

1. GENERAL INFORMATION

Insurance Company Name	Cigna HealthCare of Illinois, Inc.
NAIC Company Code	95602
HIOS Issuer ID	53882
State	Illinois
Market Type	Individual
Proposed Effective Date	01/01/2019
Primary Contact Person and Title	Steven Giori, FSA, MAAA, Actuarial Manager
Primary Contact Telephone Number	860-226-1278
Primary Contact Email	Steven.Giori@Cigna.com

Scope and Purpose of Filing: Cigna HealthCare of Illinois, Inc. (CHC of IL) is filing rates for comprehensive major medical product 53882IL004 for individuals & families, to be effective January 1, 2019. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through HealthCare.gov, brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to an existing product that has been submitted under policy form filing INDHMOIL01-2019. This policy form is not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

2. PROPOSED RATE INCREASE

The proposed weighted average annual rate change by product, without the impact of aging, is provided below.

2019 HIOS Product ID	53882IL004
Proposed Rate Change	7.0%

Please note that the Proposed Rate Change above does not equal the Product Rate Increase shown in Section I, Worksheet 2 of the URRT. As stated on page 39 of the Unified Rate Review Instructions, the Product Rate Increase Percent (over Experience Period) of 3.6% in the URRT reflects the average rate increase of the renewing plans based on the Projected Member Months. This field is calculated by the template and does not include the impact on membership mapped from a terminated plan to a new or renewing plan. Additionally, there will be further discrepancy if the projected membership by plan differs from the actual membership by plan in the experience period.

The following factors are the main drivers of the proposed rate change:

- Medical inflation and unit cost changes of medical services year over year: The underlying claim costs are expected to increase from 2018 to 2019, which is reflective of anticipated changes in the prices of medical services, the frequency with which consumers utilize services, as well as any changes in network contracts or provider payment mechanisms.
- The non-grandfathered individual market has continued to evolve since the inception of the Patient Protection and Affordable Care Act (PPACA), such as the introduction of the guaranteed issue requirement, the elimination of the individual mandate tax penalty, modified community rating, subsidies, the risk adjustment program, the external competitive landscape, transitional policy allowances, anticipated changes to regulations regarding Short Term Medical and Association Health Plans, and many other provisions. After consideration for expected risk adjustment transfers, the single risk pool experience for CHC of IL in Illinois was more adverse than assumed in the current rates. As a result, CHC of IL's best estimate of the average market-wide morbidity of the covered population has increased compared to 2018.
- Increased Profit Margin: After reviewing Cigna's capital requirements and profitability targets, CHC of IL raised the profit target assumed in pricing to a level that meets CHC of IL's corporate hurdle rate.
- Plan design changes and benefit modifications: Changes have been made to certain plans that are resulting in a decrease in expected cost share and therefore a decrease to premium. All plan designs conform to actuarial value and essential health benefit requirements.
- Health Insurance Industry Fee Changes: The suspension of the HII Fee for 2019 results in a decrease to premium compared to 2018.

- Change to the Corporate TaxRate: The Tax Cuts and Jobs Act decreased the corporate tax rate from 35% to 21%. This has been reflected in our filing for 2019 and resulted in a decrease to premium compared to 2018.

The requested rate change is not the same across all plans. The following factors drive different rate changes by plan:

- Plan design changes
- Trend leveraging due to member cost sharing provisions
- CHC of IL has made refinements to the manual rating methodology based on its most recent group experience and refreshed the claim probability distribution (CPD) used in the development of the cost sharing for its plans based on recent data for the Individual market, which leads to expected claim cost changes and different cost share among plans
- CHC of IL has updated the data and methodology used to project changes to customer utilization patterns as a result of changes in cost sharing

3. EXPERIENCE PERIOD PREMIUM & CLAIMS

- Paid Through Date:** December 31, 2017
- Premiums (Net of MLR Rebate) in Experience Period:** Premiums in experience period represent actual 2017 premiums received through 12/31/2017. [REDACTED]
 - Prior to MLR Rebates: [REDACTED]
 - Expected MLR Rebates: [REDACTED]
 - Net of MLR Rebates: [REDACTED]

- Allowed & Incurred Claims:**

All claims are processed through CHC of IL's claim system. Allowed claims shown below represent the sum of payments made under the policy to healthcare providers.

IBNR claims are calculated using completion factors, which represent the known paid claims as a percent of the estimated total accrual as of a particular lag period after a service month. Completion factors for a given reporting period are developed based on historical run-out patterns for national Individual experience, adjusted for actuarial judgment regarding deviance from the average (within a reasonable range based on historical deviance). The methodology used to calculate IBNR does not differ for allowed claims versus incurred claims.

Allowed and incurred claims in the experience period are as follows:

[REDACTED]

4. BENEFIT CATEGORIES

To determine benefit categories, CHC of IL uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- **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 surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital based professionals whose payments are included in facility fees.
- **Other Medical:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- **Prescription Drug:** Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

5. PROJECTION FACTORS

The Projection Factors described below are included in Section II, Worksheet 1 of the URRT.

- **Changes in the Morbidity of the Population Insured:** Experience was adjusted to account for expected morbidity differences between the underlying experience population and the projected 2019 population. The morbidity adjustment factor accounts for morbidity drivers specific to CHC of IL's single risk pool, including the membership distribution by metal tier, cost-share reduction subsidy status, and network type. The morbidity adjustment factor also accounts for expected market-wide morbidity changes due to the elimination of the individual mandate and increased awareness of Individual health insurance products.
- **Changes in Benefits:** The adjustment for changes in benefits was derived by comparing the average manual allowed claim cost for the 2019 product portfolio, weighted by projected 2019 membership by plan, to the average manual allowed claim cost for the 2017 product portfolio, weighted by 2017 CHC of IL experience membership by plan. This adjustment captures anticipated changes in average utilization of services due to differences between the average member cost-sharing during the experience period and the expected average member cost-sharing in the projection period.
- **Changes in Demographics:** An adjustment was made to account for the change in distribution by age and gender between the 2017 underlying experience and the expected 2019 membership. The adjustment factor was developed as the ratio of the membership-weighted average demographic factor using 2019 projected membership, and a similar factor computed using the 2017 actual membership. An area adjustment was also made to reflect differences between the distribution of membership across rating areas in our experience population and our 2019 projected population.
- **Trend Factors:** The source data to determine the trend is national group experience adjusted for market-specific differences. Adjustments were made to account for differences in utilization across major service categories and differences in the formulary between group and individual. CHC of IL's 2017 single risk pool experience is trended forward two years to 2019. The trend for group is deemed appropriate for use in development of individual rates because the networks constructed for group and individual are similar, and any differences in network are captured by a separate network savings decrement.

6. CREDIBILITY MANUAL RATE DEVELOPMENT

a. Source & Appropriateness of Experience Data used in Developing the Manual Rate

The source data used to generate the Manual Rate is trended national group experience adjusted for state- and market-specific differences. The experience for the national group book of business is deemed appropriate for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are similar to the benefits required to be ACA compliant. The adjustments to the baseline data are addressed below.

b. Adjustments made to the Data

The following adjustments were made during the development of the Manual Rate to account for differences between the source data and characteristics of the anticipated population in the Individual Market for the proposed period:

- **Morbidity Load – A [REDACTED] load** was added to the manual rate to account for the difference in morbidity risk of the population underlying the manual rate and the anticipated Individual population in 2019. CHC of IL relied on full-year 2017 allowed claims and enrollment data for the Individual market. The morbidity load comprehends the following components:
 - Overall health status in the Individual market – Customers seeking coverage through the Individual market tend to have a different average health status than those who receive coverage through their employer. The average morbidity in the Individual market is driven by external factors such as the elimination of the individual mandate, overall awareness of Individual health insurance products, and the presence or absence of transitional policies. All such factors are included in the morbidity load.
 - Membership distribution by metal tier and CSR plan – In the Individual market, individuals tend to select plans that best meet their health needs. Riskier individuals tend to choose plans with lower member cost-share. Additionally, individuals receiving CSR subsidies exhibit different utilization patterns due to differences in income and cost-share. The expected membership distribution by metal tier and CSR plan therefore impacts the overall expected morbidity in the single risk pool. This adjustment is applied to the index rate only and no plan-specific adjustments are made to account for anticipated differences in health status of enrollees across plans.

- Demographic Adjustment – The experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, an adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2019 individual market than the distribution by age reflected in the data underlying the Manual Rate.
- Impact of EHB – Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a [REDACTED] load.
- Network Savings – CHC of IL’s underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. The estimated savings of the provider network vary by geographic region, but are incorporated into the Manual Rate based on assumed enrollment by region as an average [REDACTED] decrement for 2019. The level of network savings is driven by the contractual arrangement between the health care providers and CHC of IL, and assumes certain capacity limitations for the providers; as such, significantly higher than expected volumes, carrier exits, etc. may require network reconstruction that may lead to a significant impairment in the adequacy of the rates developed herein.
- Pharmacy Formulary Savings – Pharmacy claim cost experience used in the development of the Manual Rate is based on national group experience. This group experience is representative of a broader formulary than the formulary associated with CHC of IL’s individual product. The narrower formulary results in a savings of [REDACTED] on pharmacy claim costs compared to the Manual Rate.

c. Inclusion of Capitation Payments

There are no services provided under a capitation arrangement for plans included in this filing.

7. CREDIBILITY OF EXPERIENCE

Limited fluctuation credibility was used to determine the credibility assigned to the 2017 single risk pool experience. 2017 exposure of 100,000 member months was assigned 100% credibility. Therefore, the credibility assigned to 2017 single risk pool experience was [REDACTED].

8. PAID TO ALLOWED RATIO

The expected cost-sharing ratio for each benefit plan is calculated by using 2016 and 2017 claims and enrollment data from the Individual market to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-sharing estimates. The expected Paid-to-Allowed Ratio for the 2019 single risk pool is [REDACTED].

Some differences exist between the cost-sharing as calculated above and the Metal AVs that are described in Section 18 of this document. These dissimilarities exist as a result of the following differences in methodology:

- The CPD used to calculate member and insurer cost-share is different from the underlying claims distribution in the continuance tables of the AV Calculator. The continuance tables are based on the default standard population developed by HHS using claims and enrollment from a national commercial database. The CPD is based on 2016 and 2017 claims and enrollment data from the Individual market. This experience-based CPD has a larger volume of its distribution at the tail, which represents higher average costs.
- The underlying cost assumptions for copays are different in the AV Calculator as compared to CHLIC’s experience. Since most of the proposed plans represented in this filing have copay based cost-sharing for Primary Care Physician and some plans have copays on additional services, this causes a difference between the Paid-to-Allowed ratio and the Metal AV for most plans.
- Cost-sharing for other benefits, such as separate copays for urgent care, is not captured in the AV Tool, whereas CHC of IL takes these benefits into account when deriving the paid-to-allowed ratio.

Note that the Paid-to-Allowed ratio as shown above is CHC of IL’s best-estimate of the total expected paid claims that are the liability of CHC of IL, divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in

the Projection Period. The URRT does not accurately demonstrate the process used by CHC of IL in the development of rates. As a result, in order to accurately reflect CHC of IL's Projected Allowed Experience Claims, Single Risk Pool Gross Average Premium, Risk Adjustment, and Expense assumptions in the URRT, an adjustment factor of [REDACTED] was applied to the Paid-to-Allowed ratio in Worksheet 1, cell V33 of the URRT.

9. RISK ADJUSTMENT & REINSURANCE

a. Experience Period Risk Adjustment and Reinsurance Adjustments (PMPM)

The expected member-level risk transfer amounts for 2017 were calculated based on 2017 CHLIC experience in Illinois [REDACTED]. CHC of IL-specific risk scores and other transfer formula components were calculated internally in accordance with the Notice of Benefit and Payment Parameters for 2017 final rule (CMS-9937-F). [REDACTED]

b. Projected Risk Adjustments (PMPM)

A 2019 net risk transfer [REDACTED] PMPM is assumed. This total includes a projected risk transfer [REDACTED] PMPM and risk adjustment user fees of [REDACTED] PMPM, both on an allowed basis. Equivalently, the projected risk transfer on a paid basis is [REDACTED] PMPM [REDACTED] with risk adjustment user fees of [REDACTED] PMPM.

The risk transfer formula was used for the calculation of CHC of IL's 2019 risk transfer. Components of the transfer formula were estimated at the product level, providing an estimate of the paid risk transfer PMPM at the product level.

The components of the transfer formula are outlined below with a description of the methodology used to estimate each component. [REDACTED]

Market-Average Risk Transfer Components

- Market average factor including risk (MAF including risk) – [REDACTED]
- Market average factor excluding risk (MAF excluding risk) – [REDACTED]
- Statewide average premium (SAP) – [REDACTED]

CHC of IL Risk Transfer Components

- Induced Demand Factor (IDF) – Weighted average of HHS Risk Adjustment Model IDFs based on projected 2019 CHC of IL membership by metal tier
- Geographic Cost Factor (GCF) – Weighted average of estimated 2017 GCFs [REDACTED] based on projected 2019 CHC of IL membership by rating area
- Actuarial Value (AV) – Weighted average of HHS Risk Adjustment Model AV factors based on projected 2019 CHC of IL membership by metal tier
- Allowable Rating Factor (ARF) – Weighted average of HHS Risk Adjustment Model ARFs based on projected 2019 CHC of IL membership by age
- Plan Liability Risk Score (PLRS) – The projected change in morbidity of CHC of IL's single risk pool from 2017 to 2019 was estimated as outlined in Section 5 of this document. The projected change in morbidity was used to estimate a projected change in PLRS for CHC of IL's single risk pool from 2017 to 2019. The PLRS was also adjusted for expected changes as a result of moving to the proposed 2018 risk adjustment model.

The projected 2019 net allowed risk transfer [REDACTED] PMPM was applied to the Index Rate in the development of the Market Adjusted Index Rate and does not match cell V35 on Worksheet 1 of the URRT, which is on a paid basis. The impact of net risk adjustment is [REDACTED] of CHC of IL's 2019 premiums.

c. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The reinsurance program ended with the 2016 benefit year. Consequently, no reinsurance recoveries have been applied to the Index Rate in the development of the Market Adjusted Index Rate.

10. NON-BENEFIT EXPENSES, PROFIT, & RISK

The following table illustrates anticipated breakdown of the retention components. [REDACTED]. This equates to [REDACTED] and is derived based on the projected expenses as a portion of projected average statewide premium with a target loss ratio of [REDACTED]. Actual expenses on both a PMPM and percentage of premium basis will vary based on the actual size and distribution of membership by age and plan.

a. Administrative expense load

CHC of IL's non-medical expenses are split out as follows:

- Acquisition administrative expense – this includes, but is not limited to, incentive compensation & salaries for brokers and agents, commissions†, marketing costs (working media & non-working media), and vendor fees.
- Recurring administrative expense – this includes, but is not limited to, costs relating to customer analytics, service operations, account management, and corporate overhead.

The administrative expense load is based on internal estimates from CHC of IL's Financial Analysis team and is deemed appropriate for the plans proposed in this filing. To determine this load, membership for CHC of IL's benefit plans is projected as outlined in Section 20. This membership is then applied to known budgeted amounts for administrative expenses to determine an appropriate administrative load across all plans as a percentage of premium allocation. [REDACTED].

† [REDACTED]

b. Profit & Risk Margin

CHC of IL has targeted [REDACTED] profit margin that is built into its premium rates. In the event that actual membership size and distribution differs from expectations, the actual profit margin may vary. There is no additional risk margin load.

c. Taxes & Fees

Please note that this section excludes contributions to the risk adjustment user fees, since these fees are included in the projected risk transfer, per Section 4.4.8 of the 2019 Unified Rate Review Instructions.

- Premium Tax is applied as 0.40% of premium
- Exchange User Fee is applied as [REDACTED] of premium‡

‡ Exchange User Fees are applied as an adjustment to the index rate at the market level. Hence, the 3.50% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the [REDACTED] expected fee stated above.

11. PROJECTED LOSS RATIO

The projected 2019 PPACA MLR, without adjustment for credibility, for CHC of IL's individual products is [REDACTED]

A demonstration of the projected MLR calculation is illustrated below:

- * Quality Improvement Activities, Risk Adjustment & Risk Corridor Receipts
- ** Premium/State Taxes/Federal Income Tax and ACA Fee Adjustments

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell X47 in Worksheet 1 URRT.
- Incurred Claims – projections for incurred claims are consistent with Cell X34 in Worksheet 1 of the URRT.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2019 (Final Rule)
- Earned Premium – projections for earned premium are developed by applying the projected average rate PMPM from cell V43 in Worksheet 1 of the URRT to the expected member months projections specified earlier.

- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2019 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

12. SINGLE RISK POOL

CHC of IL has included all covered lives for every non-grandfathered product/plan combination in the individual market in Illinois in the single risk pool, as specified in 45 CFR 156.80(d). Please note that CHC of IL does not have any transitional policies.

13. INDEX RATE

The Index Rate of the Experience Period for this filing is [REDACTED]. The Index Rate of the Experience Period in Section I, Worksheet 1 of the URRT represents the total combined 2017 allowed claims experience PMPM attributable to Essential Health Benefits in the single risk pool. It is consistent with the Experience Period Allowed Claims PMPM, as shown in Section II, Worksheet 1 of the URRT, since no benefits in addition to EHBs were offered in the experience period.

The Index Rate for the Projection Period for this filing is [REDACTED] and was developed in accordance with 45 CFR Part 156.80(d). The Index Rate for the Projection Period identified in Section III, Worksheet 1 of the URRT was generated using the same methodology as used in determining the Single Risk Pool Gross Premium Average Rate in Cell V43 of Worksheet 1 in the URRT. Hence, the Projected Index Rate is a representation of the Expected Allowed Claims for 2019 attributable to Essential Health Benefits, and incorporates the impact of trend, benefit, morbidity, and demographic adjustments as outlined in Sections 5 and 6 of this document. Refer to Section 7 of this document for additional information regarding the credibility attributed to single risk pool experience in the development of the Index Rate for the Projection Period. There are no benefits in addition to EHBs that are being covered under the proposed plans in 2019. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing.

14. MARKET ADJUSTED INDEX RATE

The Market Adjusted Index Rate for this filing is [REDACTED]. The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156.80 (d)(1). The following market-wide adjustments have been made to the Index Rate, as allowed under these rules:

- Risk Transfer - The Index Rate has been adjusted for the net transfer from the risk adjustment program. This adjustment equates to an impact of [REDACTED] PMPM on the Index Rate.
- Exchange User Fees - Exchange User Fees are applied as an adjustment to the Index Rate at the market level. The 3.50% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the [REDACTED] expected fee.

Please refer to Risk Adjustment and Reinsurance Section (section 9) for detailed explanation of how the risk adjustment was developed.

The Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

15. PLAN ADJUSTED INDEX RATE

a. Plan Adjusted Index Rate for the Projection Period

Only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the Market Adjusted Index Rate to arrive at the Plan Adjusted Index Rates:

- Plan-specific actuarial value and cost sharing adjustments
- Administrative costs, excluding the Risk Adjustment User Fee, and Exchange user fees

The adjustment Impact of specific eligibility categories for the catastrophic plan is not applicable since CHC of IL does not plan to offer catastrophic plans in 2019.

Note that the AV and cost-sharing adjustment encompasses expected cost-sharing differences and utilization differences due to differences in cost-sharing.

The expected cost-sharing ratio for each benefit plan is calculated by using 2016 and 2017 claims and enrollment data from the Individual market (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then used to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. Note that for each Silver HIOS Component ID the expected cost-sharing ratio was calculated separately for the Base benefit plan as well as the benefit plans for each of the three CSR variant levels. A weighted average of the respective four different plan variant levels was calculated for each Silver HIOS Component ID according to the projected membership distribution outlined in Section 20.

In addition to cost sharing differences, this adjustment also includes utilization differences due to differences in cost sharing. In evaluating adjustment for utilization changes, CHC of IL has relied on internal studies that used regression analysis to develop a relationship between historical utilization and corresponding expected plan cost-sharing. This adjustment is consistent with the description on page 63 of the 2019 Unified Rate Review Instructions. There are no explicit and/or additional adjustments used in our rate development process that reflect expected differences in utilization due to health status.

b. Plan Adjusted Index Rate for the Experience Period

The Plan Adjusted Index Rate for the Experience Period has been included in row 55 on Worksheet 2 of the URRT. This represents the expected non-calibrated statewide average premium for a non-tobacco user based on expected membership at time of 2017 Pricing. The Plan Adjusted Index Rate for the Experience Period differs from the average premium rate in Section I of Worksheet 1 due to the following items:

- Differences between projected and actual 2017 membership by age and geography
- The Plan Adjusted Index Rate represents the average projected 2017 premium for a non-tobacco user, while the average premium rate in Section I of Worksheet 1 includes non-tobacco users and tobacco users

16. CALIBRATION

CHC of IL calibrates the Plan Adjusted Index Rates to apply the allowable rating factors (age, geography, and tobacco) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below.

a. Age Curve Calibration

The weighted average age factor for the projected membership was calculated using the updated Default Federal Standard Age Curve defined in the addendum to 45 CFR 147.102(d). The average age associated with this projected membership (rounded to the nearest whole number) is [REDACTED]. This single risk pool average age was determined using the 2018 open enrollment age distribution in the single risk pool adjusted for projected changes in enrollment. The Plan Adjusted Index Rate was divided by the weighted average age factor mentioned above, to arrive at the calibrated Plan Adjusted Index Rate for a 21 year old. A demonstration of how the Plan Adjusted Index Rate and the age curve were used to generate the calibrated Plan Adjusted Index Rate for each plan is provided below.

b. Geographic Factor Calibration

Rate variations among geographical areas vary only by the geographic rating regions defined by the federal government. Area factors reflect only differences in the cost of the delivery of medical services among rating areas for a standard population and fixed market basket of covered services. The following table shows the geographic factors for each defined area in Illinois:

[REDACTED]

An average geographic factor is developed based on the projected distribution of membership across all areas. Then the calibrated Plan Adjusted Index Rate is calculated as Plan Adjusted Index Rate divided by this weighted average geographic factor.

c. Tobacco Use Rating Factor Calibration

The tobacco factor removes the portion of premium expected to be recouped through the tobacco surcharge. The Calibration factor was developed by a weighted average of the expected claim costs between tobacco user and non-tobacco user by an assumed distribution. A calibration factor of [REDACTED] is used for all plans.

A demonstration of calibration for the Plan Adjusted Index Rate is provided in the table below.

* The Plan Adjusted Index Rate represents average premium for the projected single risk pool at the unrounded average age, weighted using the best-estimate Default Federal Standard Age Curve factors. Linear interpolation between integer Default Federal Standard Age Curve factors was used in the development of the Demographic Calibration factor.

17. CONSUMER ADJUSTED PREMIUM RATE

Consumer Adjusted Premium Rate is developed by applying the following allowable adjustments to the calibrated Plan Adjusted Index Rate.

- Individual and family tier – applied by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account
- Rating area factor – applied by multiplying the area factors to the calibrated Plan Adjusted Index Rate
- Age factor – applied by multiplying the age factor to the calibrated Plan Adjusted Index Rate
- Tobacco status – applied by multiplying the tobacco factor to the calibrated Plan Adjusted Index Rate

18. AV METAL VALUES

The AV Metal Value shown in Worksheet 2 of the URRT for the following plan was based entirely on the AV Calculator. Therefore, CHC of IL has not submitted a Unique Plan Design justification for this plan.

The AV Metal Values shown in Worksheet 2 of the URRT for the plans listed below were based on the AV Calculator, with the exception of the following unique benefits for select plan designs:

- Cost Sharing for Pharmacy Generic Drugs
- Cost Sharing for Mental Health/Substance Abuse Outpatient Office Visit vs. Facility Visit Services (where OV are copay and Facility visits are ded/coins)
- Cost Sharing for Telehealth
- Copays for Urgent Care Services

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). The impacted plans, alternate methodologies, and the reason for their use is explained in the accompanying actuarial certification titled “53882_il_uniqueplandesign_8_1_2018.pdf”.

19. AV PRICING VALUES

A demonstration of the development of the Plan Adjusted Index Rate from the Market Adjusted Index Rate is provided in the table below.

CHC of IL is not incorporating any impact due to the different morbidity or health status of individuals who select certain plans in the derivation of the Pricing AV. See Section 15 in this document for an explanation of the factors used in the development of the Pricing AV.

20. MEMBERSHIP PROJECTIONS

The membership projections for CHC of IL’s benefit plans are developed internally as best estimates. They were derived from CHC of IL’s 2018 open enrollment experience and assumed channel growth in Illinois. Active membership splits were used to develop projections by exchange indicator and metal tiers, together with growth assumptions by channel. The projected distribution of member months represents our expectation of the industry average distribution of enrollment by age for the Individual Market for 2019.

21. TERMINATED PRODUCTS

The table below shows the plan mapping for terminating plans to new or existing plans in 2019.

22. PLAN TYPE

The plan types as inputted in Section I, Worksheet 2 of the URRT accurately describe the plans in this filing.

23. WARNING ALERTS

Please note that there are no warning alerts in Worksheet 2 of the URRT.

24. EFFECTIVE RATE REVIEW INFORMATION

a. Financial Information

Cigna HealthCare of Illinois, Inc. (CHC of IL)					
(\$ Millions)	2014	2015	2016	2017	2018 (Proj)
Stat Capital & Surplus	3.9	4.1	5.3	12.2	
Authorized Control Level RBC	0.3	0.3	0.3	2.1	

CHC of IL is in strong financial condition. The YE 2017 ACL RBC ratio was 569%. In prior years when the company was significantly smaller, the RBC ratio was much higher. The proposed plans and rates will have an immaterial impact on the company's financial condition, even with significant membership growth.

b. Rating Information

To see the proposed rate manual by age, area and smoking status please reference the accompanying QHP Rates Table Template. For additional rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying Plans Benefits Template.

Please note that CHLIC shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit, and a standalone exchange-certified pediatric dental policy.

c. Other

CHC of IL's anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is [REDACTED].

25. RELIANCE

I have relied on data and analysis provided by Shea Riley, Actuarial Senior Analyst in developing the proposed premium rates and in preparing the Part 1 Unified Rate Review Template submission. I have also relied on claim, premium, enrollment, and risk score data supplied by Kimberly Barbier, Informatics Senior Specialist, Sitong Chen, Actuarial Senior Analyst, and Kathryn Rouse, Actuarial Senior Specialist. The data have been reviewed for reasonableness but have not been audited. In addition, I have relied on other internal and external sources, [REDACTED], to develop the underlying assumptions used in the pricing methodology.

26. ACTUARIAL CERTIFICATION

I, Steven Giori, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify, to the best of my knowledge and judgment, that:

- a) The rates proposed in the above noted rate filing are
 - In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
 - Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
 - ASOP #5, Incurred Health & Disability Claims
 - ASOP #8, Regulatory Filings for Health Plan Entities
 - ASOP #12, Risk Classification
 - ASOP #23, Data Quality
 - ASOP #25, Credibility Procedures Applicable to Accident & Health, Group Term Life, and Property & Casualty Coverages
 - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
 - ASOP #41, Actuarial Communications
 - ASOP #50, Determining Minimum Value and Actuarial Value under the Affordable Care Act
 - Reasonable in relation to the benefits provided and the population anticipated to be covered
- b) The Projected Index Rate presented in this filing is:
 - a. In compliance with all applicable state and Federal statutes and regulations in 45 CFR 156.80(d)(1)
 - b. Developed in compliance with the applicable Actuarial Standards of Practice
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
 - d. Neither excessive nor deficient
- c) Plan level rates were generated using only the indexrate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)
- d) The geographic rating factors reflect only differences in the costs of delivery, including unit cost and provider practice pattern differences, and do not include differences for population morbidity by geographic area.
- e) The percent of total premium that represents Essential Health Benefits included in Worksheet 2, Section IV, of the Part 1 URRT was calculated in accordance with applicable Actuarial Standards of Practice
- f) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans, save the exceptions shown in Section 18, which are further explained in the accompanying actuarial certification “53882_il_uniqueplandesign_8_1_2018.pdf”.

The URRT does not demonstrate the process used to develop the rates presented in this filing. 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 IndexRate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



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