Federal Rate Filing Justification Part III
Actuarial Memorandum and Certification

Optimum Choice, Inc.

NAIC: 96940

FEIN: 52-1518174

State of Delaware Rate Review

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Section 1: Purpose

The following is a rate filing prepared by Optimum Choice, Inc.. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of Delaware. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold off the Small Business Health Options Program in Delaware for the 2019 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the Delaware Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by XXX (state confidentiality regs). If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

Section 2: General Information

Company Identifying Information

Company Legal Name:	Optimum Choice, Inc.
State:	Delaware
HIOS Issuer ID:	97569
Market:	Small Business, 1-50
Proposed Effective Date:	January 01,2019

Primary Contact Information

Name:	[redacted]
Telephone Number:	[redacted]
Email Address:	[redacted]

Section 3: Proposed Rate Changes

The proposed change in rates for this filing is 11.08% compared to the prior filing. These changes are applied uniformly to all plans within a rating area. The proposed pricing trend is 10.8% annually.

- Changes in medical service costs
  - Increasing Cost of Medical Services – Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
  - Increased Utilization – The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
  - Higher Costs from Deductible Leveraging – Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
  - Cost shifting from the public to the private sector – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost difference is being shifted to private health plans. Hospitals typically make up this difference by charging private health plans more.
  - Impact of New Technology – Improvements to medical technology and clinical practice often result in the use of more expensive services - leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
  - UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
  - Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.

- State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.

- Changes that vary by plan
  - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
  - The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

Section 4: Experience Period Premium and Claims

Paid Through Date

The experience period is 1/1/2017 through 12/31/2017, with claims paid through 2/28/2018.

Premiums (net of MLR Rebate) in Experience Period

Earned premium for our small group market business in Delaware for 2017 was approximately $411,000. MLR rebate payments are not anticipated in Delaware for the 2017 calendar year, an estimate that was provided by UnitedHealthcare's finance department. [redacted]

Support for estimate of incurred but not paid claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors.

The same completion factors are applied to both incurred and allowed claims amounts.

Section 5: Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

Inpatient Hospital

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

Capitation

Includes all services provided under one or more capitated agreements.

Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

Section 6: Projection Factors

Changes in the Morbidity of the Population Insured

The total Population Risk Morbidity Adjustment is 0%.

Trend

24 months of trend were applied to our 2017 experience to project it to the 2019 rating period. Our most recent analysis indicates annual trend in the state of Delaware for the 2018 and 2019 calendar years will be [redacted] and [redacted], respectively. The table below details the components of each trend factor.

[redacted]

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Section 7: Credibility Manual Rate Development

Source and Appropriateness of Data Used

- The fully credible experience period source data used to develop manual rates is the actual small group experience for East Pennsylvania for UnitedHealthcare Insurance Company.

Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

An adjustment to the credibility manual was made to account for catastrophic claims experience in the experience period.

Inclusion of Capitation Payments

Capitation payments are included in both the experience and projections.

Section 8: Credibility of Experience

The experience for this legal entity contains 676 member months. As such the credibility of Optimum Choice, Inc. is set to 0%, and we are applying 100% credibility to the credibility manual.

Consideration was given to ASOP #25 when determining the credibility and appropriateness of the experience and the manual rate.

Section 9: Paid-to-Allowed Ratio

Paid-to-allowed ratios were developed for each plan using the proprietary UnitedHealthcare pricing model. This model uses nationwide UnitedHealthcare experience, which is fully credible. Claim data is projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost sharing is applied, and the values of each service category are summed to determine an overall benefit value, or paid-to-allowed ratio. In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

The average paid-to-allowed ratio is based on the paid-to-allowed ratios developed for each plan using the model discussed above and weighting them by the projected membership by plan. The member distribution is discussed under Section 21 (*Membership Projections*) of this memorandum.

Section 10: Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments (PMPMs)

Risk Adjustments for the experience period are not known at this time.

Our 2017 risk adjustment transfer is estimated based on the 2016 actual results, proportional to incurred claims. This results in an approximate adjustment of $-43,903 to the experience period premium. The premium in Worksheet 1, Section 1 is net of the risk adjustment transfer.

Since this is a small group filing and the state of Delaware chose not to combine its individual and small group markets, reinsurance recoveries are not applicable to this rate filing. As such, no adjustments were made to the experience.

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Projected Risk Adjustments Net of Risk Adjustment User Fees

Optimum Choice, Inc. anticipates [redacted] for risk adjustment transfers in the state of Delaware for the 2019 plan year. We are assuming the risk level of our business relative to that of our competitors for the 2019 plan year will be similar to what it was in the 2017 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2019 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2017 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market. The HHS Notice of Benefit and Payment Parameters for 2019 specifies a risk adjustment user fee of $0.15 PMPM.

[redacted]

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The reinsurance program ended in 2016. As such, reinsurance premiums were not included in the 2019 rate development.

Section 11: Non-Benefit Expenses and Profit

Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results for 2017 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

Profit and Risk Margin

The profit and risk margin is shown in Worksheet 1, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the target loss ratio and the administrative expenses, taxes and fees.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

Taxes and Fees

Taxes and fees are expected to be [redacted] and include premium tax, exchange fees, PCORI fees, and federal income tax. The following is a breakdown of the taxes and fees.

[redacted]

Section 12: Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2019 is [redacted]. Optimum Choice, Inc. agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Section 13: Single Risk Pool

The single risk pool reflects all covered lives for every small group non-grandfathered product and plan combination for Optimum Choice, Inc. in the state of Delaware. It is established in accordance with the requirements of 45 CFR §156.80(d).

Section 14: Index Rate

The Index Rate for the experience period is approximately [redacted] of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents [redacted] of allowed claims due to the benefits in excess of EHBs.

Small Group Trend Adjustment

We are proposing premium rates that trend by quarter. The trend assumption only includes unit cost and utilization trend as this calculation is on an allowed basis.

[redacted]

Section 15: Market Adjusted Index Rate

The market adjusted index rate includes market-wide adjustments for the risk adjustment program and exchange user fees. Please refer to Section 10 (*Risk Adjustment*) and Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum for a brief description of each of these items. Incurred values were grossed up by the average paid-to-allowed ratio to reflect an allowed basis.

[redacted]

Section 16: Plan Adjusted Index Rates

The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations (45 CFR 156.80 and 147.102)

Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

Optimum Choice, Inc. does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of Optimum Choice, Inc.'s nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

Benefits in Addition to EHBs

The Index Rate for the experience period is approximately [redacted] of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents [redacted] of allowed claims due to the benefits in excess of EHBs.

Distribution and Administrative Costs

Distribution and administrative costs include premium tax, PCORI fees, SG&A, quality improvements, federal income tax, and after-tax income. These items were previously discussed in Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum. Risk adjustment transfers and user fees and exchange fees are excluded because they are accounted for in the market adjusted index rate.

Section 17: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

Age Calibration

The calculated age curve calibration is [redacted], which equals the average age factor of the expected member distribution by age. This corresponds with an approximate age of [redacted] years. The age factors used in this calculation are the HHS-specified age curve.

Geographic Calibration

The geographic factor calibration is 1, which equals the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2019 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

Tobacco Calibration

Tobacco factors are not used in the rating of these products, and no calibration is needed.

Section 18: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate by the average age and geographic rating factors, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate
/ Age Calibration Factor
/ Geographic Calibration Factor
* Consumer Specific Age Rating Factor
* Consumer Specific Geographic Rating Factor
* Small Group Trend Adjustment
=Consumer Adjusted Premium Rate

Small Group Trend Adjustment

Since this is a small group filing that includes rates with scheduled trend increases by quarter, the Index Rate, Market Adjusted Index Rate and Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year. As such, the Consumer Adjusted Premium Rate needs to include a trend adjustment specific to the quarter for which the rates are being calculated. The trend factors used to develop the consumer adjusted premium rates are shown below.

Section 19: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan. Please refer to Section 9 (*Paid-to-Allowed Ratio*) of this memorandum for further detail regarding our estimate of the portion of allowed costs covered by each plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

The 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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

Copays Paid in Conjunction with Coinsurance

Some of our plan designs include copays that are paid in conjunction with coinsurance in the coinsurance range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR 156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance, the following formula was used to estimate the insurer's cost share.

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above. The copay was entered in the "Copay if separate" column.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. For example, if the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table whose claims exceeded $1,500 were included in the calculation of the average unit cost for each benefit type.

Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

Per Occurrence Copays

Select plan designs have per occurrence copays where a copay is paid before coinsurance is applied between the deductible and maximum out of pocket. These copays accumulate to the maximum out of pocket. To reflect this type of benefit an effective insurer coinsurance rate was calculated based on the average unit cost of the service and member coinsurance rate. The calculation is as follows:

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) * (1-Member Coinsurance Rate)

Some of the copays only apply to portions of the benefit categories that the AV calculator defines. For example, the Inpatient Hospital Services includes both physician and facility charges. To the extent the plan design per occurrence copay only applies to a portion of the services, the tiered Network functionality was utilized. The mix of services within the AV calculator benefit categories was based on historical experience.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level where available.

Section 20: AV Pricing Values

The AV pricing values represent the cumulative effect of adjustments made by the issuer to move from the market adjusted index rate to the plan adjusted index rate. Each of the allowable modifiers to move from the market adjusted index rate to the plan adjusted index rate was previously discussed in Section 16 (*Plan Adjusted Index Rates*) of this memorandum.

Section 21: Membership Projections

The 2019 plan year membership projection was developed utilizing the experience period plan level membership distribution along with sales and persistency targets. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2019. Strictly for purposes of the URRT, we have projected membership by plan.

Section 22: Terminated Products

There are no products being terminated in this rate filing.

Terminated plans will be mapped to another plan in the projection period for purposes of completing the URRT.

Section 23: Plan Type

A plan type of HMO has been selected, which describes the plans exactly.

Section 24: Warning Alerts

There are no warning alerts on Worksheet 2 of the URRT.

Section 25: Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3. A list of reliances is included below.

<u>UnitedHealthcare Finance Department</u>

- Projected SG&A Assumption
- Total Projected Membership

<u>UnitedHealthcare National Pricing Team</u>

- Plan Relativity Modeling

<u>UnitedHealthcare Healthcare Economics Department</u>

- Projected Trend
- Estimates of Incurred but not Paid Claims
- Plan Relativity Modeling

Section 26: Actuarial Certification

I, [redacted], am an Associate Director Actuarial Services for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
  - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
  - Developed in compliance with the applicable Actuarial Standards of Practice.
  - Reasonable in relation to the benefits provided and population anticipated to be covered.
  - Neither excessive, deficient, nor unfairly discriminatory.

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

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

- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

- The 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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. The unique plan design actuarial certification required by 45 CFR Part 156.135 has been separately attached.

- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop their rates. Rather, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted]

6/18/2018

Date