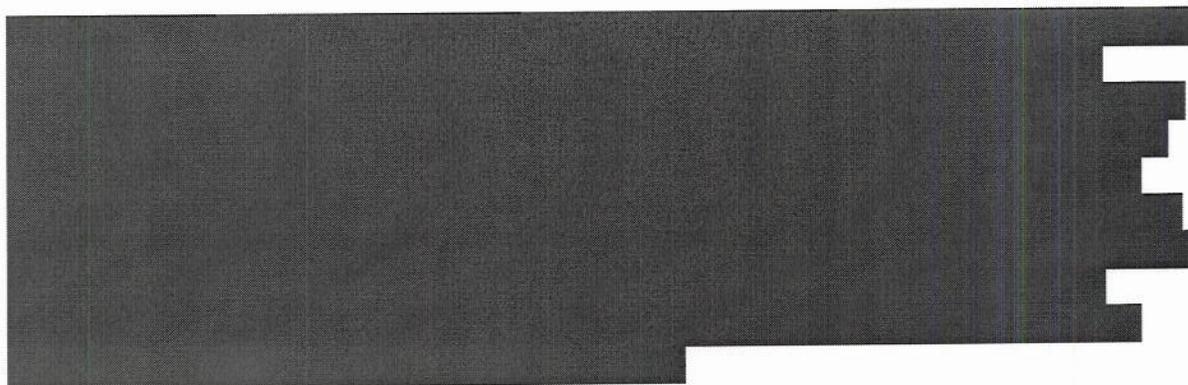


Part III Actuarial Memorandum

**Blue Cross Blue Shield of Oklahoma
Individual Rate Filing
Effective January 1, 2016**

Introduction:

This actuarial memorandum supports a rate filing on behalf of Blue Cross and Blue Shield of Oklahoma (BCBSOK), 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 Oklahoma
<i>State</i>	Oklahoma
<i>HIOS Issuer ID</i>	87571
<i>Market</i>	Individual
<i>Effective Date</i>	January 1, 2016

Company Contact Information:

Primary Contact Name	[REDACTED]
Primary Contact Telephone	[REDACTED]
Primary Contact Email	[REDACTED]

Proposed Rate Increase(s):

The proposed increase is 31.2% across the entire block of BCBSOK 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 provider networks,
- 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 differences driven by variations in member cost sharing. Therefore, the proposed rates may vary by both product and plan.

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 2014.

Premiums (net of MLR Rebate) in Experience Period:

Earned premiums were determined using corporate earned premium records. 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 = \$377,326,876
- MLR Rebates accrued = \$0

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

The rebate accruals/estimates shown above are for the blocks as defined by MLR; note that they include both grandfathered and non-grandfathered business and therefore are not equivalent to the earned premium and rebates for the single risk pool. In order to determine the MLR rebates for the single risk pool, the accrued rebate percentage relative to the Total MLR pool was applied to the single risk pool premium.

- Single Risk Pool Earned Premium = [REDACTED]
- Single Risk Pool MLR Rebates accrued = \$0

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 claims data (incomplete claims). A set of completion factors is 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 = [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]

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.

The methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in the 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.

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.

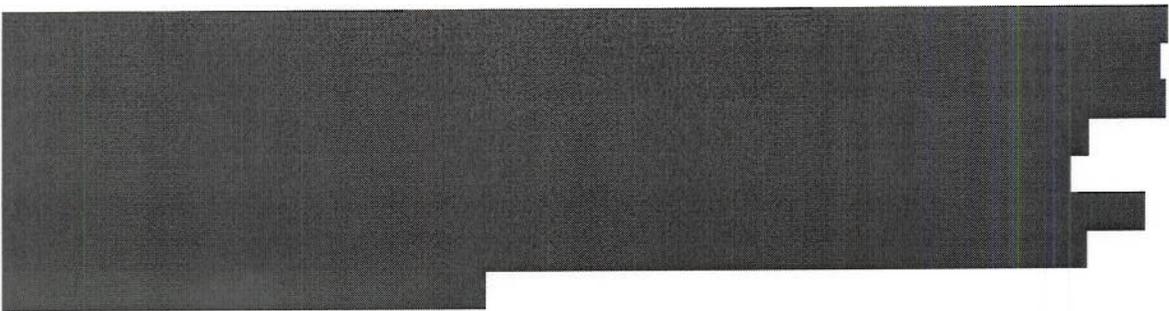
Outpatient Hospital	Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.
Professional	Includes non-capitated primary care, specialist, therapy, the professional 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.

For the "Capitation" benefit category, since capitation payments are made for each member's month of coverage for services provided under capitated arrangements, we are characterizing the per unit cost as the capitation per member per month for members with services provided under capitated arrangements.

Projection Factors:

Changes in the Morbidity of the Population Insured:



Changes in Benefits:



[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.

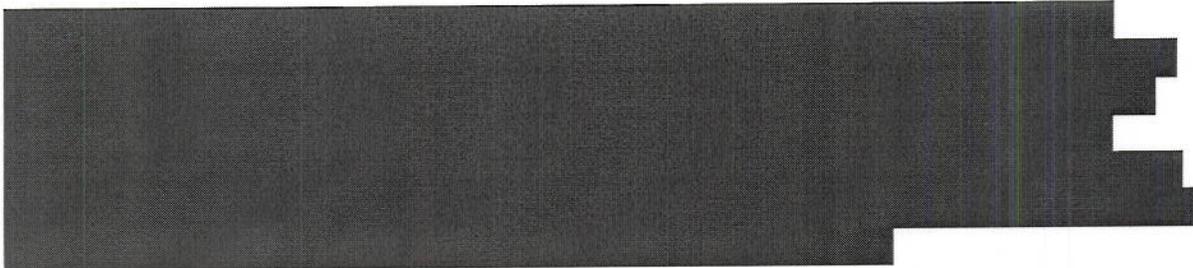
Other Adjustments:

Other adjustments were made to the allowed charges to reflect:

- [REDACTED]
- the impact of removing the pre-existing condition exclusions and rider exclusions, [REDACTED]

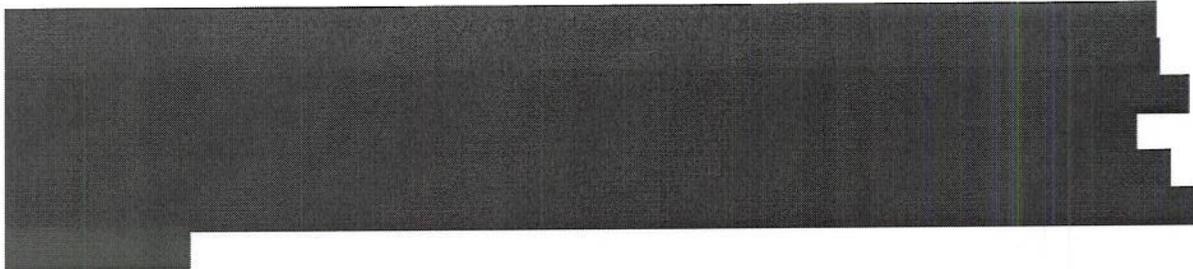
[REDACTED] The impact of removing pre-existing condition and rider exclusions was developed using internal claims data on claims denied for these reasons. [REDACTED]

Trend Factors (cost/utilization):



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.



Credibility of Experience:

We 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 BCBSOK 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 the following calculation:

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]

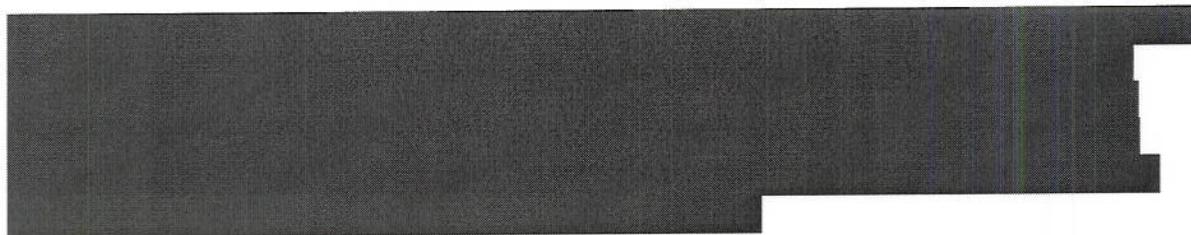
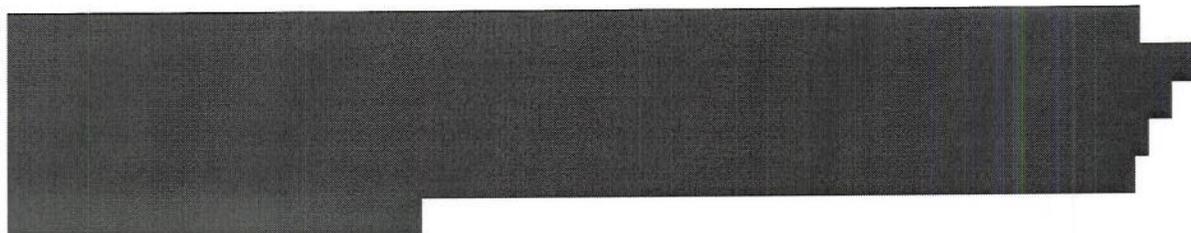
The difference between the Worksheet 1 Paid to Allowed Ratio and the Worksheet 2 Paid to Allowed Ratio is the impact of the risk adjustment user fees and the Federal reinsurance contributions which are included in the values in cell F95 and cell F96 in Worksheet 2.

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.

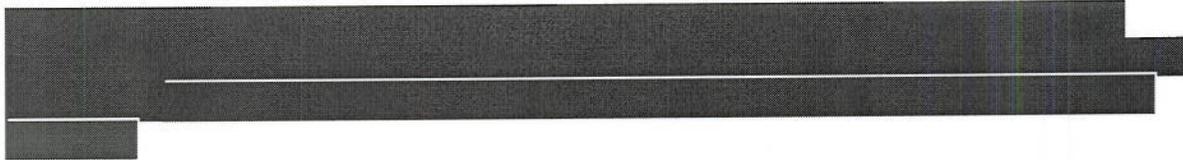
Risk Adjustment and Reinsurance:

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

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Projected Risk Adjustment PMPM:

Estimates of the risk adjustment revenue were developed using information from the Membership Model described in the “Changes in the Morbidity of the Population Insured” section and incorporating that into the risk adjustment transfer formula provided by HHS in the Final Notice of Benefit and Payment Parameters.



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
BCBSOK	[Redacted]					
Total Market	[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):** [Redacted]
- **IDF (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 risk transfer calculation is actually applied at the level of carrier/area combination as per HHS regulations.

Net Plan Average Risk Adjustment %

=



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 BCBSOK modeling results, this could have an impact on the transfers.

The difference between BCBSOK 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 BCBSOK premium other than this assumption, 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 [REDACTED]

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 [REDACTED] for 2016.

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

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

- Attachment point: \$90,000
- Coinsurance after attachment point: [REDACTED]

- Gross claims cap: \$250,000

The resulting 2016 Reinsurance recovery PMPM based on the above is [REDACTED]

The 2016 Reinsurance contribution published in the 2016 Notice of Benefit and Payment Parameters is \$27.00 PMPY, or \$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, and total expected expenses related to internal distribution costs for direct business.

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 Marketplace. Membership in 2016 is aligned with the migration model as described in the "Changes in the Morbidity of the Population Insured" 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.

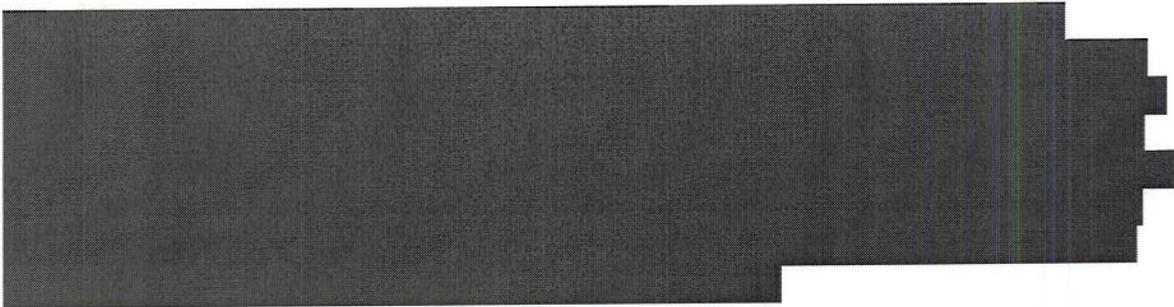
Please note, there is a distinction between the pricing margin used in ratemaking, which is [REDACTED] and the [REDACTED] pre-tax target contribution to surplus. The pricing margin used for ratemaking includes an adjustment for not being able to rate for the additional cost of children in excess of three 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.

Taxes and Fees:

All taxes and fees, whether calculated as a PMPM, PMPY, or percentage of premium, are allocated uniformly as a percentage of premiums across all products and plans. The following Taxes and Fees may be subtracted from premiums for purposes of calculating MLR:

<i>State Premium Tax</i>	1.76% of premium
<i>Annual Fee on Health Insurers</i>	█ of premium
<i>High Risk Pool Assessments</i>	█ of premium
<i>PCORI Fee</i>	\$2.18 per member per year
<i>Marketplace User Fee</i>	█ of total premium
<i>Miscellaneous Taxes</i>	█ of premium
<i>Federal Income Tax</i>	█ marginal rate



Projected Loss Ratio:

The projected loss ratio using the Federally prescribed MLR methodology is █. The MLR calculation is in accordance with the formula in the HHS Notice of Benefits and Payment Parameters.

The projected MLR is greater than 80%.

Single Risk Pool:

The Single Risk Pool for the experience period includes all non-grandfathered covered lives in the Oklahoma 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 Oklahoma Individual market. The index rate for the experience period equals the total allowed charges PMPM as no benefits were covered in excess of the projection period EHBs.

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,
- Marketplace user fees, on a market wide basis,
- Administrative costs excluding Marketplace 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]

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, on an allowed basis (grossed up by the expected

paid to allowed ratio). These modifiers include the Federal reinsurance program, risk adjustment, and Marketplace user fees.

The Market Adjusted Index Rate is calculated as follows:

MAIR = IR - FRPA - RA + MUFA, where

MAIR = Market Adjusted Index Rate

IR = Index Rate

FRPA = Federal Reinsurance Program Adjustment

RA = Risk Adjustment

MUFA = Marketplace User Fee Adjustment

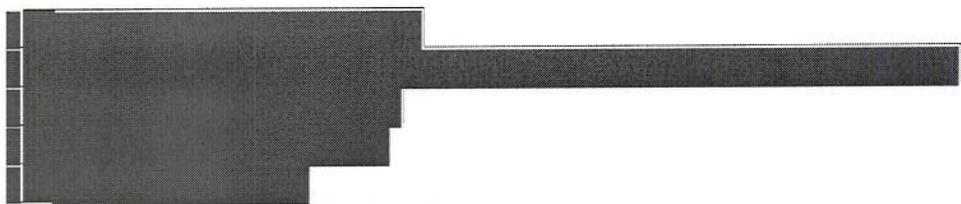
MAIR = 

The Payments and Contributions for the Federal Reinsurance Program and Risk Adjustment program are described in the "Risk Adjustment and Reinsurance" section. The Marketplace User 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:



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 Standard Component ID 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 Standard 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".

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

The geographic factors used are as follows:

<u>Rating Area</u>	<u>Geographic Factor</u>
Rating Area 1: Fort Smith, AR-OK	██████
Rating Area 2: Lawton, OK	██████
Rating Area 3: Oklahoma City, OK	██████
Rating Area 4: Tulsa, OK	██████
Rating Area 5: Non MSA	██████

The approximate average geographic factor associated with the projected single risk pool is ██████.

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.

Consumer Adjusted Premium Rate Development:

The Consumer Adjusted Premium Rate is calculated by first dividing the Plan Adjusted Index Rate by the age calibration factor and the geographic calibration 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

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

Example Calculation for age 40 in Rating Area 1

Plan: Blue Preferred Silver PPO 101 - Three \$0 PCP Visits, 87571OK0320047

Plan Adjusted Index Rate = [REDACTED]

Age Calibration = [REDACTED]

Geographic Calibration = [REDACTED]

Age 40 Factor = 1.2780

Non-Tobacco Factor = 1.0000

Rating Area 1 Factor = [REDACTED]

CAPR [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).

AV Pricing Value Adjustments Relativities

Standard Component ID	[REDACTED]
87571OK0320006	[REDACTED]
87571OK0320030	[REDACTED]
87571OK0320031	[REDACTED]
87571OK0320032	[REDACTED]
87571OK0320033	[REDACTED]
87571OK0320046	[REDACTED]
87571OK0320047	[REDACTED]
87571OK0320048	[REDACTED]
87571OK0320049	[REDACTED]

Standard Component ID	
87571OK0320062	
87571OK0320063	
87571OK0320064	
87571OK0320065	
87571OK0320066	
87571OK0320067	
87571OK0320068	
87571OK0320069	
87571OK0320070	
87571OK0320071	
87571OK0320072	
87571OK0320073	
87571OK0320074	
87571OK0320075	
87571OK0320076	
87571OK0320077	
87571OK0350006	
87571OK0350022	
87571OK0350023	
87571OK0350024	
87571OK0350025	
87571OK0350026	
87571OK0350027	
87571OK0350028	
87571OK0350029	
87571OK0350030	
87571OK0350031	
87571OK0350032	
87571OK0350033	
87571OK0350034	
87571OK0350035	
87571OK0350036	
87571OK0350037	
87571OK0350038	
87571OK0350039	

Standard Component ID	
87571OK0350040	
87571OK0350041	
87571OK0350042	
87571OK0350043	
87571OK0350044	
87571OK0460001	
87571OK0460002	
87571OK0460003	
87571OK0460004	
87571OK0460005	
87571OK0460006	
87571OK0460007	
87571OK0460008	
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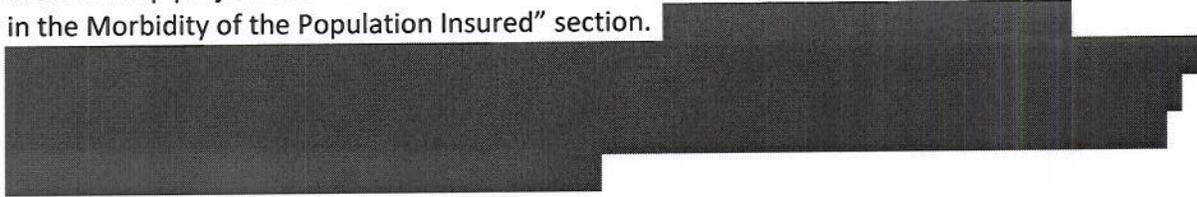
[Redacted text block]

[Redacted text block]

[Redacted text block]

Membership Projections:

Membership projections were sourced from the Membership Model described in the “Changes in the Morbidity of the Population Insured” section.



Silver Level Cost-Sharing Reduction Subsidies:



The projected enrollment by plan and subsidy level for Silver level plans is as follows:

Standard Component ID	73% CSR	87% CSR	94% CSR
87571OK0460002			
87571OK0460008			
87571OK0460009			
87571OK0460010			
87571OK0460011			
87571OK0350026			
87571OK0350033			
87571OK0350034			
87571OK0350035			
87571OK0320047			
87571OK0320066			
87571OK0320067			
87571OK0320068			
87571OK0320069			
87571OK0350027			
87571OK0350036			
87571OK0350037			
87571OK0350038			

Terminated Products:

The following products will be terminated prior to January 1, 2016. The 2016 Standard Component ID listed is the plan to which the terminated plan will be mapped.

2014 Standard Component ID	2014 Plan Name	2015 Standard Component ID	2016 Standard Component ID
87571OK0290006*	Blue Choice Bronze PPO 006		
87571OK0290006*	Blue Choice Bronze PPO 006		
87571OK0290006*	Blue Choice Bronze PPO 006		
87571OK0290006*	Blue Choice Bronze PPO 006		
87571OK0290006*	Blue Choice Bronze PPO 006		
87571OK0290010*	Blue Security Choice PPO 010		
New Plan in 2015	New Plan in 2015		
87571OK0290001*	Blue Choice Gold PPO 001		
87571OK0290002*	Blue Choice Gold PPO 002		
87571OK0290003*	Blue Choice Silver PPO 003		
87571OK0290004*	Blue Choice Silver PPO 004		
87571OK0290011*	Blue Choice Gold PPO 011		
87571OK0290012*	Blue Choice Gold PPO 012		
New Plan in 2015	New Plan in 2015		
87571OK0320001*	Blue Preferred Gold PPO 001		
87571OK0320002*	Blue Preferred Gold PPO 002		
87571OK0320003	Blue Preferred Silver PPO 003		
87571OK0320004*	Blue Preferred Silver PPO 004		
87571OK0320007*	Blue Preferred Gold PPO 007		
87571OK0380001*	Blue Options Gold PPO 001		
87571OK0380002*	Blue Options Gold PPO 002		
87571OK0380003*	Blue Options Gold PPO 003		
87571OK0380004*	Blue Options Silver PPO 004		
87571OK0380005*	Blue Options Silver PPO 005		
87571OK0290005*	Blue Choice Bronze PPO 005		
87571OK0320005	Blue Preferred Bronze PPO 005		
87571OK0290010*	Blue Security Choice PPO 010		
New Plan in 2015	New Plan in 2015		
87571OK0290010*	Blue Security Choice PPO 010		
New Plan in 2015	New Plan in 2015		
87571OK0290010*	Blue Security Choice PPO 010		

2014 Standard Component ID	2014 Plan Name	2015 Standard Component ID	2016 Standard Component ID
New Plan in 2015	New Plan in 2015		
87571OK0290010*	Blue Security Choice PPO 010		
New Plan in 2015	New Plan in 2015		
87571OK0290003*	Blue Choice Silver PPO 003		
87571OK0290004*	Blue Choice Silver PPO 004		
87571OK0320001*	Blue Preferred Gold PPO 001		
87571OK0320002*	Blue Preferred Gold PPO 002		
87571OK0320003	Blue Preferred Silver PPO 003		
87571OK0320004*	Blue Preferred Silver PPO 004		
87571OK0320007*	Blue Preferred Gold PPO 007		
New Plan in 2015	New Plan in 2015		
87571OK0380004*	Blue Options Silver PPO 004		
87571OK0380005*	Blue Options Silver PPO 005		
87571OK0290003*	Blue Choice Silver PPO 003		
87571OK0290004*	Blue Choice Silver PPO 004		
87571OK0320001*	Blue Preferred Gold PPO 001		
87571OK0320007*	Blue Preferred Gold PPO 007		
87571OK0320002*	Blue Preferred Gold PPO 002		
87571OK0320003	Blue Preferred Silver PPO 003		
87571OK0320004*	Blue Preferred Silver PPO 004		
New Plan in 2015	New Plan in 2015		
87571OK0380004*	Blue Options Silver PPO 004		
87571OK0380005*	Blue Options Silver PPO 005		
87571OK0290003*	Blue Choice Silver PPO 003		
87571OK0290004*	Blue Choice Silver PPO 004		
87571OK0320001*	Blue Preferred Gold PPO 001		
87571OK0320002*	Blue Preferred Gold PPO 002		
87571OK0320003	Blue Preferred Silver PPO 003		
87571OK0320004*	Blue Preferred Silver PPO 004		
87571OK0320007*	Blue Preferred Gold PPO 007		
New Plan in 2015	New Plan in 2015		
87571OK0380004*	Blue Options Silver PPO 004		
87571OK0380005*	Blue Options Silver PPO 005		
87571OK0290001*	Blue Choice Gold PPO 001		
87571OK0290002*	Blue Choice Gold PPO 002		
87571OK0290003*	Blue Choice Silver PPO 003		

2014 Standard Component ID	2014 Plan Name	2015 Standard Component ID	2016 Standard Component ID
87571OK0290004*	Blue Choice Silver PPO 004		
87571OK0290011*	Blue Choice Gold PPO 011		
87571OK0290012*	Blue Choice Gold PPO 012		
87571OK0320002*	Blue Preferred Gold PPO 002		
87571OK0320003	Blue Preferred Silver PPO 003		
87571OK0320004*	Blue Preferred Silver PPO 004		
87571OK0320001*	Blue Preferred Gold PPO 001		
87571OK0320007*	Blue Preferred Gold PPO 007		
New Plan in 2015	New Plan in 2015		
87571OK0380001*	Blue Options Gold PPO 001		
87571OK0380002*	Blue Options Gold PPO 002		
87571OK0380004*	Blue Options Silver PPO 004		
87571OK0380005*	Blue Options Silver PPO 005		
87571OK0380003*	Blue Options Gold PPO 003		
87571OK0290005*	Blue Choice Bronze PPO 005		
87571OK0320005	Blue Preferred Bronze PPO 005		
87571OK0290005*	Blue Choice Bronze PPO 005		
87571OK0320005	Blue Preferred Bronze PPO 005		
87571OK0290005*	Blue Choice Bronze PPO 005		
87571OK0320005	Blue Preferred Bronze PPO 005		
87571OK0290005*	Blue Choice Bronze PPO 005		
87571OK0320005	Blue Preferred Bronze PPO 005		
87571OK0290001*	Blue Choice Gold PPO 001		
87571OK0290002*	Blue Choice Gold PPO 002		
87571OK0290011*	Blue Choice Gold PPO 011		
87571OK0290012*	Blue Choice Gold PPO 012		
87571OK0350001*	Blue Advantage Gold PPO 001		
87571OK0350002	Blue Advantage Gold PPO 002		
87571OK0380001*	Blue Options Gold PPO 001		
87571OK0380002*	Blue Options Gold PPO 002		
87571OK0380003*	Blue Options Gold PPO 003		
87571OK0350004	Blue Advantage Silver PPO 004		
87571OK0350003	Blue Advantage Silver PPO 003		
87571OK0350005	Blue Advantage Bronze PPO 005		
87571OK0290001*	Blue Choice Gold PPO 001		
87571OK0290002*	Blue Choice Gold PPO 002		

2014 Standard Component ID	2014 Plan Name	2015 Standard Component ID	2016 Standard Component ID
87571OK0290011*	Blue Choice Gold PPO 011		
87571OK0290012*	Blue Choice Gold PPO 012		
87571OK0350001*	Blue Advantage Gold PPO 001		
87571OK0350002	Blue Advantage Gold PPO 002		
87571OK0380003*	Blue Options Gold PPO 003		
87571OK0380001*	Blue Options Gold PPO 001		
87571OK0380002*	Blue Options Gold PPO 002		
87571OK0290001*	Blue Choice Gold PPO 001		
87571OK0290002*	Blue Choice Gold PPO 002		
87571OK0290011*	Blue Choice Gold PPO 011		
87571OK0290012*	Blue Choice Gold PPO 012		
New Area in 2015	New Area in 2015		
New Area in 2015	New Area in 2015		
87571OK0380001*	Blue Options Gold PPO 001		
87571OK0380002*	Blue Options Gold PPO 002		
87571OK0380003*	Blue Options Gold PPO 003		
New Area in 2015	New Area in 2015		
New Area in 2015	New Area in 2015		
87571OK0350004	Blue Advantage Silver PPO 004		
New Area in 2015	New Area in 2015		
New Area in 2015	New Area in 2015		
87571OK0350003	Blue Advantage Silver PPO 003		
New Area in 2015	New Area in 2015		
New Area in 2015	New Area in 2015		
87571OK0350005	Blue Advantage Bronze PPO 005		
New Area in 2015	New Area in 2015		
New Area in 2015	New Area in 2015		
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan		
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan		
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan		

2014 Standard Component ID	2014 Plan Name	2015 Standard Component ID	2016 Standard Component ID
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan		
87571OK0310001*	Blue Cross Blue Shield Premier 1, a Multi-State Plan		
87571OK0310002	Blue Cross Blue Shield Premier 2, a Multi-State Plan		
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
87571OK0310003*	Blue Cross Blue Shield Solution 3, a Multi-State Plan		
87571OK0310004	Blue Cross Blue Shield Solution 4, a Multi-State Plan		
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		
87571OK0310005	Blue Cross Blue Shield Basic 5, a Multi-State Plan		
87571OK011**	Health Check Select	Terminated	Terminated
87571OK012**	Health Check Basic	Terminated	Terminated
87571OK013**	Health Check HSA	Terminated	Terminated
87571OK024**	Personal Blue	Terminated	Terminated
87571OK025**	Simply Blue	Terminated	Terminated
87571OK026**	Oklahoma Association of Realtors	Terminated	Terminated
87571OK027**	OK Society of CPAs	Terminated	Terminated
87571OK028**	Blue Pathway	Terminated	Terminated

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

**The product ID is listed for terminated non-single risk pool compliant plans.

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] PMPM. The difference is partially a result of 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, the Premiums on Worksheet 1 represent actual premiums while the Premiums on Worksheet 2 are calculated based on past pricing assumptions. Therefore, differences in the distribution of ages, geography, and benefits between what was projected and what actually emerged will also contribute to the difference.

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 is partially a result of 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 56 on Worksheet 2. Additionally, the Premiums on Worksheet 1 represent actual premiums while the Premiums on Worksheet 2 are calculated based on past pricing assumptions. Therefore, differences in the distribution of ages, geography, and benefits between what was projected and what actually emerged will also contribute to the difference.

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] PMPM. 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

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, and
 - 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 differences in the costs 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 factor 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.
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 Marketplaces 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,

A large black rectangular redaction box covering the signature area.

August 12, 2015

A small black rectangular redaction box covering the first part of the name.

FSA, MAAA