Kaiser Foundation Health Plan of Hawaii

Hawaii Non-Grandfathered ACA-Compliant Individual Rate Filing
Effective January 1, 2018

HIOS Issuer ID 60612
HIOS Product IDs 60612HI011 (On-Exchange) & 60612HI012 (Off-Exchange)

Actuarial Memorandum

PROPRIETARY SECTION

We have designated this part of the filing, as well as the accompanying exhibits, as proprietary and confidential as found in HRS section 431:14G-105(d) and HAR section 16-171-201(c). We believe that material presented in this confidential section contains trade secrets such as business plans, forecasts, factors and trends that would be detrimental to Kaiser if revealed to competitors.

1. General Information

a. Company Information

Company Legal Name:	Kaiser Foundation Health Plan, Inc. – Hawaii Region ("Kaiser")
HIOS Issuer ID:	60612
NAIC Number:	11538-601

b. Company Contact Information

Mischelle Schweickert, FSA, MAAA
Manager, Actuarial Services
Kaiser Foundation Health Plan of Hawaii
711 Kapiolani Blvd., Honolulu, HI 96813

(510) 268-4422
mischelle.m.schweickert@kp.org

c. Scope & Purpose of Filing

This actuarial memorandum was prepared in accordance with Section 431:14G-105 of the Hawaii Revised Statutes, Title 24, as well as applicable Federal Statutes and Regulations (45 CFR 156.80(d)(1)).

This filing and certification covers non-grandfathered ACA-compliant Kaiser Permanente Individual and Family business that will be offered both on and off the individual exchange in 2018. This filing does not cover grandfathered or transitional ("grandmothered") Kaiser Permanente Individual and Family business. The material presented in this filing was prepared for the specific purpose of certifying rates for these plans and may not be appropriate for other purposes.

This filing represents a rate revision based on the expected cost of providing coverage for the above-referenced business in 2018. Not all rating cells are impacted equally. These are clearly identified in the accompanying filing materials.

This rate filing and the associated rates reflect the Hawaii State and Federal statutes, rules, regulations and guidance as of August 8, 2017 with the additional assumption that Cost Share Reduction subsidies will be eliminated. Changes to the applicable regulations, including but not limited to termination of the Advanced Premium Tax Credits or Risk Stabilization programs could have a significant impact on rate development. Subsequent changes to these statutes, rules and regulations may make these rates deficient and would necessitate revisions to this filing.

d. Market

The filing covers products that will be offered in the individual market.

e. Policy Forms

Please reference SERFF form filing reference # KAHA-131005704 for a list of the policy forms/items that are affected by this filing.

The following HIOS product IDs are affected by this filing:

60612HI011 (Individual On-Exchange); and
60612HI012 (Individual Off-Exchange)

f. Brief description of the Benefits

The benefits provided under the plans subject to this rate filing are described in detail in the accompanying policy forms. With the exception of pediatric dental benefits on the On-Exchange product, which are permitted to be purchased through a separate stand-alone policy, and pediatric dental benefits on the Off-Exchange product, which are offered via a bundled pediatric dental policy, all essential health benefits (EHBs) are covered. No substitutions were made from the State-standard EHBs. The only benefits covered in excess of EHBs - on select plans - are ancillary benefits (adult optical benefits, chiropractic/massage services and/or gym membership benefits), and on all plans the mandated benefits effective from 1/1/2016 – coverage for autism treatment and for orthodontic treatment for orofacial anomalies.

g. Marketing Method

Plans are either sold through HealthCare.gov (the exchange) or directly by Kaiser. Various marketing methods are used including print and online media.

h. Identification of Block as Open or Closed

All plans for which rates are included in the filing will be open to new sales.

i. Terminated Products/Plans

No plans are being terminated in conjunction with this filing.

2. Proposed Rates

a. History of Rate Adjustments

Our rate adjustments for our individual population over past three years have been as follows:

- 9.2% aggregate increase for our ACA-compliant plans for the non-grandfathered population effective 1/1/2015 (SERFF ref. # KAHA-129617508)
- 34.4% aggregate increase for our ACA-compliant plans for the non-grandfathered population effective 1/1/2016 (SERFF ref. # KAHA-129988083)
- 25.9% aggregate increase for our ACA-compliant plans for the non-grandfathered population effective 1/1/2017 (SERFF ref # KAHA-130562051)

The above-referenced filings include information regarding the rate adjustments (or estimated rate adjustments) by product/plan.

b. Effective Date and Implementation of Proposed Rate Adjustment

The effective date of the proposed rates filed for each product/plan is 1/1/2018.

c. Proposed Percentage Rate Adjustment

The average adjustment to the current rates across the entire market to which the filing applies is 24.1%. The minimum and maximum rate adjustments, respectively, among all products offered in the market are 14.7% and 37.4%.

The principal reasons for this level of increase are due primarily to the fact that the actual 2016 experience of Kaiser's non-grandfathered ACA compliant individual portfolio trended much higher than projected in 2017 filings (experience trended 21% compared to the projected 5% set in the filings) and the potential cessation of the Cost Share Reduction subsidy payments. In addition, the risk adjustment payment is expected to increase based on continued low risk relative to the overall market and higher market

average premiums (even including the 14% adjustment for overhead expenses). Due to risk adjustment and other aspects of ACA it is necessary to price to the overall market. This pricing action is necessary to bring the price in line with the market.

See the Unified Rate Review Template Worksheet 2 for proposed rate adjustments as a percentage of current premium levels for each product/plan for which a rate adjustment is being proposed. Rate adjustments vary by plan as a result of recalibration of plan-specific pricing data (pricing model actuarial values).

d. Brief Description of How Rates Were Determined

See Exhibit 1 for a summary of the base rate development.

Rates were developed in accordance with the standard ACA-compliant plan rating methodology; that is allowed claims from the historical base experience period were adjusted for changes in covered benefits, trend and changes in demographics & morbidity in order to determine the projection period index rate. This rate was in turn adjusted to account for the impact of risk transfer charges & payments, and estimated exchange user fees in order to determine the market-adjusted index rate. The applicable adjustments were then applied to this rate in order to determine the reference plan base rate. The market-adjusted index rate was further adjusted to arrive at the plan-adjusted index rates as described in Section 11 below.

By following the rate development methodology outlined above, we ensured that the proposed rates meet the requirements of both applicable federal and Hawaii rating regulations, and that they are reasonable in relation to the level of benefits provided, and not excessive, inadequate, or unfairly discriminatory.

e. Average Annual Premium Per Member

The Hawaii average annual premium per member for the entire risk pool, based on the expected distribution of membership during the projection period, is as follows:

Before the proposed rate adjustment	$5,730
After the proposed rate adjustment	$7,112

f. Number of Policy Holders and Covered Lives in the State

As of December 2016, there were 9,957 policyholders and 13,195 total covered lives currently in force that are affected by the rate adjustments proposed in this filing.

3. Base Period Premium and Claims

a. Dates of Service for the Base Period Used to Develop Rates

The index rate was developed based on claims incurred for the single risk pool in Hawaii with dates of service between 1/1/2016 and 12/31/2016.

b. Date Through Which Claims Were Paid

Claims paid through 2/28/2017, plus any applicable IBNR.

c. Estimate of Allowed Claims During the Base Period Used to Develop Rates

See the accompanying Hawaii Data Submission Template for detailed support regarding the allowed claims incurred during the base period that form the basis for the projected index rate.

d. Treatment of Experience for Grandfathered Policies

The experience for all grandfathered policies was excluded.

e. Method Used for Determining Allowed Claims

Allowed claims for internal services prior to member cost-sharing are sourced directly from Kaiser's claims records while allowed claims for external expenses are calculated based on paid claims plus the estimated member's cost share. Consistent with a Health Plan view of our financial statements as well as the accepted NAIC MLR and Rebate Calculation Form methodology, non-member losses are allocated to our commercial business in proportion to gross expenses by line of business.

f. Incurred But Not Paid Claims

Estimates for claims incurred but not paid were developed separately for Kaiser internal allocated expenses vs. external/referral claims based on our standard group pricing system completion factors by major service category. The same completion factors were applied to both allowed and paid claims.

g. Premium in Base Period (Before MLR Rebates)

See the accompanying Hawaii Data Submission Template for detailed support regarding the premiums earned during the base period.

4. Adjustments to Allowed Claims During the Base Period

a. Private Reinsurance

No private reinsurance was purchased; accordingly no adjustments were made for reinsurance.

b. Pooling

The single risk pool is large enough to be considered fully credible in its own right; accordingly no adjustments were made for pooling.

5. Projection Factors

a. Changes in Covered Services

i. EHBs
An adjustment was first applied to the base period allowed amount to remove non-EHB benefits from the experience period index rate. This multiplier was calculated by summing the allowed amount for non-EHB benefits in the base period and dividing by the total allowed amount. No additional adjustment was made to the experience period index rate to include the estimated value of EHBs not included in the base experience.

ii. State Mandated Benefits Which are Not EHBs
No adjustments were necessary to incorporate new state mandated benefits for the projection period.

iii. Eliminated Benefits
No benefits covered during the base period will be eliminated during the projection period.

iv. Additional Supplemental Benefits
The projected value of non-optional packaged non-EHB benefits is included in the non-EHB rate adjustment for each plan. These benefits typically include ancillary benefits such as adult optical benefits, chiropractic/massage services and/or gym membership benefits. Please see Exhibit 7 for plan-specific non-EHB adjustment factors.

v. Changes in the Level of Covered Services
Please reference corresponding form filings for details regarding changes in the level of covered services for specific plans.

vi. EHB Substitutions
No EHB substitutions have been made.

vii. Changes in Formulary
No significant changes have been made to the formulary.

viii. Induced Demand
Allowed claims are grossed up for anticipated changes in the average utilization of services due to average cost sharing requirements in the base

period. Member cost sharing results in lower utilization and, thus, lower allowed costs, than would otherwise occur in a zero cost share environment. An estimate based on industry standard factors has been made at the plan level to reflect the assumed change in induced demand between the base and the projection period. Please see Exhibit 2 for support for the change in induced demand ("Change in Utilization Effect") shown in Exhibit 1.

b. Trend Factors (cost/utilization)

As an integrated health care provider, a large portion of Kaiser's expenses are fixed costs associated with providing medical care through our centers. Total trends by line of business and by broad service category are developed by our Financial Planning and Analysis department during the annual Rate Setting process. See the accompanying Hawaii Data Submission Template for a breakdown of cost and utilization trend projection factors by major type of service that were used to project base period claims to the projection period in the development of the index rate. We have nominally split out the utilization and unit cost components.

c. Projected Changes in the Demographics of the Population Insured

A demographic adjustment has been included based on the relationship between the demographics of the 2016 base experience period and those of the first two months of 2017.

d. Projected Changes in the Morbidity of the Population Insured

No material change in the average morbidity of the future Kaiser non-grandfathered individual population relative to the average morbidity of the current population is projected.

e. Other Projected Changes

No other adjustments were applied in developing the projected index rate.

6. Credibility Manual Rate Development

The single risk pool is large enough to be considered fully credible in its own right; accordingly no manual rate component was used in the rate development.

7. Credibility

The single risk pool is large enough to be considered fully credible in its own right; accordingly 100% credibility was assigned to the historical claims experience.

8. Credibility Adjusted Projected Claims PMPM

Not applicable.

9. Projected Index Rate

See Exhibit 1 for the development of the single risk pool projected index rate for the projection period.

10. Market-Adjusted Index Rate

See Exhibit 1 for the calculation of the single risk pool market-adjusted index rate for the projection period from the projected index rate. Exhibit 4 shows the development of the projected ACA-related fees referenced below.

a. Risk Transfer Payments/Charges

We have assumed a risk adjustment based on the expected risk transfer results for 2016. This adjustment is included in Exhibit 1.

We have also included the $1.68 PMPY risk adjustment administrative fee in this section.

b. Transitional Reinsurance

There is no transitional reinsurance for the 2018 plan year.

c. Exchange User Fees

See Exhibit 4 for the development of the projected exchange user fees, including the proportion of projected enrollees that are expected to enroll through HealthCare.gov (the exchange) , as well as the assumed fee as a percentage of exchange premiums and the resulting PMPM rate.

11. Plan-Adjusted Index Rates

Please see Exhibit 7 for the development of plan-adjusted index rates. This exhibit clearly shows the following plan-specific adjustments:

a. Actuarial value and cost-sharing design of the plan

The pricing model actuarial factors shown in Exhibit 7 were derived using cost and utilization data for a standard population provided by a national actuarial consulting firm,

calibrated to Kaiser experience. This model was used to calculate the impact of the various cost share and plan elements for EHBs, including the utilization copayment effect. The reference plan used as the basis for the pricing actuarial values is a $0 cost share plan valued using the same industry standard factors described above. Due to differences in Kaiser's own experience and the national experience that was ostensibly used to calibrate the federal AV calculator, the resulting variances between the respective actuarial values by plan are not unexpected. Note that selection differences are not accounted for in deriving these factors.

Tobacco calibration to a non-tobacco user is applied as a multiplicative factor against the actuarial value and cost-sharing design adjustment such that the resulting plan-adjusted index rates reflect non-tobacco users. See Exhibit 6 for the development of the tobacco calibration adjustment factor, based on the assumptions that 12% of members aged greater than 20 are tobacco users, and that 100% of them will indicate that they are tobacco users and will therefore pay the higher tobacco use rates.

b. The plan's provider network, delivery system characteristics, and utilization management practices

Kaiser's provider network, delivery system characteristics, and utilization management practices do not vary by plan; therefore no adjustment has been applied for this impact.

c. Benefits provided under the plan that are in addition to the EHBs

The pricing actuarial values for each plan are adjusted to take into account the projected value of any non-optional non-EHB benefits that may be packaged with our underlying base medical plans. These benefits include the two mandated benefits described above, as well as ancillary benefits such as adult optical benefits, chiropractic/massage services and/or gym membership benefits. The adjustment factors are based on the per member per month costs of the non-EHB benefits, calculated as a percentage of the cost of providing the EHBs for the plans. In the case of the mandated benefits, the per member per month costs are those in Exhibit 7. In the case of the ancillary benefits, per member per month costs are based on the value of the capitation rates that Kaiser has negotiated with our respective ancillary providers. No adjustments related to selection were included in the development of these factors due to the ancillary benefits being optional. Please see Exhibit 7 for the plan-specific non-EHB adjustment factors.

d. Administrative costs, excluding exchange user fees

See Section 14(a) below for the development of the projected non-benefit expense. This has been converted into a factor for the purposes of developing plan-adjusted index rates.

e. Expected impact of the specific eligibility categories for catastrophic plans

Not applicable since no catastrophic plan is offered.

f. Adjustment for cessation of cost share reduction subsidies

To address the potential end to cost share reduction subsidies, an adjustment has been made to all on-exchange, Silver plans, per guidance from Department of Commerce and Consumer Affairs. This adjustment reflects the loss of subsidy, potential membership growth/loss and other factors. The assumptions and build-up of the adjustment can be found in Exhibit 12.

12. AV Metal Values

The AV Metal Values shown in Section II of Worksheet 2 were developed using the federal AV Calculator populated in accordance with federal instructions. AV metal values for certain plans containing separate copays for maintenance and other generic drug tiers were developed using a blended generic copay. The AV metal values were within the de minimis range using the stand alone federal AV calculator, but fell outside the range using AV calculator built into the P&B template.

13. Paid to Allowed Ratio

The paid to allowed average factor in the projection period in Section III of the Federal Unified Rate Review Template Worksheet 1 is a composite of the pricing model actuarial values for the plans listed in Worksheet 2, adjusted for the induced utilization impact as shown in Exhibit 2 accompanying the actuarial memorandum.

14. Non-Benefit Expenses Including Risk and Profit Margin

a. Projected Non-Benefit Expenses

i. General Administrative Expenses
Our administrative expense charge is based on historical administrative costs trended forward to 2018. These expenses include projected administrative expenses, medical management expenses and broker fees/commissions. Please see Exhibit 5 for the calculation of the projected administrative expense on a PMPM basis. This is later converted into a percentage load in Exhibit 7.

ii. Commissions and Broker Fees
Commissions and broker fees are included in (i) above.

iii. Premium Tax
As a non-profit entity, Kaiser Foundation Health Plan is not subject to premium tax.

iv. Other Taxes, Licenses and Fees

We have included the $0.20 PMPM patient centered outcomes research fee assessments mandated under the Affordable Care Act in our taxes and fees load. We have also included a 2018 HIP fee estimated at 1%. As with our general administrative expenses, this fee has been converted into a percentage load in Exhibit 7.

v. Health Care Quality Improvement and Fraud Detection Expenses

Due to the small magnitude of these expenses relative to our total healthcare and non-benefit expense, they have not been factored explicitly into our rate development.

vi. Profit (or Contribution to Surplus) & Risk Margin

The target margin is shown in Exhibit 4.

b. Varying Non-Benefit Expenses by Plan

Non-benefit expenses do not vary by plan.

15. Allowable Rating Factors

In accordance with the prescribed ACA rating methodology, rates are calculated by multiplying the base rate for the single risk pool by the corresponding plan factor, age factor, area factor and tobacco usage factor. Rates for child dependents are limited to the three oldest children in a family aged under 21.

a. Age Factors

The state-specific (CMS default) standardized age factors are used.

b. Geographic Factors

Only one geographic rating region for the State is used.

c. Tobacco Factors

The rating factor for individuals who indicate that they are tobacco users is unchanged from 2016. Application of this factor begins at age 21. The factor is contained in Exhibit 6.

d. Family Composition

Not applicable for the individual market.

16. Development of Rate Tables

The plan-adjusted index rates were calibrated in order to be able to apply the proposed rating factors (i.e. age and tobacco) to calculate the final rates to be charged to consumers by normalizing for the following factors:

a. Age Calibration

The plan-adjusted index rates were calibrated for the average age of the non-grandfathered population. An average age factor was derived by applying YTD Feb. 2017 member months against the prescribed CMS age factors. This resulted in a factor of 1.710, which corresponds roughly to that of a 49-year-old (nearest age factor). The allowed claims are then divided by this factor to adjust to a 21 year-old level, which has an age factor of 1.00.

Consistent with federal guidance, no rating adjustment has been made to account for the limitation of rates for child dependents to the three oldest children aged under 21 in a family.

b. Tobacco Calibration

The plan-adjusted index rates were calibrated by 0.980 for the tobacco surcharge. Development of the calibration is shown in Exhibit 6.

c. Pediatric Dental EHBs

Since pediatric dental benefits are being offered either via separate stand-alone policies or through bundled pediatric dental policies, no adjustment has been applied to the underlying medical rates to account for the value of pediatric dental benefits.

17. Company Financial Position

Please reference our most recent quarterly NAIC financial statement which was submitted to the Hawaii of Division of Insurance on March 31, 2017, for details regarding Kaiser's current financial position.

Our RBC ratios for the past three years, relative to the Authorized Control Level RBC are as follows:

2014	407%
2015	354%
2016	383%

We do not expect the proposed rate adjustment to significantly impact Kaiser's RBC and likewise do not anticipate significant future membership growth.

18. Loss Ratios

a. Loss Ratio Requirements

To the best of my knowledge, there are no Hawaii-specific or Federal loss ratio requirements to which the policies that are the subject of this filing are required to comply.

b. Projected Federal MLR

Worksheet 6 of the Hawaii Data Submission Template shows an estimate of the anticipated Federal Medical Loss Ratio for the projection period as outlined in 45 CFR Part 158. Given the size of Kaiser's individual population and therefore the relatively small impact of the credibility adjustment, for the purposes of this illustration we are assuming 100% credibility of the experience, consistent with that used in the development of rates. All adjustments to the numerator and denominator are separately shown in Worksheet 6 and are consistent with the values reported in the Unified Rate Review Template and the other exhibits that accompany this actuarial memorandum.

Note that due to the complexity of the MLR calculation and the resulting difficulty in reflecting this accurately using the filing data obtained using the prescribed format, the calculation that accompanies this filing is showing a lower projected MLR than Kaiser's internal calculations, which project a MLR that is significantly higher than the rebate threshold.

19. Reliance

The rates included in this filing were prepared by me or under my direction. In the course of developing the rates, I relied on information sourced from Kaiser's Decision Support System. I evaluated that data for reasonableness and consistency. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary.

20. Actuarial Certifications

Please reference the non-proprietary section of this actuarial memorandum for the required actuarial certifications.

Unified Rate Review Template

Note that the Unified Rate Review Template (URRT) does not exactly replicate the process followed to develop our rates and factors as detailed above and therefore projected values may not match precisely. Rather, the URRT represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted

by the allowable modifiers. The development of elements included the URRT that have not already been explained in the preceding sections of this memorandum are addressed below.

Benefit Categories

The benefit categories in Section II of Worksheet 1 are mapped based on type of service and place of treatment codes as follows:

- the inpatient category includes hospital inpatient facility, inpatient visits (rounding), inpatient surgery – non-maternity and maternity services;
- the outpatient category includes hospital outpatient facility, emergency/urgent care, hospital outpatient, other professional and outpatient surgery services;
- the professional category includes diagnostic services, office visits, cardiovascular, chemotherapy/pharmacy, dialysis and PT/OT/ST services;
- other medical represents other services, principally DME and ambulance;
- no capitated costs are shown; and
- prescription drug represents pharmacy costs.

Membership Projections

The membership projection across the plans in Section II of Worksheet 2 was developed by considering Kaiser's projected on- and off-exchange membership in aggregate according to our latest business plan, multiplied by the current membership proportion by plan based on our February 2017 enrollment in exchange plans and off-exchange plans respectively. No specific assumptions were made regarding the portion of projected enrollment that will be eligible for cost sharing reduction subsidies at each subsidy level in the Silver plan(s).

Actuarial Certification

a. Identification of Certifying Actuary

I, Mischelle Schweickert, am a member of the American Academy of Actuaries and meet its qualification standards for preparing and certifying rate filings for health maintenance organizations (HMOs). I am preparing this actuarial memorandum for Kaiser Foundation Health Plan of Hawaii ("Kaiser") in accordance with Section 431:14G-105 of the Hawaii Revised Statutes, Title 24, as well as applicable Federal Statutes and Regulations (45 CFR 156.80(d)(1)).

To the best of my knowledge and judgment, the following are true with respect to this rate filing:

b. Certification of Index Rate

The rates and factors included in this filing, including the projected index rate:

- comply with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1));
- were developed in compliance with the applicable Actuarial Standards of Practice;
- produce premium rates that are reasonable in relation to the benefits provided and the population anticipated to be covered;
- the resulting rates are neither excessive, inadequate nor unfairly discriminatory as filed; and
- were developed using only the permitted rating classifications.

c. Certification of Plan-Adjusted Index Rates

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-adjusted rates.

d. Certification of Metal AV

Except as indicated otherwise in the filing materials, the Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. The alternate calculation is actuarially sound and complies with generally accepted actuarial principles and methodologies.

e. EHB Substitutions

No EHB substitutions were made.

f. Geographic Factors

Only one geographic rating region was used for the entire state.

g. Compliance with Applicable State and Federal Laws and Regulations

This filing is in compliance with all applicable Federal and State Laws and Regulations, including the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010.

h. Compliance with Actuarial Standards of Practice

This filing has been prepared in accordance with the following Actuarial Standards of Practice:

- Actuarial Standard of Practice No. 5, “Incurred Health and Disability
- Claims”;
- Actuarial Standard of Practice No. 8, “Regulatory Filings for Health Plan
- Entities”;
- Actuarial Standard of Practice No. 12, “Risk Classification (for All
- Practice Areas)”;

- Actuarial Standard of Practice No. 23, “Data Quality”;
- Actuarial Standard of Practice No. 25, “Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages”; and
- Actuarial Standard of Practice No. 41, “Actuarial Communications”.

i. Other

The percent of total premium that represents essential health benefits included in the Unified Rate Review Template Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

Mischelle Schweickert

Digitally signed by: Mischelle Schweickert
DN: CN = Mischelle Schweickert email = mischelle.m.schweickert@kp.org C = AD O = Kaiser Permanente
Date: 2017.09.20 21:04:06 -07'00'

Mischelle Schweickert, FSA, MAAA
Manager, Actuarial Services
Kaiser Foundation Health Plan of Hawaii

(510) 268-4422
mischelle.m.schweickert@kp.org

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