CAREFIRST BLUECROSS BLUESHIELD
PART III ACTUARIAL MEMORANDUM

1. REDACTED ACTUARIAL MEMORANDUM (AM): CareFirst (CF) is making no redactions so both AM submissions are the same.

2. GENERAL INFORMATION:

A. **Company Legal Name**: Group Hospitalization and Medical Services, Inc. (NAIC # 53007) (GHMSI)
B. **State**: Commonwealth of Virginia (northern).
C. **HIOS Issuer ID**: 40308.
D. **Market**: Individual, Non-Medigap (On & Off Exchange)
E. **Effective Date**: 01/01/17 – 12/31/17

F. **Primary Contact Name:** Mr. Brad Boban, A.S.A., M.A.A.A.
G. **Primary Contact Telephone Number:** 410-998-6230
H. **Primary Contact E-Mail Address:** Brad.Boban@CareFirst.com

PROPOSED RATE INCREASE(S): In compliance with the "Patient Protection and Affordable Care Act" (ACA, H.R. 3590) and toward the same 2016 objectives of maximizing access and affordability, long-term financial viability and customer rate stability, the range of increases for members that will be remaining on the same metal level (Silver and Gold) are **+7%** (Gold) to **+19%** (Silver) for a composite **15%**.

We will no longer sell bronze plans in 2017. The existing Bronze plans are being uniformly modified into Silver plans. Incorporating the members who are uniformly modified, GHMSI is proposing to raise premiums by **31.6%** on average, prior to age band changes. (For CFI the proposed average renewal is **32.2%**). For renewing customers, an age band change adds 2.6% to the renewal, on average, with a range of 0.0% to 4.7% for ages 22 and upwards per the CMS age curve. This filing applies to all new and renewing, in-force business in the guaranteed renewable, non-grandfathered, ACA, metaled benefit plans.

Reason for Rate Increase(s): The expected rate changes vary from **+6.8%** to **+72.1%** for 2017 renewals in this filing (prior to any impact of age band changes).

A significant driver of both the average increase, and the wide range of increases, are the benefit changes being made to our bronze plans. The 2016 bronze plans are being uniformly modified into silver plans in 2017, and will have significantly lower deductibles on average ($2,500 vs $4,500), and offer a greater number of services not subject to a deductible.

Also contributing to the range of increases are changes to the assumptions regarding induced utilization in our pricing AVs. In 2016, we had assumed a component of induced utilization related to the presence of an HSA account, which has been removed for 2017. For the component of induced utilization related to metal level, we have narrowed our gold:bronze ratio from 1.20 in 2016 to 1.08 in 2017, which aligns with the federal induced demand factors in the risk adjustment model. These changes cause bronze plans (had they remained bronze) and silver HSA plans to receive above average increases, while silver non-HSA and gold plans receive below average.

As a result of the richer benefits and the changes to our induced demand assumptions, members who are uniformly modified from bronze to silver will see rate increases of around **+72%**

Additional primary factors that contribute to the increase of all members include a) a worsening of the pool morbidity (+11% net impact when considering the offset from risk adjustment), b) an increase in the level of projected incurred claims trend (+4%), c) the end of the temporary reinsurance program (+3%) and d) a reduction in the administrative costs factor; partially driven by the moratorium of the health insurer fee (-3%).

3. MARKET EXPERIENCE:

4.1 EXPERIENCE PERIOD PREMIUM AND CLAIMS: The incurred period is 01/01/15 through 12/31/15, as required. There are no anticipated MLR rebates in the experience period. Allowed claims have been developed by combining paid claims with member cost-sharing amounts as well as Federal CSR amounts.

Paid Through Date: 02/29/16
Premiums (Net of MLR Rebate) in Experience Period: $49,193,347
Allowed and Incurred Claims Incurred during the Experience Period: $60,015,788

4.2 BENEFIT CATEGORIES:

A. Inpatient Hospital
B. Outpatient Hospital
C. Professional
D. Other Medical (non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other)
E. Prescription drug
F. Capitations

4.3 PROJECTION FACTORS:

Changes in the Morbidity of the Population Insured: CF estimates a morbidity risk factor of 1.166. We have used "life ID" data to examine experience by metal and origin, both for the single risk pool as a whole, and for the subset who remain enrolled as of 02/29/16. We have assumed that all Bronze members who don't lapse are uniformly modified into a Silver plan, and that bronze members with an HCC in 2015 will lapse at a lower rate than bronze members with no HCC, raising the PMPM for formerly-bronze members by ~22%. Additionally, the projection incorporates the experience of the platinum members into their 02/29/16 metal level, after they were uniformly modified into gold plans (70% remained in gold, 20% moved to silver, 10% lapsed).

Changes in Benefits: No covered services are being added or removed between the experience period and the projection period. There is an estimated impact to claims of +0.4% due to the increased utilization anticipated to occur as the average deductible of the pool decreases due to the uniform modification of bronze plans into silver.

Changes in Demographics: The average age during 2015 was 37.7. As of 02/29/16 the average age had increased by +0.4 to 38.1. Based on our internal age curve with a slope of 4.4:1, this change was estimated to impact claims by +1.3%.

Other Adjustments: An adjustment has made to the drug portion of claims to account for a projected increase in the level of drug rebates, which will lower net drug costs.

Trend Factors (Cost/Utilization): The proposed trend of 9.0% is an increase of 240 basis points from 2016's 6.6%. In 2016, the trend was set based on small group experience, as the small group experience was much less disrupted by the transition from pre-ACA to ACA. For 2017, with an extra year of ACA experience available, we have focused on an ACA/metaled-only trend analysis to get a better read of the true underlying changes in unit cost and utilization for a stable, homogenous population. The utilization trend projections incorporate the estimate +0.4% from changing induced utilization, per the URRT component of the instructions.

4.4 CREDIBILITY MANUAL RATE DEVELOPMENT: Not applicable, as experience was determined to be fully credible.

4.5 CREDIBILITY OF EXPERIENCE: The calendar 2015 base data includes 126,449 members months (average monthly of 10,537) and is therefore considered 100% credible.

4.6 PAID TO ALLOWED RATIO: Projected at 75.2%, on average.

4.7 RISK ADJUSTMENT AND REINSURANCE:

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM: The estimates of the experience period Risk Adjustment transfers in the URRT are based on a multi-carrier analysis by Wakely Consulting Group. The reinsurance estimates are based upon internal estimates of reinsured claim amounts, with experience paid through 02/29/16. Both estimates were performed at the metal level of granularity.

Projected Risk Adjustments PMPM: There is an anticipated $109 PMPM risk adjustment receipt for 2017. This is based on an analysis of the market by Wakely Consulting Group and our own projections using estimates of the PLRS, ARF, IDF, GCF and state average figures. We assigned 75% credibility to our calculated 2017 number.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only): Zero.

4.8 NON-BENEFIT EXPENSES AND CONTRIBUTION TO RESERVE (CtR) & RISK: The 2017 “desired incurred claims ratio” (DICR) is 84.0%.

Administrative Expense Load: As a percentage of total premium, administrative expenses and broker fees have slightly fallen from 10.4% in 2016 to 10.1% in 2017.

CtR & Risk Margin: 1.6% (versus 0.0% for 2016), post-Federal income tax.

Taxes and Fees:

- Federal Income Tax (FIT) is 0.4% (CtR of 2.0% and 20% tax rate).
- State Regulatory Trust Annual Assessment Fee of 0.1%.
- Health Insurer Fee is at 0.0% considering non-deductibility for tax purposes.
- PCORI of ~$2.33 PMPY, $0.19 PMPM.
- Risk Adjustment User Fees = $0.13 PMPM.
- Exchange User Fees are $9.57 PMPM (1.5% of premium = 3.5% FFE Fee x ~44% of members On-Exchange).

5 PROJECTED LOSS RATIO: Our projected DICR for MLR purposes is 88.1%, meeting the 80.0% minimum of “Public Health Service Act” (PHSA) 218.

6 APPLICATION OF MARKET REFORM RATING RULES:

6.1 SINGLE RISK POOL (SRP): Our SRP reflects all covered lives for every non-grandfathered product in our market, inclusive of transitional policies, per 45 CFR Part § 156.80 (d).

6.2 INDEX RATE: The experience period index rate is $601. The projected index rate is $836.

6.3 MARKET ADJUSTED INDEX RATE:

- **Federal Reinsurance Program Adjustment:** 1.000.
- **Risk Adjustment:** 0.827.
- **Marketplace User Fee Adjustment:** 1.016.

6.4 PLAN ADJUSTED INDEX RATES: The “cost-share” factor includes 1) pricing AVs and 3) metal level induced demand factors. There is 1 type of network – PPO.

6.5 CALIBRATION: Done for age only (geographic is unnecessary since CF only sells in Rating Area 10).

Age Curve Calibration – Based on the required age calibration methodology, we have calibrated to an average age of 46.6 from the age curve. The rate for each age has been calculated using the standard age factor of each age relative to the standard age factor for the rounded weighted average age of 47 (a factor of 1.563).

6.6 CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT: Rate charts are provided for all of the consumer adjusted premiums.

7 PLAN PRODUCT INFORMATION:

7.1 HHS ACTUARIAL METAL VALUES (AV): All 2017 plans include varying cost share levels for some services that depend on the setting in which care is delivered, which is not accommodated by the Federal AV calculator. As an acceptable alternate method for unique plans, the Federal AV calculator was used to compute two separate AVs for each impacted plan – one which applied the higher level of cost share, and one which applied the lower. The results were blended assuming 2/3 of the designated services are rendered in higher cost share setting and the remaining 1/3 at the lower.

Printouts for each plan are provided in the AM section of the Supporting Documentation tab of the SERFF filing, and also as part of the QHP binder submission under separate cover.

7.2 AV PRICING VALUES: The Plan Level Summary page shows the total AV Pricing Value, as well as the detail of each allowable rating factor that contributes to the total.

7.3 MEMBERSHIP PROJECTIONS: Projected enrollment is based on actual enrollment by plan as of 02/29/16. Final 2017 plan-level enrollment results from the underlying mapping of our 2016 plans into the proposed 2017 plan designs.

7.4 TERMINATED PRODUCTS: A listing of all terminated non-ACA products, as well as a list of the ACA plans being uniformly modified is included in the AM.

7.5 PLAN TYPE: PPO.

7.6 WARNING ALERTS:

- A warning is triggered on worksheet 1 which reads:

  WARNING - Wksh 1 - Market Experience Total PMPM (Cell H30) is not equal to Allowed Claims (Cell G16). CF believes the warning message is in error, as these two cells should not be equal, as best as can be ascertained from the instructions. Cell G16 is the experience period allowed claims PMPM, adjusted to exclude reinsurance and risk adjustment amounts. Cell H30 is a worksheet computed PMPM that is derived from the actual experience period utilization statistics by service category and does not reflect adjustments to remove reinsurance/risk adjustment.

- Additional warnings are triggered when CSR amounts are entered on worksheet 2:

  WARNING - Wksh 2 - Plan Product Info - Cell M65 - (Section III - Portion of above payable by HHS's funds on behalf of insured person in dollars) should be 0 for exchange plans for year 2014 and 2015. This message is an error that needs to be corrected by CMS, and per Dennis Yu on the 04/10/15 URRT conference call, the un-validated URRT should be submitted.

8 MISCELLANEOUS INSTRUCTIONS:

8.1 Effective Rate Review Information:

- <u>**Renewability**</u>
  Once the coverage is in effect, it is automatically renewed each year unless terminated by subscriber or terminated by CareFirst BlueCross BlueShield (CF) due to non-payment. CF has the right to terminate the contract if a) Subscriber fails to pay premiums or make other payments that are due as described in the Agreement, b) Subscriber fails to maintain eligibility, c) The QHP the subscriber is enrolled in is decertified. The coverage of dependents will automatically terminate if there is a change in their age, status or relationship to the Subscriber such that they no longer meet the eligibility requirements as stated in the agreement.

- **Issue Age Limits:**
  There are no issue age limits for these policies, as they are guarantee-issue ACA policies.

8.2 Reliance: Risk Adjustment analyses were provided to us by Wakely Consulting Group.

8.3 Actuarial Certification: Included in the AM.