

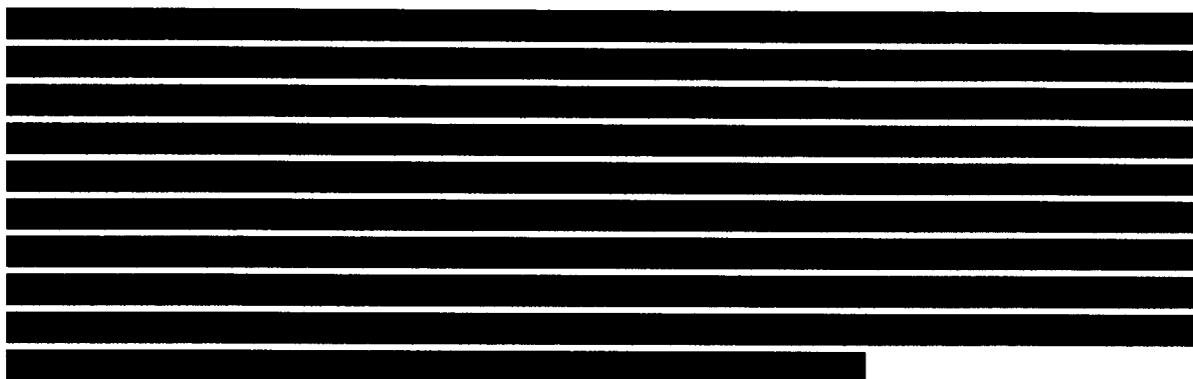
Part III Actuarial Memorandum

**BlueCross BlueShield of Illinois
Individual Rate Filing
Effective January 1, 2016**

Health Care Service Corporation
Blue Cross Blue Shield of Illinois
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Introduction

This Actuarial Memorandum supports a rate filing on behalf of Blue Cross and Blue Shield of Illinois (BCBSIL), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association for the Individual medical policies.



Sales of these policies began on January 1, 2014. The experience period used for the development of these filed rates is calendar year 2014. Whether this data proves to be reflective of normal patterns or an anomaly due to the transition to the new circumstances remains unknown.

This Actuarial Memorandum has been prepared for the sole purpose of demonstrating compliance with regulatory authority, including the Department of Health and Human Services' Part III Actuarial Memorandum and Certification Instructions and is not intended for and may not be appropriate for any other purpose.

General Information

Company Identifying Information

<i>Company Legal Name</i>	Blue Cross Blue Shield of Illinois
<i>State</i>	Illinois
<i>HIOS Issuer ID</i>	36096
<i>Market</i>	Individual
<i>Effective Date</i>	January 1, 2016

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Company Contact Information

<i>Primary Contact Name</i>	[REDACTED]
<i>Primary Contact Telephone</i>	[REDACTED]
<i>Primary Contact Email</i>	[REDACTED]

Proposed Rate Increase(s)

The proposed increase is 17.8% across the entire block of BCBSIL Individual ACA-compliant plans effective January 1, 2016, and reflects the expected migration to available plans. The premium rate changes will vary by plan.

Reason for Rate Increase(s)

The proposed rates are primarily based on the following factors:

- Claim experience for the population insured in the experience period,
- Anticipated medical inflation from the experience period to the projection period,
- Anticipated utilization changes from the experience period to the projection period,
- Changes in member cost sharing,
- Anticipated change in morbidity of the single risk pool population,
- Anticipated change in morbidity of the market wide population,
- Anticipated changes in demographics,
- Anticipated changes in the provider network,
- Anticipated payments from and contributions to the Federal Transitional Reinsurance Program,
- Permitted rating factors (geographic area, age and tobacco use), and
- Anticipated administrative expenses including taxes and fees imposed on the insurer

The cost relativities among products are different from the experience period to the prospective rating period due to anticipated non-uniform changes in network reimbursement levels. Additionally, the rates vary by plan due to the leveraging and utilization driven by variations in member cost sharing. Therefore, the proposed rates may vary by both product and plan.

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Experience Period Premium and Claims

Paid Through Date

Payments have been made through January 31, 2015 on claims incurred during the experience period calendar year.

Premiums (net of MLR Rebate) in Experience Period

Earned premiums were determined using corporate earned premium records. Individual earned premium is derived by taking the collected premiums plus the change in unearned premium (prior month unearned premium reserve less current month unearned premium reserve). After determining earned premiums, the 2014 accrual for MLR rebates, if any, was backed out.

We do not anticipate refunding premiums through MLR rebates for 2014. The earned premiums and MLR rebates accrued are:

- Earned Premium = \$1,630,577,401
- MLR Rebates accrued = \$0

The 2014 rebate accrual was calculated in accordance with the prescribed methodology from the HHS MLR Report.

Allowed and Incurred Claims Incurred During the Experience Period:

Allowed claims and Incurred claims are pulled from the same source(s) and calculated using a similar methodology. Only claim amounts for members in the Individual single risk pool for claims which have already been processed are included in our claim data (incomplete claims). A set of completion factors are then applied to the incomplete claims to develop the expected Allowed and Incurred Claims for the experience period.

Allowed claims for capitation are assumed to equal the capitation amount in the experience period divided by the paid to allowed ratio for fee-for-service professional claims. Both allowed and incurred claims were reduced by drug manufacturer rebates.

The allowed claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = ██████████
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = ██████████

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- Best estimate of claims incurred but not paid as of the Paid Through Date = [REDACTED]

The incurred claims incurred during the experience period, are:

- Best estimate of claims incurred and paid through the claim system as of the Paid Through Date = [REDACTED]
- Best estimate of claims incurred and paid outside the claim system as of the Paid Through Date = [REDACTED]
- Best estimate of claims incurred but not paid as of the Paid Through Date = [REDACTED]

Claims paid outside the claim system consist primarily of drug manufacturer rebates and capitation paid to providers. The methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in Experience Period was the same.

The methodology used to develop the estimate of claims incurred but not yet paid incorporates estimates based upon developed completion factors, a regression method, and credibility. Consideration is given to additional relevant information not fully reflected in the models. Model results are evaluated for reasonableness and actuarial judgment may be applied.

The claims used to develop any completion factors reflect the experience period claims for the information submitted. The incurred but not paid claims are not unusually high or unusually low relative to the experience period claims paid.

Benefit Categories

The claims experience that appears on Worksheet 1, Section II, is broken into six benefit categories: Inpatient Hospital, Outpatient Hospital, Professional, Other Medical, Capitation and Prescription Drug. We used a combination of claim/procedure specific attributes (including but not limited to ICD-9, Revenue Codes, CPT4, HCPCS and NDCs) to determine which category each claim in the experience period falls.

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Benefit Category	Category Description
Inpatient Hospital	Includes non-capitated facility services for medical, surgical, maternity, 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, and other professional services, other than hospital based professionals whose payments are included in facility fees.
Other Medical	Includes non-capitated ambulance, DME, prosthetics, supplies, and other services.
Capitation	Includes all services provided under one or more capitated arrangements.
Prescription Drug	Includes drugs dispensed by a pharmacy, net of any rebates received from drug manufacturers.

Due to the variability of benefits included in the "Other Medical" benefit category, we are characterizing this as simply "Annual Units per Member", such that the per unit cost is meant to represent the annual per member allowed charges.

A capitation payment is generated for each member's month of coverage. As such, we are characterizing the measurement unit in Worksheet 1, Section II as member months.

Projection Factors

Changes in the Morbidity of the Population Insured

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Changes in Benefits

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

Changes in Demographics

The assumptions for changes in demographics were developed by comparing the population mix from the experience period to the assumed population mix in the projection period. The assumed population mix in the projection period was developed in the manner described in the "Changes in the Morbidity of the Population Insured" section.

Age and gender cost relativities were developed using internal allowed claims data normalized for other demographic characteristics and applied to each of the 2014 single risk pool and 2016 expected population to determine the expected change in cost due to age and gender mix.

Other Adjustments

Other adjustments were made to the allowed charges to reflect [REDACTED] and the impact of removing the pre-existing condition exclusions and rider exclusions. The impact of removing pre-existing condition and rider exclusions was developed using internal claims data on claims denied for these reasons. [REDACTED]

Trend Factors (cost/utilization)

[REDACTED]

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[REDACTED]

The source data has adjustments applied:

- to normalize for age and gender
- for seasonality patterns
- for any one-time events not anticipated to reoccur during the projection period
- for anticipated changes to the provider contracts that differ from those underlying the experience period, and
- for anticipated changes to prescription drug mix and utilization.

[REDACTED]

Credibility of Experience

We have assigned full credibility to our base experience data, appropriately adjusted to reflect the material changes anticipated between the experience period and the projection period.

There are no material changes from the prior credibility procedures.

Paid to Allowed Ratio

The paid to allowed average factor in the projection period for the market, shown in Worksheet 1, Section III uses the assumed population distribution across the metallic plans. Each metallic plan assumes a paid to allowed ratio based entirely on BCBSIL historical experience. The paid to allowed average factor may ultimately differ from the factor presented if member migration to the metallic plans does not follow the distribution assumed.

Worksheet 1, Section III shows an expected aggregate paid to allowed factor of [REDACTED]
Worksheet 2, Section IV shows an expected aggregate paid to allowed factor of [REDACTED], based on following calculation:

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Paid Amount = Total Incurred claims, payable with issuer funds (cell F93)
+ Net Amount of Reinsurance (cell F95)
+ Net Amount of Risk Adjustment (cell F96)

Allowed Amount = Total Allowed Claims (cell F86)

Worksheet 2 Paid to Allowed Ratio = [REDACTED]

The difference between the Worksheet 1 Paid to Allowed Ratio and the Worksheet 2 Paid to Allowed Ratio is the impact of the risk adjustment user fees and the Federal reinsurance contributions which are included in the values in cell F95 and cell F96 in Worksheet 2.

The “portion of allowed claims payable by HHS’s funds on behalf of insured person” is excluded from the paid to allowed calculation.

The ratio for each plan is consistent with the corresponding metallic actuarial value, but adjusted for narrow networks to be reasonably lower due to the leveraging impact of anticipated reduced claims costs associated with provider network differences.

Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

[REDACTED]

[REDACTED]

Projected Risk Adjustments PMPM

Estimates of the Risk Adjustment revenue were developed using information from the Membership Model described in the Population Morbidity section, and incorporating that into the risk adjustment transfer formula provided by HHS in the final notice of benefit and payment parameters.

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[REDACTED]

Market and plan level inputs to the risk adjustment transfer formula are shown in the table below.

Carrier	PLRS	IDF	GCF	ARF	AV	Market Share
BCBSIL	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total Market	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

The inputs were estimated using the following information. PLRS, IDF, GCF, ARF, and AV are defined by HHS in the Final Notice of Benefit and Payment Parameters.

- **PLRS (Plan Liability Risk Score):** The baseline is estimated from the Membership Model, then adjusted for estimated carrier risk capture efficiency. Risk capture efficiency is the ability of a carrier to properly document the risk it carries. Large carriers and carriers with experience in other risk adjustment markets (such as Medicare Advantage) are expected to more efficiently document the conditions of their members.
 It is important to note that the risk scores used in the Membership Model are not HHS risk scores, and as such do not contain a provision for the metal level of the enrollee.
- **(Induced Demand Factor):** [REDACTED]
- **GCF (Geographic Cost Factor):** Sourced from the Membership Model and calculated as prescribed by HHS regulations.
- **ARF (Allowable Rating Factor):** Ages of enrollees are sourced from the population model, and the standard CMS age curve is applied to determine the ARF.
- **AV (Actuarial Value):** [REDACTED]
- **Market share:** Sourced from the Membership Model.

Final calculation of risk adjustment transfer estimate is below. Note that the calculation is actually applied at the level of carrier/area combination as per HHS regulations.

Net Plan Average Risk Adjustment %

$\frac{[REDACTED]}{[REDACTED]}$	$\frac{[REDACTED]}{[REDACTED]}$
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Net Plan Average Risk Adjustment %	██████
Net Plan Average Risk Adjustment % Adjusted for Market Premium	██████

The pool that buys insurance and the risk of this pool was generated by the Membership Model. To the extent that purchasing decisions and risk scores are different from the BCBSIL modeling results, then this could have an impact on the transfers.

The difference between BCBSIL average premium and market average premium is sourced from the Membership Model. This difference is the basis for the "Net Plan Average Risk Adjustment % Adjusted for Market Premium" shown in the chart above. To the extent that Market Premium differs from BCBSIL premium other than this assumption, then this could have a significant impact on transfers.

The estimated risk adjustment transfers are net of the Risk Adjustment User Fee and were allocated uniformly to all products and plans as a percentage of the premium. For the purposes of Worksheet 1, Section III and Worksheet 2, Section IV, we have converted the percentage of premium as described to a PMPM. The final PMPM netted for the user fee is ██████

Projected ACA Reinsurance Recoveries Net of Reinsurance:

Underlying medical and prescription drug experience data from existing blocks of Small Group and Individual business from Health Care Service Corporation were evaluated for claim incidence rates. This data set was used to simulate how the national Reinsurance recoveries would develop during 2016.

Further, HHS has stated they intend to adjust the published coinsurance rate to achieve disbursing the entire amount of the Reinsurance Contributions collected. This is an expected ██████ for 2016.

We then simulated the 2016 published payment parameters under various coinsurance scenarios to achieve a national payout of ██████ assuming an eligible membership base of ██████.

Based on this, the 2016 Reinsurance recovery parameters that were applied to the claims distribution are:

- Attachment point: \$90,000
- Coinsurance after attachment point: ██████
- Gross claims cap: \$250,000

The resulting 2016 Reinsurance recovery PMPM based on the above is ██████

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The 2016 Reinsurance contribution published in the 2016 Notice of Benefit and Payment Parameters is \$27.00 PMPY or about \$2.25 PMPM.

Therefore the assumed amount of the Reinsurance assessment, which is Reinsurance recoveries net of Reinsurance contributions, is [REDACTED] PMPM.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

The administrative expense load built into the pricing of the Individual products is based on allocated expenses as they exist in the current operating model, adjusted for expected 2016 membership, expected expense inflation, and other budgeted adjustments related to the Individual block of business. Additionally, all Individual premiums include a flat load to account for commissions, which incorporate the expected external sales commission percentage.

The source data is based on allocated expenses applicable to each line of business as they exist in the current operating model which has been adjusted for expected expense inflation, expected membership in 2016, and changes in operations as a result of the Exchanges. Membership in 2016 is aligned with the migration model as described in the Membership Projections section.

Administrative expenses are allocated uniformly as a percentage of premium across all products and plans.

Profit (or Contribution to Surplus) & Risk Margin

The pre-tax target contribution to surplus, inclusive of underwriting gain/ loss margin and any additional risk margin, is [REDACTED] of the billed premiums. The after-tax target contribution to surplus, inclusive of underwriting gain/ loss margin and any additional risk margin, is [REDACTED] of the billed premiums. The target as a percent of premium has not changed from the prior submission.

Please note, there is a distinction between the pricing margin used in ratemaking, which is [REDACTED], and the [REDACTED] pre-tax target contribution to surplus. The pricing margin used for ratemaking includes an adjustment for not being able to rate for the additional cost of children in excess of three children on a policy. In addition, the pricing margin used for ratemaking includes an adjustment for not being able to collect premium from terminating Advanced Premium Tax Credit (APTC) eligible members in the first month of their grace period.

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Single Risk Pool

The Single Risk Pool for the experience period includes all non-grandfathered covered lives in the Illinois Individual market. This includes transitional products and plans. The Single Risk Pool for the projection period includes all covered lives projected to enroll in a fully ACA-compliant plan during the projection period.

Index Rate

The index rate represents the estimated total allowed claims per member per month (PMPM) for all non-grandfathered plans for essential health benefits (EHBs) in the Illinois Individual market.

[REDACTED]

[REDACTED]

The Index Rate is then adjusted for:

- Expected payments and charges under the risk adjustment program including the Risk Adjustment User Fee,
- Expected payments from and contributions to the Transitional Reinsurance Program,
- Exchange user fees, on a market wide basis,
- Administrative costs excluding Exchange user fees,
- Other taxes and fees as described in the Taxes and Fees section, and
- Contribution to Surplus & Risk Margin

The plan rate level can be determined by further adjusting the Index Rate for:

- [REDACTED]

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- [REDACTED]

Market Adjusted Index Rate

The Market Adjusted Index Rate is the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules. These modifiers include the federal reinsurance program, risk adjustment, and exchange fees.

The Market Adjusted Index Rate is calculated as follows:

$$\text{MAIR} = \text{IR} - \text{FRPP} + \text{FRPC} - \text{RAR} + \text{RAF} + \text{EF}, \text{ where}$$

MAIR = Market Adjusted Index Rate

IR = Index Rate

FRPP = Federal Reinsurance Program Payments

FRPC = Federal Reinsurance Program Contribution

RAR = Risk Adjustment Receipts

RAF = Risk Adjustment Fees

EF = Exchange Fees

[REDACTED]

The Payments and Contributions for the Federal Reinsurance Program and Risk Adjustment program are described in the "Risk Adjustment and Reinsurance" section. The Exchange Fee is described in the "Taxes and Fees" section.

Plan Adjusted Index Rate

The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for the AV Pricing Value.

The AV Pricing Value is made up of the following components:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

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The AV Pricing Value is the product of these components. The values for each of these components and the final resulting AV Pricing Value for each SCID can be found in the AV Pricing Values section.

[REDACTED]

Calibration

Age Curve Calibration

The approximate weighted average age associated with the projected 2016 single risk pool is [REDACTED]. The approximate average age factor associated with the projected single risk pool is [REDACTED].

[REDACTED]

The age curve calibration adjustment is not plan specific. The same approximate average age factor was applied to all plans in the projected single risk pool.

CMS's instruction to us was to remove an adjustment to our age calibration that was intended to recognize expected additional incurred claims for families having more than three children under age 21, who can only be charged for the first three children under age 21. The instruction to remove this adjustment falls under an "assumption or method prescribed by law," as discussed in Actuarial Standards of Practice No. 41, *Actuarial Communications*.

There are greater expected medical costs for families with more than three children than for families with three children. In my professional judgment, an actuarially sound ratemaking methodology needs to appropriately recognize this additional cost in the ratemaking process. To both comply with CMS's instructions regarding age calibration and to produce rates that are actuarially sound, we are increasing our pricing margin by an amount that will allow premiums to cover this additional cost. The additional cost results in an increase to premium of [REDACTED].

We would like to point out the distinction between the pricing margin used in ratemaking from the pre-tax target contribution to surplus, which is discussed in the section of this memorandum entitled Profit (or Contribution to Surplus) & Risk Margin.

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I have reviewed Actuarial Standard of Practice No. 8, *Regulatory Filings for Health Plan Entities* in addition to reviewing Actuarial Standard of Practice No. 41 in determining and disclosing an actuarially sound approach.

Geographic Factor Calibration

[REDACTED]

[REDACTED] age of the newly developed factor and the current geographic rating factor for the area.

The geographic factors used are as follows:

<u>State</u>	<u>Rating Area</u>	<u>Area Factor</u>
IL	Area 01	[REDACTED]
IL	Area 02	[REDACTED]
IL	Area 03	[REDACTED]
IL	Area 04	[REDACTED]
IL	Area 05	[REDACTED]
IL	Area 06	[REDACTED]
IL	Area 07	[REDACTED]
IL	Area 08	[REDACTED]
IL	Area 09	[REDACTED]
IL	Area 10	[REDACTED]
IL	Area 11	[REDACTED]
IL	Area 12	[REDACTED]
IL	Area 13	[REDACTED]

The approximate average geographic factor associated with the projected single risk pool is [REDACTED]

The geographic factor calibration adjustment is not plan specific. The same approximate average geographic factor was applied to all plans in the projected single risk pool.

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Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by first dividing the Plan Adjusted Index Rate by the average age factor and the average geographic factor. The result can then be multiplied by the individual's specific age factor, geographic factor, and tobacco factor to determine the approximate Consumer Adjusted Premium Rate. The premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account.

CAPR = Consumer Adjusted Premium Rate

$$\text{CAPR} = \frac{\text{Plan Adjusted Index Rate}}{\text{Age Calibration} \times \text{Geographic Calibration} \times \text{Tobacco Factor}} \times \text{Age Factor} \times \text{Geographic Factor}$$

Example Calculation for age 40 in Rating Area 1

Plan: Blue Choice Preferred Silver PPO 104, 36096IL0990004

Plan Adjusted Index Rate = [REDACTED]

Age Calibration = [REDACTED]

Geographic Calibration = [REDACTED]

Age 40 Factor = [REDACTED]

Non-Tobacco Factor = [REDACTED]

Rating Area 1 Factor = [REDACTED]

$$\text{CAPR} = \frac{[REDACTED]}{[REDACTED] \times [REDACTED] \times [REDACTED]} \times [REDACTED] \times [REDACTED]$$

The Premium Rate listed in the Rates Template is [REDACTED]. Differences are due to rounding.

AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were entirely based on the AV Calculator.

AV Pricing Values

The AV Pricing value represents the relative cost of each plan. The table below indicates the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2).

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Plan ID	FPL 200-250%	FPL 150-200%	FPL 100-150%
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Terminated Products

The following products will be terminated prior to January 1, 2016.

Product ID	Product Name	Product Type/Description	Association Product?	Open or Closed	Grandfathered Product?
36096IL034	BlueEdge HSA	PPO	No	Closed	No
36096IL035	Select Blue	PPO	No	Closed	No
36096IL036	SelectBlue Advantage	PPO	No	Closed	No
36096IL037	Blue Value	PPO	No	Closed	No
36096IL038	BlueChoice Select	PPO	No	Closed	No
36096IL039	BlueChoice Value	PPO	No	Closed	No
36096IL040	BlueValue Advantage	PPO	No	Closed	No
36096IL048	BlueChoice Pathway	PPO	No	Closed	No
36096IL049	Blue Pathway	PPO	No	Closed	No
36096IL053	Illinois Harness Horseman's Association	Custom Product	Yes	Closed	No
36096IL054	Advocate Physician Partners	Custom Product	Yes	Closed	No
36096IL055	Cc Services Inc Agents Cotton States	Custom Product	Yes	Closed	No
36096IL085	HMO Individual Conversion	Transfer/Conversion	No	Closed	No
36096IL086	Individual PPO Conversion/Transfer	Transfer/Conversion	No	Closed	No
36096IL087	Traditional Blue	PPO	No	Closed	No
36096IL088	Basic Blue	PPO	No	Closed	No

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The following table provides a crosswalk between the terminated plans and the new plans for 2016.

Original Standard Component ID	Original Plan Name	2015 Standard Component ID	2016 Standard Component ID
36096IL0790001*	Blue Choice Gold PPO 001		
36096IL0790001*	Blue Choice Gold PPO 001		
36096IL0790001*	Blue Choice Gold PPO 001		
36096IL0790001*	Blue Choice Gold PPO 001		
36096IL0790001*	Blue Choice Gold PPO 001		
36096IL0790002*	Blue Choice Gold PPO 002		
36096IL0790002*	Blue Choice Gold PPO 002		
36096IL0790002*	Blue Choice Gold PPO 002		
36096IL0790002*	Blue Choice Gold PPO 002		
36096IL0790002*	Blue Choice Gold PPO 002		
36096IL0790003	Blue Choice Silver PPO 003		
36096IL0790003*	Blue Choice Silver PPO 003		
36096IL0790003*	Blue Choice Silver PPO 003		
36096IL0790003*	Blue Choice Silver PPO 003		
36096IL0790003*	Blue Choice Silver PPO 003		
36096IL0790004*	Blue Choice Silver PPO 004		
36096IL0790004*	Blue Choice Silver PPO 004		
36096IL0790004*	Blue Choice Silver PPO 004		
36096IL0790004*	Blue Choice Silver PPO 004		
36096IL0790004*	Blue Choice Silver PPO 004		
36096IL0790005	Blue Choice Bronze PPO 005		
36096IL0790005*	Blue Choice Bronze PPO 005		
36096IL0790005*	Blue Choice Bronze PPO 005		
36096IL0790005*	Blue Choice Bronze PPO 005		
36096IL0790005*	Blue Choice Bronze PPO 005		
36096IL0790006	Blue Choice Bronze PPO 006		
36096IL0790006*	Blue Choice Bronze PPO 006		
36096IL0790006*	Blue Choice Bronze PPO 006		
36096IL0790006*	Blue Choice Bronze PPO 006		
36096IL0790006*	Blue Choice Bronze PPO 006		
36096IL0790007*	Blue Choice Gold PPO 007		
36096IL0790007*	Blue Choice Gold PPO 007		
36096IL0790007*	Blue Choice Gold PPO 007		
36096IL0790007*	Blue Choice Gold PPO 007		
36096IL0790007*	Blue Choice Gold PPO 007		

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Original Standard Component ID	Original Plan Name	2015 Standard Component ID	2016 Standard Component ID
36096IL0790008*	Blue Choice Security PPO 008		
36096IL0790008*	Blue Choice Security PPO 008		
36096IL0790008*	Blue Choice Security PPO 008		
36096IL0790008*	Blue Choice Security PPO 008		
36096IL0790008*	Blue Choice Security PPO 008		
36096IL0810001	Blue Precision Gold HMO 001		
36096IL0810001*	Blue Precision Gold HMO 001		
36096IL0810001*	Blue Precision Gold HMO 001		
36096IL0810001*	Blue Precision Gold HMO 001		
36096IL0810001*	Blue Precision Gold HMO 001		
36096IL0810001*	Blue Precision Gold HMO 001		
36096IL0810002	Blue Precision Silver HMO 002		
36096IL0810002*	Blue Precision Silver HMO 002		
36096IL0810002*	Blue Precision Silver HMO 002		
36096IL0810002*	Blue Precision Silver HMO 002		
36096IL0810002*	Blue Precision Silver HMO 002		
36096IL0810002*	Blue Precision Silver HMO 002		
36096IL0810003	Blue Precision Bronze HMO 003		
36096IL0810003*	Blue Precision Bronze HMO 003		
36096IL0810003*	Blue Precision Bronze HMO 003		
36096IL0810003*	Blue Precision Bronze HMO 003		
36096IL0810003*	Blue Precision Bronze HMO 003		
36096IL0810003*	Blue Precision Bronze HMO 003		
36096IL0810004	Blue Precision Platinum HMO 004		
36096IL0810004*	Blue Precision Platinum HMO 004		
36096IL0810004*	Blue Precision Platinum HMO 004		
36096IL0810004*	Blue Precision Platinum HMO 004		
36096IL0810004*	Blue Precision Platinum HMO 004		
36096IL0810004*	Blue Precision Platinum HMO 004		
36096IL0810005	Blue Precision Gold HMO 005		
36096IL0810005*	Blue Precision Gold HMO 005		
36096IL0810005*	Blue Precision Gold HMO 005		
36096IL0810005*	Blue Precision Gold HMO 005		
36096IL0810005*	Blue Precision Gold HMO 005		
36096IL0810005*	Blue Precision Gold HMO 005		
36096IL0810006*	Blue Precision Gold HMO 006		
36096IL0810006*	Blue Precision Gold HMO 006		

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Original Standard Component ID	Original Plan Name	2015 Standard Component ID	2016 Standard Component ID
36096IL0810006*	Blue Precision Gold HMO 006		
36096IL0810006*	Blue Precision Gold HMO 006		
36096IL0810006*	Blue Precision Gold HMO 006		
36096IL0810006*	Blue Precision Gold HMO 006		
36096IL0760001*	Blue PPO Gold 001		
36096IL0760002*	Blue PPO Gold 002		
36096IL0760003*	Blue PPO Silver 003		
36096IL0760004*	Blue PPO Silver 004		
36096IL0760005*	Blue PPO Bronze 005		
36096IL0760006*	Blue PPO Bronze 006		
36096IL0760010	Blue Security PPO 010		
36096IL0760012	Blue PPO Gold 012		
36096IL0760013*	Blue PPO Gold 013		
36096IL0780001	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
36096IL0780002*	Blue Cross Blue Shield Premier 2, a Multi-State Plan		
36096IL0780003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
36096IL0780004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
36096IL0780005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		

*For purposes of the URRT Worksheet 2, this 2014 Standard Component ID is not mapped to a 2016 Standard Component ID.

Warning Alerts

Warning Alert 1: Worksheet 2, Section III has a Warning Alert in cell A54 referencing the Plan Adjusted Index Rate PMPM. This value is compared to the Premiums (net of MLR Rebate) PMPM in Worksheet 1. The difference in the comparison values is [REDACTED]. The difference results from entering \$0 in the Plan Adjusted Index Rate field in the template for terminated non-single risk pool compliant plans, as per the instructions. The premium for these plans is included in Worksheet 1, but is not included in row 54 on Worksheet 2. Additionally, there is a difference in the distribution of ages, geography and benefits that was projected when the rates were filed versus what actually emerged.

Warning Alert 2: Worksheet 2, Section III has a Warning Alert in cell A56 referencing the Total Premium (TP). This value is compared to the Total Premiums (net of MLR Rebate) in Worksheet 1. The difference in the comparison values is [REDACTED]. The difference results from entering \$0 in the Plan Adjusted Index Rate field in the template for terminated non-single risk pool compliant plans, as per the instructions. The premium for these plans is included in

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Worksheet 1, but is not included in row 56 on Worksheet 2. Additionally, there is a difference in the distribution of ages, geography and benefits that was projected when the rates were filed versus what actually emerged.

Warning Alert 3: Worksheet 2, Section III has a Warning Alert in cell A67 referencing the Total Incurred claims, payable with issuer funds. The value is compared to the Aggregate Incurred Claims in the Experience Period in Worksheet 1. The difference in the comparison values is [REDACTED]. This difference is a result of the effects of the Risk Adjustment and Reinsurance programs, which are not included in the total experience in Worksheet 1, but are included in the plan level experience in Worksheet 2.

Warning Alert 4: Worksheet 2, Section III has a Warning Alert in cell A72 referencing the Incurred Claims PMPM. The value is compared to the PMPM Incurred Claims in the Experience Period in Worksheet 1. The difference in the comparison values is [REDACTED]. This difference is a result of the effects of the Risk Adjustment and Reinsurance programs, which are not included in the total experience in Worksheet 1, but are included in the plan level experience in Worksheet 2.

Reliance

I have relied upon financial data, summaries and analyses prepared by responsible officers and employees of Health Care Service Corporation and my analysis included such review of the assumptions as I considered necessary.

Actuarial Certification

I, [REDACTED], am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and I meet the qualification standards necessary to prepare and certify rate filings for health plan entities.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice, including:

- ASOP No. 1, Introductory Actuarial Standard of Practice
- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 41, Actuarial Communications

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I hereby certify to the best of my knowledge that:

1. I am a member of the American Academy of Actuaries.
2. The projected index rate is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (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;
3. The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates;
4. 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;
5. The newly developed geographic rating factors reflect only difference in the cost of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area. The final geographic rating factors for the projection period is a weighted average of the newly developed factor and the current geographic rating factor for a given area;
6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans; and
7. I have reviewed the values entered into the Part I Unified Rate Review Template and believe the values and assumptions upon which they are based are reasonable.

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

Respectfully submitted,

[Redacted Signature]

[Redacted Title]

Date: July 30, 2015