2024. This change is largely the result of increasing the contribution to reserve from 1.0% to 2.0%. The federal loss ratio for MVP in 2022 was 86.9%, and the rolling three-year average (2020-2022) is 93.9%.

MVP provided the actual gain/(loss) compared to the ordered risk margin for the most recent three years, as follows.

[10] The sum of the individual components may not equal the total shown due to rounding.

Year	Actual Gain/(Loss)	Expected Risk Margin (As Ordered)
2020	-8.6%	1.0%
2021	-6.2%	1.0%
2022	5.3%	1.5%
Total	-3.2%	

MVP also provided the Company's historical risk-based capital (RBC) ratio for the last three years, outlined in the table below.

Year	RBC Ratio
2020	429.4%
2021	354.0%
2022	369.0%

It is slightly concerning that MVP has experienced an overall negative profit in the last few years, and there was a significant decrease in the RBC in 2021. L&E notes that it is not sustainable to have significant losses, and therefore, a higher CTR could be justified. However, Vermont business accounts for approximately 9% of MVP's overall business[11] and the actual 2022 margin was 5.3%, which was higher than expected. Given this information, L&E believes that a CTR between 0.5% to 3.0% would be considered reasonable.

[11] Based on direct written premium amounts as reported in the 2022 SHCE.

Recommendation
L&E recommends that the unit cost trends be modified to reflect:

- *Green Mountain Care Board (GMCB) Hospital Budget:* L&E recommends revising the trends to reflect the final orders regarding FY2024 hospital budgets. This will decrease the 2024 first quarter rates by -3.4%.

- *Rx Trend:* Based on historical trend and actual-to-expected analyses, L&E recommends an allowed pharmacy trend of 5.8%. This will decrease the 2023 first quarter rates by approximately 0.3%.

- *COVID-19 Testing Utilization:* L&E recommends that the assumed reduction in COVID-19 testing be increased to a 40% reduction, consistent with the decline in COVID-19 testing claims for April 2022 through March 2023 as compared to calendar year 2022. This would result in a 0.1% decrease to the filed premium rates.

The recommended rate increase is as follows:

Reason for Change	1Q '24 Annual Increase
Base Rate Change	-4.1%
Age/Gender Factor Changes	0.0%
Change in Retention	1.3%
Total Manual Rate Change	***-2.9%***

Quarter	1Q '24 Annual Manual Rate Change
2Q '23 / 1Q '23	1.9%
3Q '23 / 2Q '23	1.9%
4Q '23 / 3Q '23	1.9%
1Q '24 / 4Q '23	-3.1%
Membership Distribution Shift[12]	0.5%
Total Annual Rate Change	***3.3%***

Quarter	Manual Rate Change
2Q '24 / 1Q '24	1.5%
3Q '24 / 2Q '24	1.5%
4Q '24 / 3Q '24	1.5%

Quarter	Membership as of Apr '23	Recommended Annual Total Manual Rate Change
1Q23	1,245	3.3%
2Q23	0	4.8%
3Q23	285	6.4%
4Q23	137	8.0%

[12] The difference in the in membership between the experience period and April 2023, which was the current membership at the time of rate development.

L&E believes that, if modified as described above, this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.

Sincerely,

Traci L. Hughes, FSA, MAAA
Vice President & Senior Consulting Actuary
Lewis & Ellis, Inc.

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

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[13], 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[14], 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:

- Traci Hughes, FSA, MAAA, Vice President & Senior Consulting Actuary at Lewis & Ellis, Inc.
- Jacqueline B. Lee, FSA, MAAA, Vice President & Principal at Lewis & Ellis, Inc.

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 October 4, 2023. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 29, 2023.

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.
- 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.

[13] 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.

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

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

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statutes, 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.