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June 22, 2020

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

Re: Blue Cross and Blue Shield of Vermont Q3 2020 Large Group Filing (SERFF # BCVT-132350241) and The Vermont Health Plan Q3 2020 Large Group Filing (SERFF # BCVT-132350492).

The purpose of this letter is to provide a summary and recommendation regarding the proposed Large Group Filings for Blue Cross and Blue Shield of Vermont (BCBSVT) and The Vermont Health Plan (TVHP) (collectively, "the filing") 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. TVHP is a licensed health maintenance organization (HMO) and for-profit subsidiary of Blue Cross Blue Shield of Vermont. TVHP provides large group coverage to employers in Vermont.

2. This filing establishes the formula, manual rate and accompanying factors that will be used for Large Group renewals. This filing includes support for key assumptions, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors. The overall impact of this filing was estimated based on the previously approved factors from the prior filings.

3. This filing addresses BCBSVT and TVHP Insured and Cost Plus large groups. Throughout the filing and this report, BCBSVT and the related company, TVHP, are referred to collectively as BCBSVT, except when specified. There are approximately 4,500 subscribers and 7,900 lives affected across 41 groups for the BCBSVT Q3 2020 Large Group filing and the corresponding TVHP filing.

4. The most important component of any group's premium is their past claims experience. Group-level premiums for coverage years beginning 1Q 2021, for example, will be based on the most current experience available at the time. For this reason, no group's actual premium increase pursuant to this filing is currently known.

5. The filing indicates that the impact of "Formula and Factor Changes" on premiums is 1.9%[1] (approximately $11.14 PMPM)[2]. This is true, but this value should not be interpreted as representing the expected premium change for covered members/groups. Treating these amounts as equivalent assumes that all groups' experience 2019 claims equal to 2018 claims, an assumption which is not expected to hold. The 1.9% can be itemized in the following manner:

[1] The components are multiplicative and therefore may not add up to exactly 1.9%.

[2] The Company estimated the overall impact by comparing rates calculated as of 2020 using the currently approved rate manual and rates calculated as of 2021 using the proposed rate manual.

a. Change to Projected Claims: **3.0%**
b. Change in Administrative Charges: **1.0%**
c. Change in Contribution to Reserve: **0.1%**
d. Changes in Federal Programs: **-2.1%**

6. The average group will likely experience a premium change of approximately 5.9%, itemized below.

    a. Change to Projected Claims: **7.0%**
    b. Change in Administrative Charges: **0.9%**[3]
    c. Change in Contribution to Reserve: **0.1%**
    d. Changes in Federal Programs: **-2.1%**

    The difference between the "formula and factor change" of +1.9% and the expected premium change of 5.9% is approximately +3.9%. This reflects the amount that future renewal premiums are expected to increase as a result of group-specific increases in claims experience. Note that L&E is approximating this value based on BCBSVT's calculations regarding a hypothetical group which has no group-specific experience. Such a group would be rated according to BCBSVT's estimate of cost for similar groups. The increase in the manual rate for such a group therefore serves as a proxy for L&E's anticipation of average premiums across BCBSVT's large group business.[4]

7. The actual premium increase experienced by a particular group will vary from the average of 5.9%. Each group's rate increase will consider their recent claims experience, changes in the distribution of members enrolled, and changes in benefit. A newly formed large group would experience 1Q2021 premiums that were approximately 5.9% higher than a similar newly formed large group in 1Q2020.

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the proposed methodology used to calculate the Insured and Cost Plus large group premiums for groups renewing after approval of this filing. The Company provided exhibits and support for each component of the premium development, including trend, administrative costs, contribution to reserves, aggregate stop loss and risk charge factors, network changes and large claim factors.

For medical trend development, the Company used claims incurred between November 2015 and October 2019. Completion factors[5] were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

[3] This value differs as a percentage of premium from the 1.0% shown above solely because of a different average premium value. There is no difference in administrative cost assumptions.

[4] In providing this hypothetical case study, BCBSVT stated that it "should not be interpreted as the current filing resulting in a 5.9 percent premium increase… for the full block of business." While L&E agrees that there are limitations to this method of approximating the block's aggregate rate increase, we believe it is the most appropriate method available to address this important concern for the Board's review.

[5] 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.

The data includes claims from BCBSVT Cost Plus groups, BCBSVT Administrative Services Only (ASO) groups with less than 5,000 members, BCBSVT Insured Small and Large Groups including small groups enrolled in Qualified Health Plans, BCBSVT insured AHP's, and The Vermont Health Plan (TVHP) Insured Small and Large Groups. BCBSVT and TVHP cover substantially similar populations under similar benefit packages. The Company felt that combining these homogeneous populations created greater consistency and credibility within the trend factor development. Adjustments were made to the data to reflect network differences between the two companies.

Trend for members who have Medicare as their primary coverage was analyzed separately.

Filing Analysis

1. *Medical Trend Development:* Medical trend varies by company and plan type due to contracting differences. For all products combined, the Company is requesting a total allowed[6] medical trend of 7.0% per year. This total allowed medical trend amount is broken down into 2.0% for utilization and intensity and 4.4% for unit cost for most medical services. The 7.0% includes the impact of outpatient drugs which are trended at a higher rate, as described further below.

   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 also removed outlier claimants. This data was then analyzed by using exponential regression. The Company chose a utilization trend of 2.5% per year for facility claims and 1.0% for professional claims. These average to an overall medical utilization trend assumption of 2.0% per year.

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

   - Year-over-year rolling PMPMs;
   - Exponential regressions; and
   - Times series analysis.

   Each of the different methods produced varied results, which indicates uncertainty in the projected utilization trends. The Company noted that emerging 2020 professional experience may be trending higher than these historical trends would suggest.

   BCBSVT has consistently relied on historical utilization changes to project future utilization changes in past filings, using various regression algorithms. Regression on various rolling 12-month datapoints had the following results:

Regression	Annual Utilization Trend
24 Rolling	0.5%
36 Rolling	2.1%
48 Rolling	1.9%

   In consideration of these numbers and the year-over-year trends in recent years, BCBSVT assumed a 2.0% per year utilization trend.

[6] 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.

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 0.6% to 3.1% per year.[7] We believe BCBSVT's trend assumption is reasonable and do not recommend any changes at this time.

Unit Cost

The unit cost trend for medical trend is projected to be 4.4% based on an analysis of the hospital budget increases implemented in recent years as well as other providers in the BCBSVT service area. By segment, this increase varies as shown below:

Market Segment	Annual Unit Cost Trend
BCBSVT Managed Care	4.4%
BCBSVT Non-Managed Care	4.4%
TVHP Managed Care	4.4%
Combined	4.4%

This projection includes a 5.4% increase for Vermont facilities and providers impacted by the GMCB's hospital budget review and a 3.3% for other facilities and providers. This 5.4% assumes that hospitals will have to file higher increases for October 2020 than the increases approved in 2019 due to a gap between changes in hospital expenses and the net patient revenue changes approved by the Board. BCBSVT supported this assumption by comparing the Fiscal Year 2019 Vermont Hospital Budgets Year-End Actuals[8] (FY19 Actuals) to Fiscal Year 2019 Vermont Hospital Budgets (FY19 Budgets) to demonstrate that FY19 Actuals Net Patient Revenue (NPR) was 0.8% lower than FY19 Budget Net Patient Revenue and FY19 Actuals Operating Expenses were 2.9% higher than FY19 Budget Operating Expenses. This does suggest that future budget increases will need to consider this updated, "re-based" information. The difference between these two values, or 2.1%, was assumed as an increase in hospital budget unit cost increases over the prior year. L&E finds the calculations of this assumption to be reasonable. L&E recommends that the Board consider these items and the potential impact of COVID-19 on the coming hospital budget decisions in determining these adjustments are appropriate at this time.

Additionally, as groups will be rated using the most up-to-date data available, the base period for group-level rating is assumed to reflect a time period when the October 2019 budget increases had already taken effect. This means that the assumed annual cost trend primarily reflects the higher assumed 2020 budget increases, not the approved 2019 budget increases. L&E does not have the group-specific data necessary to estimate the impact of unit cost changes on premium directly. However, we can

[7] Values near the middle of the range are expected to occur more often.

[8] https://gmcboard.vermont.gov/sites/gmcb/files/Board-Meetings/FY19%20Actuals%20Report-%20updated%202.26.20%2012pm.pdf

approximate the impact of changes to the 2.1% re-basing assumption. For each change of 1.0% to the rebasing, premiums will likely change by approximately 0.4% in the same direction.

Unit cost increases for providers outside the BCBSVT service area were derived from the Blue Trend Survey.[9]

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, and the Company noted that a change needed to be made. This change did not have a material impact on the rates.

Pharmaceuticals Processed through Medical Benefit

A methodological change from the prior year's filing is that BCBSVT has isolated claims related to pharmaceuticals covered by the medical benefit (as opposed to pharmaceuticals dispensed in a retail setting). These prescriptions are differentiated from others due to their being applicable to medical deductibles and cost sharing rather than the prescription drug benefits. This is often because they are dispensed in an outpatient medical facility. For simplicity, we will refer to these as "outpatient drugs" in this report. These claims are treated as a special carve-out in the determination of medical trend. The trend for this category is not split into utilization and unit cost components.

Historical cost for outpatient drugs was provided by incurral month for the last several years and shown to be increasing at a steady rate. The Company assumed an 11.3% increase in cost per year for outpatient drugs.

The assumed 11.3% increase is consistent with historical trends since late 2015. This higher trend rate is applied instead of the unit cost and utilization trends described above for the roughly 10-15% of medical cost associated with outpatient drugs.

Total Allowed Medical Trend

The utilization and intensity trend of 2.0% combined with the unit cost trend of 4.4% results in most medical claims being trended at a 6.4% annual rate. With the inclusion of outpatient drugs trended at 11.3% per year, the total medical allowed trend in the filing is 7.0%. These relationships are shown in the table below:

Medical Cost Type	Cost Trend	Utilization Trend	Total Allowed Trend
Outpatient Rx	N/A	N/A	11.3%
Other Medical	4.4%	2.0%	6.5%
Total	N/A	N/A	7.0%

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 5.3% to 8.8%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.

[9] The Blue Trend Survey is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

BCBSVT's assumed total allowed medical trend of 7.0% 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.

2. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend, including the impact of contracting changes with the Pharmacy Benefit Manager, of 10.5%. This aggregate assumption is composed of the following components:
    - Non-specialty utilization trend
    - Generic cost trend
    - Brand cost trend
    - Impact of brand drugs going generic
    - Specialty trend
    - Vaccines, OTC, etc.

    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. The following table shows the results of the Company's analysis and the requested 10.5% overall allowed pharmacy trend.

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend
Generic	0.0%	0.0%	0.0%
Brand	8.6%	0.0%	8.6%
Brands Going Generic	-51.0%	0.0%	-51.0%
Specialty	N/A	N/A	19.0%
Total	N/A	N/A	10.5%[10]

    The Company's method of projected pharmacy trends is materially similar to the prior filing. In this filing, a utilization trend is developed for brand and generic drugs combined, with separate unit cost trends.

    The Company calculated unit cost trends of 0.0% for generic and 8.6% for brand drugs. Both of these are consistent with recent trends in the observed changes in cost for these categories, as demonstrated in the Company's filing exhibits.

    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. These drugs are assumed to reduce in price by 51% due to the availability of generic alternatives.

    The Company has isolated drugs which were brand drugs during the base period but which will have generic alternatives in 2021. For these drugs, the unit cost does not increase by the 8.6% assumed for other brand

[10] This figure includes the impact of contracting adjustments in addition to the trends by drug tier.

drugs. Instead, they are being reduced by 51% to reflect the price impact of cheaper competitors and/or members purchasing the generics instead of the brand drug.

L&E believes the method of projecting brands going generic is reasonable and appropriate. The assumed unit cost trends for generic, brand, and brand-going-generic are reasonable.

The utilization trend for non-specialty drugs is projected to be zero. This is based on historical utilization hovering at a very constant level since at least 2015. We agree with the Company's decision to use no utilization trend for non-specialty drugs.

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 difficult to assess given the low frequency and wide variance in unit costs. Unlike in prior filings, the Company has not carved out particular high-cost drugs. The Company explained that the impact of this additional complexity was limited, and they have elected to group all specialty claims into a single category for the purpose of trend development. L&E believes this methodology change is reasonable. The assumed specialty trend is 19.0%, based on regression analysis of historical claims. The Company's selection of a 19.0% trend assumption is reasonable in light of the historical increases in cost observed.

The Company projects overall pharmacy allowed trend to be about 10.5% per year. This reflects not only unit cost and utilization changes but also contracting changes with the PBM (Pharmacy Benefit Manager). This total pharmacy allowed trend is reasonable in aggregate as well as when analyzed by the components described above.

3. *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 determined using the Company's Benefit Relativity models[11] 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	Approx. Percent of Claims
Medical	7.0%	7.8%	78%
Rx	10.8%	11.4%	22%
Total	7.7%	8.6%	100%

   The methodology of using the Benefit Relativity models to estimate the impact on paid claims with and without the allowed trend is consistent with last year's filing. 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

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

allowed trends, the paid trends after leverage adjustments were made, and the impact of projected pharmacy contract changes.

	Allowed Trends	Paid Trends
Medical	7.0%	7.8%
Drug	10.8%	11.4%
Total	7.7%	8.6%

4. *Administrative Costs:* Administrative costs were projected based on past administrative costs. The administrative experience period for this filing is January 2019 through November 2019. Those costs are allocated to groups either on a per-account basis, a per-member basis, or a per-contract basis, as appropriate. Transitional costs related to one-time events, which will not recur in the future, were removed. The previously approved administrative charge was $50.20 PMPM. The proposed admin charge is $53.91 PMPM. The Company has experienced an increase in the administrative costs in 2019, and this increase is attributable to the following factors:
    - *Administrative Trend (2.5%):* The proposed administrative costs were developed by trending forward the actual administrative costs for 2019. 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. This is consistent with the prior filing. The increases due to administrative cost trend and personnel costs did not change materially from last year. Note this 3.0% wage increase is applied only to a portion of the administrative costs, and results in a change to premium of roughly 0.3%.
    - *Updated Experience:* The actual 2019 administrative costs differed from anticipated in the prior filing. Reflecting this updated information resulted in an increase to admin costs of about $2.70 PMPM. This increase in administrative cost flows through to the projected 2021 administrative costs.
    - *Decrease in Total BCBSVT Membership:* BCBSVT is projecting a decrease in overall membership for 2021 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. While it is not practicable for BCBSVT to reduce staffing as rapidly as enrollment has fallen, BCBSVT has developed the administrative charge as if they did. So, rather than increasing the admin charge by 6%, they have instead increased it by 3%.

    The process for reflecting the most recent information available is actuarially sound. Additionally, the Company did not reflect the full change in enrollment when calculating the increase in fixed cost per member. That is, a higher increase to administrative costs would be supportable.

    During L&E's review of the filing, BCBSVT discovered an error in the calculation of the administrative costs. The HCA billback paid by TVHP was inadvertently including in the administrative cost development, despite also being included as a separate line item. The Company requested to remove this amount from the administrative fee. L&E agrees with this change. The impact of this change appears to be a reduction of approximately $0.20 to the proposed premiums, or less than a 0.1% change.

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

5. *Federal Fees:* H.R.1865 - Further Consolidated Appropriations Act repealed the ACA's Section 9010 insurer fee for 2021. For groups renewing in 2020, the proposed rating manual applies a pro-rated fee

of 2.2% of premium for coverage months in 2020. For coverage months during 2021 and later, the fee is 0.0%.

The 2.2% fee applied to coverage during 2020 is reasonable in relation to the historical cost of this fee and is applicable only to a portion of the coverage year for groups renewing prior to year-end.

6. *Contribution to Reserves (CTR):* The proposed CTR is 1.5% for Insured Large Groups and 0.375% for Cost Plus Groups. The proposed CTR is the same as the proposal in the prior year's filing.

   L&E believes the proposed CTR of 1.5% for fully insured groups and 0.375% for Cost Plus groups is reasonable in order to maintain RBC levels in light of medical trend and provide an adequate margin over and above the minimum to keep appropriate RBC levels in the case of an adverse event without being excessive.

   While L&E believes the proposed CTR of 1.5% for fully insured groups and 0.375% for Cost Plus groups 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.

7. *Worse than Expected Experience:* For the combined BCBSVT and TVHP block that is used for rate development, the Company experienced 2019 claims PMPM that were 0.2% higher than what was implied in their 2020 rate filing. For this reason, the change in projected claims is approximately equal to an additional year of trend (8.6%) plus 0.2%.

8. *Other Rate Manual Changes:* The Company made updates to the rating factors for stop loss reinsurance and for valuing different benefit designs. These changes should not impact the premiums for the block as a whole but are intended to more accurately reflect the variation in risk between groups by better mirroring benefit differences.

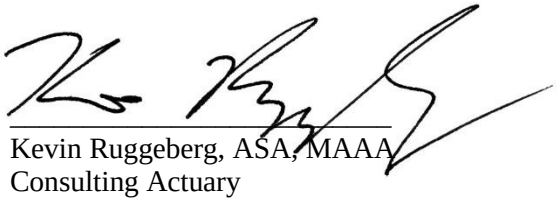
   The Company adjusted the benefit relativity model and stop-loss premium calculations, as is typical practice. These changes appear reasonable.

Recommendation

L&E believes that this filing, modified to address the items referenced below, 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. With these changes, the explicit increase resulting from this filing would be 1.9% and the expected premium increase experienced by policyholders would be 5.9%.

- Correct the administrative charges to remove the TVHP billback amounts included in the base period.
- Use the updated unit cost trend calculation which removes the immaterial formula error referenced above for BCBSVT Non-Managed Care groups.
- Consider the impact of FY2019 Year-End Actuals Hospital Budget reporting as well as potential disruptions from COVID when reviewing the medical unit cost assumptions.

Sincerely,



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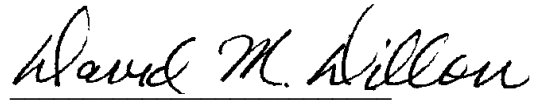

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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[12], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[13], 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 June 22, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is June 22, 2020.

Disclosures in Actuarial Reports

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

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

[12] 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.

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

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

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

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