OVERVIEW

This document contains the Part III Actuarial Memorandum for CareSource West Virginia Co.’s (CWV’s) individual comprehensive medical block of business, effective January 1, 2018. These individual rates are guaranteed through December 31, 2018. These products are offered both on and off the Individual Insurance Exchange. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the Actuarial Memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This memorandum may not be appropriate for other purposes.

The information in this Actuarial Memorandum has been prepared for the use of CWV and is intended for use by the West Virginia Offices of the Insurance Commissioner (OIC), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CWV’s individual rate filing. However, I recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this Actuarial Memorandum or rate filing to other users. Likewise, other users of this Actuarial Memorandum should not place reliance upon this Actuarial Memorandum that would result in the creation of any duty or liability for Milliman under any theory of the law.

The results are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

The 2018 plan year premium rates provided in this Actuarial Memorandum were developed based upon the current Affordable Care Act (ACA) statutes and regulations in full force and effect as of date this Actuarial Memorandum is submitted, but assuming cost-sharing reduction subsidies are not funded. Accordingly, the 2018 plan year premium rates provided in this Actuarial Memorandum are contingent upon the current ACA statutes and regulations, including, but not limited to, the advanced premium tax credits, and the individual mandate requirement and penalty not changing (“Financial Uncertainties”), either through legislative or regulatory amendment, court decision, or a decision by Congress, the Health and Human Services Secretary or the Centers of Medicaid and Medicare director to not fund advance premium tax credits or decision not to enforce the individual mandate requirement and penalty, for the upcoming 2018 plan year due to the fact that any change in the Financial Uncertainties have the potential to greatly impact the 2018 plan year premium rates provided in this Actuarial Memorandum. Therefore, since this Actuarial Memorandum and the 2018 plan year premium rates were developed based upon the current ACA statutes and regulations in full force and effect as of the date this Actuarial Memorandum is submitted and any prospective changes to the Financial Uncertainties are not accounted for in the 2018 plan premium rates, CWV retains and reserves the right to amend this Actuarial Memorandum and 2018 plan premium rates accordingly should there be any changes to the Financial Uncertainties.

As prescribed by the West Virginia OIC, the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will not be funded and therefore are not calculated as described in current regulations and guidance. Furthermore, the West Virginia OIC prescribes the impact of CSR subsidy non-payment should be spread across all plans in the single risk pool (rather than impacting silver plans only), which could result in insufficient silver premiums and excessive bronze and gold premiums. Future modifications in legislation, regulation and/or court decisions regarding the funding of CSR payments may affect the extent to which the premium rates are neither excessive nor deficient.
I. GENERAL INFORMATION

Company Identifying Information

Company Legal Name: CareSource West Virginia Co.
State: West Virginia
HIOS Issuer ID: 50328
Market: Individual
Effective Date: January 1, 2018

Company Contact Information

Primary Contact Name: Scott Brockman
Primary Contact Telephone Number: (937) 531 2626
Primary Contact Email-Address: Scott.Brockman@caresource.com

Consultant Contact Information

Primary Contact Name: Erik Huth
Primary Contact Telephone Number: (262) 796 3468
Primary Contact Email-Address: erik.huth@milliman.com

Plan Descriptions and Benefits

These products provide comprehensive medical benefits for services received within the provider network. The products have various cost sharing designs which are a combination of deductibles, coinsurance, and copayments that vary for in-network services.

Products 50328WV001 and 50328WV002 are HMO products with Gold, Silver, and Bronze benefit plan options and provide coverage for inpatient, outpatient, physician, prescription drugs, and miscellaneous services subject to deductible, coinsurance, and copays. Products 50328WV003 and 50328WV005 are HMO products with Bronze and Silver benefit plan options and has the same coverage of services subject to deductible, coinsurance, and copays as CWV’s other products. All member cost-sharing (deductibles, coinsurance, and copays) accrue toward the annual out-of-pocket maximum. Pharmacy cost sharing reflects a five-tier (generic, preferred brand, non-preferred brand, preferred specialty, and non-preferred specialty) copayment or coinsurance structure for Products 50328WV001 and 50328WV002. Products 50328WV003 and 50328WV005 (Federal Standard plans) cost sharing reflects a four-tier (generic, preferred brand, non-preferred brand, and specialty) copayment or coinsurance structure consistent with regulation.

All plans within the products have the same Essential Health Benefits (EHBs). Products 50328WV001 and 50328WV003 include additional non-EHB coverage for adult routine eye examinations and Products 50328WV002 and 50328WV005 include additional non-EHB coverage for adult eyewear, adult routine eye examinations, and adult dental services. No EHB substitutions were made.

II. PROPOSED RATE INCREASE(S)

This filing is both an initial rate filing for four new plans and a requested rate change filing for ten of CWV’s individual Affordable Care Act (ACA) compliant non-group plan rates originally filed for effective dates January 1, 2017 through December 31, 2017. The experience basis, benefit plans, rating factors, and other projection assumptions were updated for this filing.
CWV’s 2018 plan designs include copay, deductible, out-of-pocket maximum, and other benefit changes from their existing 2017 plan designs to comply with changes in the most recent AV Calculator and to also better compete in the market.

I develop premium rates for these individual plans using CWV’s 2016 West Virginia individual experience and CareSource’s 2016 Ohio individual experience, in conjunction with internal research proprietary to Milliman and other industry studies and surveys. I consider a number of items in developing the premium rates, including but not necessarily limited to the:

- Projected morbidity level of the population anticipated to purchase the products,
- Proposed benefit plan designs,
- Anticipated medical trend, both utilization and cost of services,
- Applicable taxes and fees, including those newly applicable since 2014 under ACA, and
- Anticipated risk adjustment payments (receipts).

This memorandum addresses the rate increase requested for CWV’s individual HMO product, which impacts 5,120 members. The rate increase being requested weighted by current enrollment for CWV’s products is an aggregate 19.0%. The requested rate increase varies by plan and area within the individual HMO product with a minimum adult rate change of a 6.1% decrease and a maximum adult rate change of a 42.5% increase. The maximum rate change for a person with the highest rating age factor increase (i.e., a 20-year old) is 117.7% (42.5% maximum plan base rate increase and 52.8% age rating factor increase).

These plans are Affordable Care Act (ACA) compliant plan rates, effective for 12 months beginning January 1, 2018 and ending December 31, 2018. Exhibit 1 displays the rate change by plan and area.

The minimum and maximum premium rate changes described are for the base rate (age 21 rate). Due to the revised 2018 federal age curve premium rates, rate changes for dependents will be 20.5% to 52.8% higher. The overall impact is an additional 0.6% increase to aggregate premium, resulting in an overall 19.0% increase for members (adults and dependents).

Reason for Rate Change

- Base Experience – A credibility-weighted blend of CWV’s 2016 West Virginia individual ACA and CareSource’s 2016 Ohio individual ACA experience (adjusted for differences between Ohio and West Virginia) is the basis for CWV’s 2018 premium rates. CareSource’s 2015 Ohio individual ACA experience is the basis for CWV’s 2017 premium rates, adjusted for differences between Ohio and West Virginia, since CWV first offered plans in the individual market in 2016.

- Trend – I price CWV’s 2018 premiums using a annual trend.

- Morbidity – CWV estimates , CWV’s 2017 pricing did not include an estimate for risk adjustment transfer, since it had no West Virginia experience at that time.

- Non-Payment of CSR Subsidies – Based on guidance from OIC, this filing assumes CSR subsidies will not be funded in 2018, but CWV will be responsible for paying claims at the reduced cost sharing variant levels. I spread the impact of the increased claim payments across all metallic levels in the single risk pool, based on guidance from OIC.

- Other Factors – Other factors include changes in plan benefits, changes in determining the plan design behavior factors of plans, administrative expenses, and provider reimbursement and pharmacy contracting changes.
There are a number of 2017 to 2018 plan-specific changes that cause the rate increase to vary by plan, including changes in plan benefits, changes in pricing values and the plan design behavior factors, and changes to the provider reimbursements. These changes are applied at the benefit plan level resulting in different rate increases by plan.

Additional detail supporting these assumptions is provided in Sections V and VI.

**Rate Change History**

CWV’s aggregate 2017 individual HMO rate change was [X]% reflecting 2016 enrollment by plan. These products were first introduced in West Virginia in 2016.

**III. EXPERIENCE PERIOD PREMIUM AND CLAIMS**

CareSource is a managed care organization, contracting with provider networks to provide medical and pharmacy care to its members. CWV contracts with carriers on a fee-for-service basis. CWV’s contractual arrangements for actual claims for services were directly incorporated in the development of the 2018 rates.

**Claims Paid Through Date**

The claims incurred in the experience for both non-capitated and capitated services reflect payments through January 31, 2017.

**Premiums (Net of MLR Rebate) in Experience Period**

The earned premium reported in Worksheet 1 of the URRT reflects the sum of member level premium for the 2016 experience period in West Virginia. CWV’s 2016 individual loss ratio exceeded the MLR requirement. Therefore, an adjustment for MLR rebates was not included. CWV’s 2016 West Virginia premium is not net of its 2016 estimated risk adjustment payment, per the 2018 instructions.

**Allowed and Incurred Claims Incurred During the Experience Period**

CWV’s incurred claims include fee-for-service claims and prescription drug claims. The allowed claims were provided directly from CWV’s claim records.

CWV provided the 2016 claims on a completed basis by using lag development factors for lags across all commercial services. This method estimates the portion of claims that have been paid to date for each incurrel month based on past claim lag data, which reflects historic time lags in CWV’s medical and prescription drug claim data between the month of service (i.e., the incurrel month) and the month of claim processing (i.e., the processed month).

Table 1 displays a breakdown of the individual allowed claims, incurred benefits, and earned premium for CareSource’s 2016 West Virginia experience.
IV. BENEFIT CATEGORIES IN WORKSHEET 1, SECTION II OF THE URRT

Experience: The experience period claim information by benefit category represents CWV’s ACA-compliant individual medical plans in West Virginia in 2016.

I categorize utilization and cost information by benefit using CWV’s 2018 projected West Virginia claims distribution by major service category. CWV’s projected 2018 fee-for-service medical claims are included by service category:

- 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. Units represent the annual number days of utilization per 1,000 members.

- 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. Units represent the annual number of visits per 1,000 members.

- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees. Units represent the annual number of visits per 1,000 members or the annual number of procedures per 1,000 members depending on the service. A procedure represents the number of administration and supply CPT-4 and HCPCS codes. For professional services listed as a visit, the visit represents the professionals’ time (the procedures administered during the visit are separate).

- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc. Units represent the annual number of visits, cases, or procedures per 1,000 members depending on the service.

CWV’s drug claims are included in the “Prescription Drug” line in the URRT with a benefit category of “Prescriptions” and represent drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers. Units represent the annual number of scripts per 1,000 members.
V. PROJECTION FACTORS APPLIED TO EXPERIENCE

CWV’s 2018 rates are based on a credibility-weighted blend of 2016 West Virginia and Ohio experience. I assign CWV’s 2016 West Virginia experience [credibility].

Projected Enrollment

I project CWV’s 2018 West Virginia enrollment based on projections provided by CWV. Table 2 shows CWV’s assumed 2018 individual enrollment by metal level and plan.

![Table 2](attachment:image)

Changes in the Morbidity of the Population Insured

Changes in Benefits

I adjust CWV’s 2018 index rate to reflect anticipated changes in the average utilization of services due to differences in average 2016 cost sharing requirements and average 2018 cost sharing requirements.

I use Milliman’s *Health Cost Guidelines* (HCGs), in conjunction with the historical experience of CWV’s Individual market block of business, in order to estimate the benefit changes for each of the items listed above.

I account for the change in plan mix as it raises the allowed amount PMPM from 2016 to 2018 and reflects lower utilization in 2018 due to the leaner benefit plan design mix in 2018.

EHBs are consistent between the 2016 experience period and the 2018 projection period. However, CWV’s mix of EHB and non-EHB services changed between the experience and projection period. I account for these changes separately, including adjustments for adult routine vision examinations, adult eyewear, and adult dental benefits.

Changes in Demographics

I assume CWV’s 2018 individual enrollment will have the product type and metal level as provided by CWV and shown in Table 2. Within each product and metal, I assume CWV’s 2018 individual enrollment distribution by age, gender, and tobacco status will mirror the demographics underlying CWV’s emerging 2017 enrollment.

My rate projection is based on 2016 experience, and reflects the average demographics and geographic mix of the 2016 enrollees. My development of the 2018 Index Rate reflects the anticipated differences in the demographic and geographic mix of the population, as compared to the 2016 experience period.
Provider and Pharmacy Reimbursement Changes

CWV has negotiated 2018 West Virginia provider discount levels that are different than the reimbursement levels underlying the 2016 experience. I adjust CWV's 2018 index rate for the difference between the 2016 and 2018 provider reimbursement levels. CWV has also negotiated improved pharmacy contracting terms in 2018 relative to 2016. I adjust 2018 index rate for the expected pharmacy contract savings.

Other Adjustments

Table 3 displays the adjustments described above that flow into the “Other” adjustments in URRT Worksheet 1, Section II.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>CareSource West Virginia Co.</th>
<th>West Virginia Individual ACA Plans</th>
<th>Development of Other Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic / Tobacco Mix Change</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Provider Reimbursement / Pharmacy and Contracting Change</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Covered Benefit Changes</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Plan Mix and its Impact on Utilization</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Resulting Other Factor Change</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Trend Factors

I trend CWV’s West Virginia 2016 experience forward to 2018 using an aggregate annual trend of approximately 5.1% (annual utilization and charge trends of approximately 0.7% and 4.4%, respectively), as shown in Table 4. I develop the trend assumptions with input from CWV and general industry reports regarding recent trends in medical inflation.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>CareSource West Virginia Co.</th>
<th>West Virginia Individual ACA Plans</th>
<th>2016 to 2018 Annual Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Category</td>
<td>Utilization Trend</td>
<td>Cost Trend</td>
<td>Total Trend</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Professional</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other Medical</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Capitation</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Note: Factors are rounded.

VI. CREDIBILITY MANUAL RATE DEVELOPMENT

CWV's 2018 rates are based on a credibility-weighted blend of 2016 West Virginia and Ohio experience. I assign CareSource’s 2016 Ohio experience (adjusted for differences between Ohio and West Virginia) 44.3% credibility.
Source and Appropriateness of Experience Data Used

CareSource’s Ohio experience is appropriate to use as the experience basis for a credibility manual rate since product and plan benefits, claims administration, and other operations are the similar between Ohio and West Virginia.

CareSource provided the 2016 claims on a completed basis by using lag development factors for lags across all commercial services. This method estimates the portion of claims that have been paid to date for each incurreal month based on past claim lag data, which reflects historic time lags in CareSource’s medical and prescription drug claim data between the month of service (i.e., the incurreal month) and the month of claim processing (i.e., the processed month). CareSource’s incurred claims represent the sum of two items: 1) fee-for-service claims, and 2) prescription drug claims. The allowed claims were provided directly from CareSource’s claim records.

CareSource’s 2016 completed Ohio individual ACA experience was adjusted for its estimated 2016 risk adjustment payments to bring experience to the statewide morbidity level and then for differences in demographic mix, benefits, state-specific morbidity, area factors, and provider reimbursement level between CareSource’s 2016 Ohio individual ACA experience and CWV’s 2018 West Virginia assumptions. Exhibit 2 outlines the factors used to convert the 2016 Ohio ACA experience to a 2018 manual rate calibrated to West Virginia. Exhibit 2 provides all adjustments I apply to CareSource’s 2016 Ohio allowed claims PMPM to estimate CWV’s 2018 West Virginia credibility manual rate allowed claims PMPM.

The credibility manual rate utilization and unit costs shown in Worksheet 1, Section II of the URRT are developed as shown in Exhibit 2.

Projected Enrollment

Enrollment is projected using CWV’s estimates of market penetration and 2018 marketing expectations.

Adjustments Made to the Data

This section includes a description of each factor used to adjust the experience of the manual rates and supporting information related to the development of those factors.

Changes in the Morbidity of the Population Insured

CareSource estimates it will [X]% of incurred claims for Ohio ACA members. I price by bringing CareSource’s 2016 experience to the statewide morbidity level by [X]% claims (Exhibit 2, line 2). I [X]% the statewide Ohio experience morbidity to be at the statewide West Virginia 2018 morbidity (Exhibit 2, line 3) and, therefore, I assume no 2018 risk adjustment transfer for the manual portion of the rate development.

Changes in Benefits

I adjust for the utilization impact due to cost sharing differences in CareSource’s Ohio ACA experience plans and CWV’s 2018 West Virginia plans. I determine the difference in CareSource’s 2016 Ohio plan design behavior factors and CWV’s projected 2018 West Virginia plan design behavior factors results in a [X]% to the projected West Virginia index rate, as shown in Exhibit 2, line 4.

I add a [X]% to West Virginia’s manual rate to reflect the additional EHBs required in West Virginia (infertility treatment and bariatric surgery) not included in the Ohio ACA experience and Non-EHBs. Exhibit 2, line 13 shows this adjustment.
I decrease West Virginia’s manual rate 1.5% to reflect the difference in additional utilization from CSR plan enrollees between CareSource’s 2016 Ohio ACA experience and CWV’s projected experience, as shown in Exhibit 2, line 8.

The composite change in benefits is reflected in the projected allowed costs for the Single Risk Pool in URRT Worksheet 1. However, the AV and Cost Sharing factors for each plan will reflect their unique benefits, including any changes in benefits, on a plan-specific basis relative to the reference plan. As such, the index rate will reflect the Changes in Benefits for all plans but the plan-specific AV and Cost Sharing factors will ensure the Plan Adjusted Index Rates are developed properly for the different plans.

Changes in Demographics

I adjust CareSource’s 2016 Ohio ACA experience allowed PMPM to reflect the difference between CareSource’s 2016 Ohio enrollment and CWV’s projected 2018 West Virginia enrollment. I base CWV’s projected 2018 enrollment off of CWV’s 2017 year-to-date enrollment mix and CWV projections.

Exhibit 2, lines 9 and 10 display the 17.4% and 0.2% increases to the projected index rate due to differences in Ohio 2016 ACA and West Virginia 2018 projected age and tobacco demographics.

Other Adjustments

CWV has negotiated 2018 West Virginia provider discount levels different than the reimbursement levels underlying CareSource’s 2016 Ohio ACA experience. The provider negotiations are proprietary in nature. I adjust CareSource’s ACA experience allowed PMPM for both the difference between the provider reimbursement levels and the average charge fee between CareSource’s Ohio rating areas and CWV’s West Virginia rating areas. I also adjust CareSource’s ACA experience for the area utilization relativity between Ohio and West Virginia based on Milliman’s HCGs. Exhibit 2 displays the impact of area charge (line 5), provider reimbursement (line 6), and area utilization (line 7) factors as a 3.7% decrease, a 30.2% increase, and a 12.0% increase, respectively, to the projected West Virginia index rate.

Trend Factors

I trend CareSource’s ACA experience forward to 2018 using an aggregate annual trend of 5.1%, as shown previously in Table 4. Exhibit 2, line 11 shows the trend adjustment.

Inclusion of Capitation Payments

Not applicable.

VII. CREDIBILITY OF EXPERIENCE

CWV’s 2016 West Virginia ACA experience includes member months. Based on a Milliman credibility study, I determine a full credibility threshold of member months. I calculate CWV’s 2016 experience credibility using the following formula:
VIII. PAID TO ALLOWED RATIO

The Paid to Allowed ratio shown in Worksheet 1, Section III of the URRT was developed by calculating the average ratio of Paid (i.e., after member cost sharing) to Allowed (i.e., before member cost sharing) claims for each plan, weighted by projected member months by plan as shown in Appendix A. Table 5 provides the experience paid to allowed factors for CWV's individual ACA metal level plans.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Member Months</th>
<th>Paid Claims PMPM</th>
<th>Allowed Claims PMPM</th>
<th>Paid-to-Allowed Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td></td>
<td>$611.89</td>
<td>$705.02</td>
<td>86.8%</td>
</tr>
<tr>
<td>Silver</td>
<td></td>
<td>$496.46</td>
<td>$604.14</td>
<td>82.2%</td>
</tr>
<tr>
<td>Bronze</td>
<td></td>
<td>$111.21</td>
<td>$184.86</td>
<td>60.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$349.41</td>
<td>$442.63</td>
<td>78.9%</td>
</tr>
</tbody>
</table>

The projected paid and allowed claims reflect the member month weighted average by metal level from Worksheet 2, Section IV of the URRT, but without the impact of risk adjustment. The total paid-to-allowed ratio is consistent with Worksheet 1, Section III of the URRT. The average AV metal value is based on AVs calculated using the federal AV calculator, weighted on projected allowable cost by metal level. Table 6 provides the projection paid to allowed factors for CWV's individual ACA metal level plans.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Member Months</th>
<th>Paid Claims PMPM</th>
<th>Allowed Claims PMPM</th>
<th>Paid-to-Allowed Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td></td>
<td>$730.06</td>
<td>$799.82</td>
<td>91.3%</td>
</tr>
<tr>
<td>Silver</td>
<td></td>
<td>$555.35</td>
<td>$681.10</td>
<td>81.5%</td>
</tr>
<tr>
<td>Bronze</td>
<td></td>
<td>$522.23</td>
<td>$676.24</td>
<td>77.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$553.61</td>
<td>$683.30</td>
<td>81.0%</td>
</tr>
</tbody>
</table>

I price 2018 plans using an internal Milliman cost relativity model based on Milliman's commercial HCG’s to calculate the paid to allowed ratios. This proprietary model is updated annually and developed using experience of over 40 million lives. The model estimates actuarial equivalent relative values of different benefit plans using estimated medical costs calibrated to CWV (including service area, provider reimbursement, degree of health care management, etc.). Appendix A also displays the average paid to allowed ratios by plan.
IX. RISK ADJUSTMENT AND REINSURANCE

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

CWV estimates it will receive [redacted] PMPM in 2016 net reinsurance recoverables for individual ACA members and [redacted] PMPM in 2016 risk adjustment transfers for West Virginia individual ACA members. These amounts are net of reinsurance contributions and risk adjustment administrative fees, respectively.

Projected Risk Adjustments PMPM

Risk transfer payments are estimated at the plan level using the published transfer payment formula, taking into account CWV’s expected differences from the state average. The composite risk adjustment transfer payments are allocated proportionally to all plans based on plan premiums. I estimate CWV will [redacted] PMPM net of risk adjustment administrative fee.

I estimate the 2018 experience risk adjustment as [redacted], based on CWV’s [redacted] 2016 PMPM risk adjustment [redacted] trended [redacted] to reflect the 2016 through 2018 statewide change in premium PMPM, and reduced 14% to reflect the 2018 change to use an equivalent to statewide incurred claims rather than statewide premium as the multiplicative factor in the risk adjustment transfer estimate formula. I develop my estimated [redacted] 2016 to 2018 statewide change in premium PMPM by analyzing average 2016 to 2017 exchange Silver premium rate changes of each carrier, information about carrier 2018 pricing, and reflecting consumer movement toward lower premium plans.

I assume no risk adjustment transfer payments for the credibility manual rate since the credibility manual allowed claims PMPM is already reflective of estimated statewide average risk. For the projection period risk adjustment reported in URRT Worksheet 1, Section II, I calculate a credibility-weighted average risk adjustment transfer of [redacted] (55.7% / 44.3% blend of the experience and credibility manual risk adjustment transfer amounts), which includes the $0.14 PMPM risk adjustment administrative fee.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The federal transitional reinsurance program is a temporary program that ended in 2016. Since this program is not expected to continue in 2018, I assume that reinsurance contributions and reinsurance recoveries will be zero. As a result, I did not project any federal transitional reinsurance contributions or recoveries for 2018.

X. NON-BENEFIT EXPENSES AND PROFIT AND RISK

Exhibit 3 displays the total expenses, profit and taxes and fees. Exhibit 4 displays the expenses by plan. (Exhibit 3 and 4 values may not tie to URRT Worksheet 1, Section III values due to rounding within URRT Worksheet 1).

Administrative Expense Load

I estimate CWV’s administrative expenses to be [redacted] PMPM, as shown in Table 7. This estimate is entered as a percent of premium that does not vary by plan in Worksheet 1, Section III of the URRT. It is based on CWV’s estimate of 2018 projected expenses. I adjust the budget amount for ACA implementation expenses. Corporate overhead was allocated to CWV’s individual line of business. This amount does not include any profit, risk load, taxes, or assessments described below. PMPMs within Table 7 may not tie to PMPMs within URRT Worksheet 1, Section III due to rounding within URRT Worksheet 1.
Table 7
CareSource West Virginia Co.
West Virginia Individual ACA Plans
Summary of Administrative Expenses

<table>
<thead>
<tr>
<th>Administrative Expense</th>
<th>PMPM</th>
<th>% of Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Admin</td>
<td>$80.13</td>
<td>10.14%</td>
</tr>
<tr>
<td>Quality Improvement/Health IT</td>
<td>16.24</td>
<td>2.05%</td>
</tr>
<tr>
<td>Commission</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Commercial Reinsurance Recoveries</td>
<td>-22.70</td>
<td>-2.87%</td>
</tr>
<tr>
<td>Commercial Reinsurance Premiums</td>
<td>26.57</td>
<td>3.3%</td>
</tr>
<tr>
<td>Payment Processing Fee</td>
<td>0.05</td>
<td>0.01%</td>
</tr>
<tr>
<td><strong>Subtotal: Administrative Expense Load</strong></td>
<td><strong>$100.29</strong></td>
<td><strong>12.68%</strong></td>
</tr>
</tbody>
</table>

Note: Values are rounded.

Target Contribution to Surplus (a/k/a Profit) and Risk Margin

I build in 2.57% of premium for a pre-tax target contribution to surplus that does not vary by product or plan. I do not build in any additional loads for profit or risk. I consider the uncertainty of estimated claims in the 2018 market and federal MLR requirements in the target. Exhibit 5 demonstrates the reconciliation of the pre-tax and post-tax profit margin (Exhibit 5 values may not tie to URRT Worksheet 1, Section III values due to rounding within URRT Worksheet 1).

Taxes and Fees

Table 8 displays the projected taxes and fees that may be subtracted from premiums when calculating CWV’s loss ratio for MLR purposes (with the exception of the $0.14 risk adjustment fee that is shown net of reinsurance recoveries and risk adjustment receivables and not in this section). The composite value is displayed in Worksheet 1, Section III of the URRT.

Table 8
CareSource West Virginia Co.
West Virginia Individual ACA Plans
Summary of Taxes and Fees

<table>
<thead>
<tr>
<th>Description</th>
<th>PMPM</th>
<th>% of Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Premium Tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-Centered Outcomes Research Institute Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exchange Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurer Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Income Tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Taxes and Fees</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Values are rounded.
XI. PROJECTED LOSS RATIO

The projected loss ratio based on federally prescribed MLR methodology, excluding allowable adjustments, such as for credibility, quality improvement expenses, and high deductible is 86.3%, as shown in Exhibit 6 (Exhibit 6 values may not tie to URRT Worksheet 1, Section III values due to rounding within URRT Worksheet 1).

XII. SINGLE RISK POOL

CWV rates are developed using a single risk pool, established according to the requirements in 45 CFR section 156.80(d), and reflect all covered lives for every non-grandfathered product / plan combination in the State of West Virginia individual health insurance market.

XIII. INDEX RATE

Index Rate Development

The experience index rate represents the estimated total combined EHB allowed claims PMPM of CWV’s non-grandfathered individual West Virginia plans. The index rate has not been adjusted for risk adjustment transfers, reinsurance fees / recoveries, or Exchange fees. The experience period index rate reflects the actual mixture of tobacco / non-tobacco population, area factors, and the actual mixture of risk morbidity that CWV received in the Single Risk Pool during the experience period.

The experience period index rate is less than the experience period total allowed claims PMPM since CWV covers non-EHBs.

The index rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The projected index rate reflects the projected 2018 mixtures of tobacco / non-tobacco population, area factors, and the projected mixture of risk morbidity that CWV expects to receive in the single risk pool. The projected index rate has not been adjusted for payments and charges projected under the risk adjustment and reinsurance programs, or for Exchange user fees.

I develop the 2018 projected index rate from a credibility-weighted blend of 2016 allowed claims experience and the 2018 West Virginia manual rate allowed PMPM. The projected index rate is shown in Worksheet 1, Section III of the URRT.

Section V (Projection Factors Applied to Experience) describes the development of the West Virginia experience portion of the index rate, and Section VI (Credibility Manual Rate Development) describes the development of the 2018 West Virginia manual rate. CWV has no transitional plan members included in the projected index rate. The projected index rate covers a 12-month period for individuals effective January 1, 2018 through December 31, 2018. As described in Sections V and VI, the projected index rate reflects the anticipated claim level of the projection period with respect to trend, benefits, and demographics.

The projected index rate for January 1, 2018 through December 31, 2018 is $679.88, as shown in Worksheet 1, Section III of the URRT, and in Exhibit 2.

XIV. MARKET-ADJUSTED INDEX RATE

The market-adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 CFR Part 156, §156.80(d)(1). I project exchange fees as 3.5% of premium (Section X. Non-Benefit Expenses and Profit & Risk), reinsurance recoveries net of contribution as $0.00 PMPM, and a risk adjustment transfer $87.99 PMPM (Section IX. Risk Adjustment and Reinsurance). Table 9 displays the development of the market-adjusted index rate.
XV. PLAN-ADJUSTED INDEX RATE

The market-adjusted index rate is adjusted to compute the plan-adjusted index rates using the following allowable adjustments:

**Actuarial Value and Cost Sharing Adjustment**

The CMS Actuarial Value Calculator was used to determine the metal level actuarial value for each plan. The Actuarial Value and cost-sharing factors were developed in an internal Milliman cost relativity model, which is based on Milliman’s commercial HCGs. This model estimates actuarial equivalent relative values of different benefit plans using estimated medical costs calibrated to CWV (including service area, provider reimbursement, degree of health care management, etc.). Appendix F displays this development.

Appendix F column 2 represents the plan design behavior factor for each plan as priced (i.e., before the values are normalized to the composite plan design behavior factor). Appendix F column 4 represents the actuarial values for each plan and is consistent with Appendix A subject to rounding, while Appendix F, column 5 represents the AV and Cost Sharing used in other appendices and is calculated as the composite of column 3 (column (2) normalized to composite to 1.000) and column 4.

The AV and Cost Sharing factors reflect full plan liability for CSR silver plans.

**Provider Network, Delivery System, and Utilization Management Adjustment**

CWV provided their estimated provider network reimbursement rates based on their contractually negotiated reimbursement arrangements to date. Negotiations are ongoing, and contractual provider reimbursements may vary from the ones I assume in my pricing. Section V. Projection Factors Applied to Experience provides additional details.

**Adjustment for Benefits in Addition to the EHBs**

I adjust Products 50328WV002 and 50328WV005 to include Non-EHB adult dental, eyeglass, and adult vision exam benefits. Eyeglasses are covered up to an annual maximum of $250. Basic and major adult dental services are covered up to a combined annual maximum of $800. I adjust Products 50328WV001 and 50328WV003 to include Non-EHB adult routine eye exams. Exhibit 7 shows the value of Non-EHBs in addition to EHBs.
Impact of Specific Eligibility Categories for the Catastrophic Plan

CWV is not offering a Catastrophic plan in 2018.

Adjustment for Distribution and Administrative Costs

Distribution and administrative costs were developed and applied to each plan as a mix of “percent of premium,” “percent of claim,” and PMPM bases.

The plan-adjusted index rate development is shown in Appendix B.

Adjustment for Tobacco Premium Differential

CWV applies a tobacco premium load for users age 21 and over that varies by age. I determine this rate was reasonable as it results in a similar weighted average premium adjustment compared to the projected tobacco morbidity surcharge. Exhibit 8 displays the development of the tobacco adjustment factor.

XVI. CALIBRATION

The approximate average age of the single risk pool to equal the correct age calibration factor is . The age curve calibration is applied to all plans. I composite the CMS-approved premium factors by the projected membership at each age based on emerging 2017 membership. I then round the weighted average premium factor to the nearest table value to determine the average rounded age. My development of the weighted average age calibration complies with the standard age curve methodology and with applicable rating rules. Exhibit 9 displays the development of the age calibration factor.

CWV applies geographic rating factors to its plans as shown in Table 10. The geographic rating factors were developed based on the area factors in Milliman’s HCGs, projected provider reimbursement discounts in each geographic area, and the relative geographic and reimbursement-based differences among areas used in the 2017 pricing. Exhibit 10 displays the development of the geographic calibration factor.

<table>
<thead>
<tr>
<th>Rating Area</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating Area 1</td>
<td></td>
</tr>
<tr>
<td>Rating Area 2</td>
<td></td>
</tr>
<tr>
<td>Rating Area 3</td>
<td></td>
</tr>
<tr>
<td>Rating Area 4</td>
<td></td>
</tr>
<tr>
<td>Rating Area 5</td>
<td></td>
</tr>
<tr>
<td>Rating Area 8</td>
<td></td>
</tr>
<tr>
<td>Rating Area 9</td>
<td></td>
</tr>
<tr>
<td>Rating Area 10</td>
<td></td>
</tr>
<tr>
<td>Rating Area 11</td>
<td></td>
</tr>
</tbody>
</table>

The development of the calibrated plan adjusted index rates are shown in Appendix C.
XVII. CONSUMER-ADJUSTED PREMIUM RATE DEVELOPMENT

The consumer-adjusted premium rate is the final premium rate for a plan charged to an individual utilizing the rating and premium adjustments as articulated in the applicable market reform rating rules. It is the product of the calibrated plan adjusted index rate, the geographic rating factor, the age rating factor, and the tobacco rating factor. The tobacco rating factors are 1.00 for children and between 1.10 and 1.18 for ages 21 and over.

Appendix D summarizes Appendices A, B, and C and shows a consumer adjusted premium rate calculated from the index rate.

Rates are charged only for the three oldest covered children under the age of 21 for family coverage. Attachment A provides all rating factors and a sample premium calculation.

XVIII. AV METAL LEVELS

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed using the CMS Actuarial Value calculator and are shown in Attachment B.

XIX. AV PRICING VALUES

Appendix E provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and a breakdown of the components attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2), to arrive at the plan level rate.

The AV and Cost Sharing factor calculation is the product of the non-normalized actuarial value and normalized benefit design behavior change factor from my pricing models. This calculation is shown in Appendix F. The impact of each plan’s actuarial value and cost sharing includes the expected impact of each plan’s benefit design on the member’s utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. I use the Milliman HCGs to estimate the value of cost-sharing and relative utilization of services for each plan. My pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

The AV pricing values reflect full plan liability for CSR silver plans.

XX. MEMBERSHIP PROJECTIONS

CWV projected membership (as displayed in Worksheet 2, Section IV of the URRT) is detailed in Section V and in Table 2 of this memorandum.

Methodology to Project Cost Sharing Reduction (CSR) Eligibles: I estimate CSR eligibles based on the actual 2017 distribution to date.

Projected Cost Sharing Reduction (CSR) Eligibles: For the Silver level plans, I assume a member will generally select the richest benefit plan the member qualifies for a given income level (I understand that some individuals will not select the richest subsidy for which they qualify based on personal preference, but I do not expect this impact to be material). This approach produced the distribution across the Silver level plans shown in Table 11.
XXI. TERMINATED PRODUCTS

Exhibit 11 outlines the 2017 plans terminating prior to January 1, 2018 and the 2018 plan to which they are mapped.

A number of 2016 plans were crosswalked prior to January 1, 2017. These are listed in Exhibit 11.

XXII. PLAN TYPE

CWV’s plans are HMO plans as noted in Worksheet 2, Section I of the URRT.

XXIII. WARNING ALERTS

The following warning alerts appear in Worksheet 2, Section III of the URRT:

Total Allowed Claims (Row 61) – This warning is triggered because risk adjustment transfers are included in worksheet 2, but not included in worksheet 1. URRT instructions state, “The Total Allowed Claims (TAC) across all benefit plans for the Experience Period should be consistent with the Allowed Claims entered in Section I of Worksheet 1, except it should be net of Risk Adjustment transfers.”

Allowed Claims PMPM (Row 74) – This warning is triggered because these values are simply the values causing the row 61 warning divided by member months.

The following warning alerts appear in Worksheet 2, Section IV of the URRT:

Total Allowed Claims (Row 87) – This warning is triggered because risk adjustment transfers are included in worksheet 2, but not included in worksheet 1, similar to the row 61 warning. URRT instructions state, “The Total Allowed Claims (TAC) across all benefit plans for the projection period should be consistent with the total allowed claims and the projected risk adjustments entered in Section III of Worksheet 1.”

Total Incurred Claims, Payable with Issuer Funds (Row 94) – This warning is triggered because these values are based on the values causing the row 87 warning. Risk adjustment transfers are included in worksheet 2, but not included in worksheet 1.

Incurred Claims PMPM (Row 99) – This warning is triggered because these values are simply the values causing the row 94 warning divided by member months.

Allowed Claims PMPM (Row 100) – This warning is triggered because these values are simply the values causing the row 87 warning divided by member months.
XXIV. EFFECTIVE RATE REVIEW INFORMATION

Information is available upon request.

XXV. RELIANCE

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I rely on information provided to us by the CWV management and its affiliates. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum along with many of my conclusions may be materially affected.

I perform a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

A data reliance letter is attached to this rate submission.

XXVI. ACTUARIAL CERTIFICATION

I am an Actuary with the firm of Milliman, Inc. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of CWV.

I certify to the best of my knowledge and judgment:

1. The projected index rate is:
   - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
   - Developed in compliance with the applicable Actuarial Standards of Practice,
   - Reasonable in relation to the benefits provided and the population anticipated to be covered, and
   - Not excessive, but potentially deficient based on my best estimates of the 2018 individual market.

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

3. 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.

4. The geographic rating factors reflect only differences in the costs of delivery (e.g., unit costs, provider practice pattern differences) and do not include differences for population morbidity by geographic area.

5. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.
The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of 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.

The 2018 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2018 plan year premium rates provided in this Actuarial Memorandum. Changes include, but are not limited to, any legislative or regulatory amendment, court decision, or a decision by Congress, the Health and Human Services Secretary or the Centers for Medicare and Medicaid Services director whether to fund cost-sharing reduction subsidies, advance premium tax credits or a decision not to enforce the individual mandate requirement and penalty. Milliman expresses no opinion with regard to the future funding of CSR payments.

The information provided in this Actuarial Memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

The results are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

Respectfully submitted,

Erik C. Huth, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.

ECH/kal

Attachments
RELIANCE LETTER
April 24, 2017

Mr. Erik Huth, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
15800 Bluemound Road. Suite 100
Brookfield, WI 53005-6069

Re:  CareSource’s 2018 Individual Pricing

Dear Erik:

I, Scott Brockman, Director Risk Adjustment & Actuarial Science, CareSource West Virginia Co. (CareSource) hereby affirm the data sources, assumptions, and information identified below and provided to Milliman, Inc. for developing CareSource’s 2018 individual commercial premium rates were prepared under my direction. These items were relied upon by Milliman and are, to the best of my knowledge, accurate and complete. Finally, I affirm all information that affects the 2018 individual premium rate development has been given to you, and I have disclosed all items of which I am aware that would have a material impact on the rate projections.

The information provided includes:

1. Specific 2017 plans CareSource intends to renew or terminate,
2. Benefit plans and networks CareSource offers in 2018,
3. The rating regions in each state in which CareSource offers products in 2018,
4. HIOS Product Names, Product IDs, and Plan Names for each 2018 benefit plan,
5. Renewal / new plan status based on compliance with the Uniform Modification regulations.
6. Historical 2016 claim experience and membership for CareSource's products and plans,
7. Estimates of CareSource’s 2016 risk adjustment transfer payments, federal reinsurance recoveries, and cost-sharing subsidy receipts,
8. Confirmation that the cost relativity associated with each rating area provided by CareSource does not include the impact of morbidity,
9. Projected administrative expenses and target profit margin,
10. Projected 2018 enrollment by county and plan,
11. Description of contractual provider reimbursement arrangements, including actual 2016 and projected 2018 provider discounts by service category,
12. Other information provided by CareSource in various meetings, phone calls, emails, and other correspondence,
Assurance that CareSource has completed the plan benefit template and has found no meaningful discrepancies in Actuarial Value calculations.

April 24, 2017
Date

Signature