MEDICA®

Actuarial Memorandum

1. Purpose and Limitations

The purpose of this document, which is submitted in conjunction with the Part I Unified Rate Review Template (URRT), is to comply with the requirements of the Part III Actuarial Memorandum and to support the premium rates developed for Medica Insurance Company's (Medica's) individual Affordable Care Act (ACA) products, with an effective date of January 1st, 2022. These products will be offered both on and off the individual insurance exchange in Iowa. This rate filing is not intended to be used for other purposes.

This memorandum reflects Medica's current assumptions and working knowledge of the ACA's regulatory framework as of June 11th, 2021, which includes assumed defunding of the cost sharing reduction (CSR) program. If further information is shared that puts these assumptions at risk, Medica reserves the right to modify components of the rate filing submission.

Per Health and Human Services (HHS) instruction, issuers must upload two versions of the Part III Actuarial Memorandum. This version is the un-redacted version intended for CMS review. For reference to the redacted version of the Part III, please see the corresponding supporting document.

Medica designates the information submitted by Medica through HIOS as exempt from disclosure under Exemption 4 of the HHS's Freedom of Information Act (FOIA).

2. General Information

Company Identifying Information

- Company Legal Name: Medica Insurance Company
- State: IA
- HIOS Issuer ID: 93078
- Market: Individual
- Effective Date: January 1, 2022

Company Contact Information

- Primary Contact Name: Christopher Juhlke
- Primary Contact Telephone Number: (952) 992-3644
- Primary Contact Email Address: christopher.juhlke@medica.com

Policy Form Numbers

The following policies will be offered both on and off the individual insurance exchange:

IA-CHI-PC-22-01; IA-Elevate-PC-22-01; IA-Empower-PC-22-01; IA-Inspire-PC-22-01; IA-Insure-PC-22-01;

3. Proposed Rate Change

The proposed rate change for Medica's individual business rates effective January 1, 2022 is [redacted] over rates effective January 1, 2021. This rate increase reflects an estimate of the average increase that will be offered to current members based on April 2021 in-force business absent of rate changes due to attained age.

The proposed annual rate changes by product in this filing range from [redacted].

Reason for Rate Change(s)

The significant factors driving the proposed rate change primarily include:

- [redacted]

Additional Information

- Select plans include cost sharing modifications due to actuarial value compliance.
- The proposed benefit factor changes will result in rate changes that vary across plan designs.
- Medica's rate change history is documented in Exhibit B.
- Medica is modifying its plan portfolio and the corresponding plan mapping is summarized in Exhibit J.

4. Market Experience

4.1 Experience Period Premium and Claims

Paid Through Date

The experience period for this filing is calendar year 2020. The paid through date is April 30th, 2021.

Premiums in Experience Period

As shown in Worksheet 1, Section I of the URRT, the calendar year 2020 experience period includes [redacted] of earned premium. This does not include any adjustment for expected MLR Rebates.

Allowed and Incurred Claims Incurred During the Experience Period

As shown in Worksheet 1, Section I of the URRT, the calendar year 2020 experience period includes [redacted] of incurred claims and [redacted] of allowed claims.

All incurred and allowed claims are reported through Medica's claim system. Additional amounts are added to account for expected Risk Arrangement payouts in the experience period. Claims incurred but not paid (IBNP) as of April 30th, 2021 for the calendar year 2021 experience period are estimated to be approximately [redacted]. Separate sets of completion factors are used for paid claims and allowed claims.

The Corporate Actuarial team calculates the IBNP and has provided the following summary:

Medica uses internal data sources to identify adjudicated claims paid in the current year and the two most recent historical years. This data contains claims reimbursed on a fee-for-service basis. A lag factor is applied to adjudicated claim amounts to arrive at a "best estimate" of incurred claims for each of the aforementioned years.

Standard methodologies have been used to develop the lag factors. For older lags (duration 5+), a pure completion method is used. This method derives a factor by selecting an appropriate averaging method using the most current claim triangles. For more recent durations (durations 1-4), both the completion and projection methods are used, along with

a blending of these methods using the Bornhuetter-Ferguson (BF) technique. The projection method calculates a baseline PMPM using the average of historical, fully-credible incurred data. This baseline PMPM is then normalized for working days in the month, seasonality, and other adjustments that may affect incurred costs. PMPMs are trended to current costs using factors that vary by product. The lag factor is derived by selecting one of these three methods. The projection method is given greater weight in earlier development periods, while the lag factor and BF methods are given greater weight in later periods.

4.2 Benefit Categories

Utilization and cost information are categorized by benefit using Milliman's *Health Cost Guidelines*™ (HCGs) categories. Milliman's categories are assigned based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- Inpatient Hospital (facility charges with an overnight stay)
- Outpatient Hospital (facility charges without an overnight stay)
- Professional (with units measured as a mix of visits, cases, procedures, etc.)
- Other Medical (with units measured as a mix of visits, cases, procedures, etc.)
    - This includes categories such as Home Health, Transportation, DME, Hearing Aids, etc.
- Capitation (not applicable)
- Prescription Drug (prescriptions not billed by a facility or professional)

4.3 Projection Factors

4.3.1 Trend Factors (Cost/Utilization)

The trend used to get from the experience period to the projection period is based on an un-leveraged prospective annual trend of [redacted]. The trend assumptions used in the projection are based on Medica's standard trend projection process. The trend assumptions do not include the impact of changes in demographics, benefit design, or morbidity.

[redacted]

4.3.2 Credibility Manual Rate Development

Not applicable. The projected experience described in Section 4 is assumed to be fully credible for rate development, so no credibility manual is needed.

Inclusion of Capitation Payments

Not applicable. There are no capitation payments assumed in the projection period.

4.3.3 Credibility of Experience

In accordance with *Actuarial Standards of Practice (ASOP) #25 – Credibility Procedures*, Medica's Iowa experience includes [redacted] member months and is assumed to be fully credible for purposes of developing claim projections.

[redacted]

4.3.4 Development of Projected Index Rate

Changes in Morbidity of the Population Insured

Medica is assuming a change in the population risk morbidity from the experience period to the projection period of [redacted]. This adjustment reflects the anticipated change in claim costs outside the underlying demographics of the covered population. This change in morbidity is also assumed when estimating the risk adjustment transfer for the projection period. This is displayed in the Morbidity Adjustment in Worksheet 1, Section II of the URRT.

[redacted]

Changes in Benefits

Medica applied an adjustment to the experience period claims to account for projected changes in the average utilization of services due to differences in average cost sharing. A value of [redacted] is included in the Plan Design Changes in Worksheet 1, Section II of the URRT.

Changes in Demographics

A demographic adjustment of [redacted] was applied to the experience period claims to account for the projected changes in the age, geographic region, and network mix of the underlying experience data. This is included in the Demographic Shift in Worksheet 1, Section II of the URRT.

Other Adjustments

An adjustment of [redacted] is included Other in Worksheet 1, Section II of the URRT. This includes [redacted]

[redacted]

4.3.5 Development of Market-wide Adjusted Index Rate

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

Medica's estimated risk adjustment transfer for the experience period was a net [redacted]. This amount is included in Worksheet 2, Section III of the URRT. This includes an assumed net payment into the High Cost Risk Pool reinsurance program of [redacted].

Medica's net reinsurance recoveries attributable to the experience period are $0.00 PMPM.

Projected Risk Adjustment PMPM

Medica assumes that it will enroll a lower morbidity than the market average risk in the projection period. A risk adjustment [redacted] is projected. This includes an assumed net [redacted]. The material assumptions that impacted this estimate include the level of Medica's morbidity, the level of market morbidity, and the state average premium. Any resulting risk adjustment transfer payments would be allocated proportionally across all plans in Medica's individual market single risk pool.

The risk adjustment user fee of $0.25 PMPM is reflected in the Taxes and Fees of Worksheet 2, Section III of the URRT.

Exchange User Fees

The exchange user fee is calculated as 2.75% of anticipated on-exchange premiums, and then spread across the entire single risk pool as required by regulation. Medica assumes that on-exchange premiums will be [redacted].

4.4 Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

The components of the administrative expense load as shown in Worksheet 1, Section III of the URRT are summarized in Table 1.

Table 1
Summary of Administrative Expenses

Description	PMPM	% of Premium
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Medica's administrative expense load includes general administration, commissions paid to brokers and agents, and Health Care Quality Improvements (HCQI). Medica allocates administrative expenses by product, state and legal entity. Base fees paid to third party administrators on a PMPM basis are charged directly to the appropriate product. With the exception of regulatory costs and Medica Health Management (MHM) costs, the remaining administrative expenses are allocated to the market business segments to determine a PMPM. Regulatory costs are charged directly to the appropriate entity. MHM costs are captured in specific cost centers which are charged directly to MHM. The support cost centers (Human Resources, Facilities and a portion of IT and General Administration) are allocated to each of the other cost centers. Medica's Corporate Finance staff meets periodically with a representative of each cost center to review the allocation method.

Medica pays commissions on a flat per policy basis and does not vary payments by metal level or enrollment period.

Contribution to Surplus and Risk Margin

The targeted risk margin after federal income taxes is [redacted] applied proportionally to all plans.

Taxes and Fees

Table 2 summarizes the components of the taxes and fees shown in Worksheet 2, Section III of the URRT.

Table 2
Summary of Taxes and Fees

Description	PMPM	% of Premium
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

The Exchange User Fee is reflected in the above table, but is not included in the Taxes and Fees total in the URRT as it is already built into the Market Adjusted Index Rate per Section 6.3.

The reinsurance contributions are not reflected here, as documented in Section 4.3.5.

4.5 Paid-to-Allowed Ratio

Exhibit C details the paid-to-allowed ratio by plan design and is consistent with the membership projections in Worksheet 2, Section IV of the URRT. The silver metal level plans include an additional load to account for the expected defunding of the CSR program.

5. Projected Loss Ratio

The projected MLR for Medica based on the federally prescribed methodology is [redacted]. The numerator of the projected MLR contains projected claim costs and HCQI expenses net of receipts from the risk adjustment program. The denominator consists of total premiums net of premium taxes, income tax, and regulatory fees. Please note that the MLR presented here does not capture all adjustments, including multi-year averaging, credibility, and deductible.

Exhibit D provides a summary of the components included in the MLR projection.

6. Application of Market Reform Rating Rules

6.1 Single Risk Pool

This filing, including the URRT, complies with the single risk pool requirements documented in 45 CFR Part 156, §156.80(d). The experience period data is based on all Medica individual market policies in Iowa. The projection period reflects all projected covered lives for every non-grandfathered product/plan combination for Medica in the Iowa individual market.

6.2 Index Rate

Experience Period

As shown in Worksheet 1, Section I of the URRT, the index rate for the experience period is [redacted]. The experience period index rate reflects the estimated total combined allowed EHB claims experience PMPM in the single risk pool, and is not adjusted for payments and charges under the risk adjustment and reinsurance programs, nor for marketplace user fees.

Projection Period

The index rate, defined as the anticipated EHB portion of projected allowed claims with respect to trend, benefit, and demographics, divided by all projected single risk pool lives, is [redacted].

6.3 Market-Adjusted Index Rate

The market-adjusted index rate is calculated as the sum of the projection period index rate, the net impact of the risk adjustment program, and the exchange user fees. Table 3 details the projection period index rate, allowable market-wide modifiers as defined in 45 CFR Part 156, §156.80(d)(1), and the resulting market-adjusted index rate.

Table 3
Market-Adjusted Index Rate

Description	PMPM
Projection Period Index Rate	[redacted]
Net Impact of the Risk Adjustment Program	[redacted]
Net Impact of State Reinsurance Program	[redacted]
Exchange User Fee Adjustment	[redacted]
Market-Adjusted Index Rate	[redacted]

The adjustments in Table 3 reflect all of the market-wide modifiers allowed in federal regulation and the average demographic characteristics of the single risk pool. Please note the allowable market-wide modifiers were adjusted to an allowed basis in the development of the market-adjusted index rate which is consistent with the basis of the projected index rate.

6.4 Plan-Adjusted Index Rates

Exhibit E summarizes the plan-adjusted index rates, developed as the market-adjusted index rate further adjusted for all the allowable plan-level modifiers defined in 45 CFR Part 156, §156.80(d)(2).

The allowable modifiers as described in 45 CFR Part 156, §156.80(d)(2) are the following:

- Actuarial value and cost-sharing design of the plan,
- Plan's provider network and delivery system characteristics, as well as utilization management practices,
- Plan benefits in addition to the EHBs,
- Administrative costs, excluding exchange user fees, and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans

AV and Cost-Sharing Adjustment

Each plan's AV and cost-sharing adjustment includes a benefit factor adjustment and an adjustment to account for the expected impact of each plan's cost sharing amounts on the member's utilization of services. Medica's internal benefit factor model, which uses a single continuance table for all plans, was used to estimate how members purchase services differently based on the amount of plan-specific cost sharing. By utilizing a single continuance table, the model's adjustments assume the same demographic and risk characteristics for each plan priced and therefore exclude expected differences in the health status of members assumed to select the plan.

[redacted]

Adjustment for Benefits in Addition to the EHBs

Medica's plans do not include any benefits other than EHBs (neither supplemental benefits nor state mandates eligible for state reimbursement), so the plan adjusted index rates do not include a plan-level adjustment for benefits in addition to the EHBs.

Plan's Provider Network and Delivery System Characteristics

Network adjustments are developed based on an analysis of variation in cost by provider network. The adjustments are developed by analyzing the cost variation among providers in the care system networks against the open access network as a whole. The analysis uses provider cost relativities and actual network experience when available, adjusted for population demographics. Additionally, network-specific discounts are applied to the cost relativities, where applicable.

In the absence of network experience, a utilization-weighted relativity is calculated for the open-access network and each care system network by major service category (inpatient, outpatient, physician, pharmacy, and mental health). The relativities by service category are combined using the service category mix of the actual experience. These final overall cost relativities are used as a basis for the final network adjustments.

Exhibit F provides a summary of the proposed provider network adjustments applied to the plan-adjusted index rates.

Expected Impact of the Specific Eligibility Categories for the Catastrophic Plan

A specific eligibility adjustment reflects the difference in expected demographics between the catastrophic plan and the non-catastrophic plans due to the unique eligibility requirements of the catastrophic plans (i.e. that only individuals under the age of 30 or eligible by reason of financial hardship can enroll). This adjustment reflects that costs vary by age, and that the cost of the population expected to enroll in this plan is anticipated to be lower than the non-catastrophic plans.

No change is being proposed to the current adjustment of [redacted].

6.5 Calibration

A single calibration adjustment is applied uniformly to all plans. The market-wide calibration factor is [redacted]. Detailed support of the calibration factor is provided in Exhibit H.

Age Curve Calibration

The average age factor used in the calibration process is [redacted], resulting in an age calibration factor of [redacted] as displayed in Worksheet 2, Section III of the URRT. This was determined by applying the standard age curve established by HHS to the projected member distribution by age, with an adjustment for the maximum of three child dependents under the age of 21.

Under this methodology, the approximate average age rounded to a whole number associated to the single risk pool average age factor is [redacted].

Geographic Factor Calibration

The average geographic rating factor is 1.0000, resulting in a geographic calibration factor of 1.0000 as displayed in Worksheet 2, Section III of the URRT.

Exhibit G provides a summary of the proposed geographic rating factors applied to the plan-adjusted index rates.

The geographic rating factors were developed based on an analysis of variation in cost by geographic region. Using Medica's individual market data, the membership and allowed claims were distributed into the rating areas based on the location of the member as well as adjusted for high claimants, demographics, and network. Data was then credibility weighted and adjusted for any expected future cost changes. To smooth changes from year to year, Medica makes business decisions on the materiality of the proposed rating factor change for each geographic region.

Tobacco Factor Calibration

The average tobacco rating factor used in the calibration process is [redacted], resulting in a tobacco calibration factor of [redacted] as displayed in Worksheet 2, Section III of the URRT. A tobacco load is applied to adult tobacco users age 21 and older.

No change is being proposed to the current adjustment of [redacted].

6.6 Consumer-Adjusted Premium Rate Development

Medica derives consumer-adjusted premium rates by calibrating the plan-adjusted index rate and applying the rating factors specified by 45 CFR Part 147, §147.102. See Exhibit A for the proposed rate manual and sample rate calculation.

7. Plan Product Information

7.1 AV Metal Values

For all plans described below, the AV metal levels were developed using only the federal AV calculator. Medica does not believe any of these plans requires an alternative methodology.

AV Pricing Values

Exhibit I provides a summary of the AV pricing values by plan as displayed in Worksheet 2, Section I of the URRT 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).

7.2 Membership Projections

Medica projected membership as displayed in Worksheet 2, Section IV of the URRT by considering the size of the projected Iowa individual market in the current year and an assumed penetration rate of this market.

For silver level plans in the individual market, an estimate was made for the portion of projected enrollment that will be eligible for cost sharing reduction (CSR) subsidies at each subsidy level. Table 4 displays the distribution and projected members for all the silver plans, including the alternative silver plans which CSR eligibles can purchase.

Table 4
Distribution of Membership Across Silver Metal Tier

Silver Metal Tier	Membership Distribution	Membership
Standard	[redacted]	[redacted]
94% AV Level Silver Plan	[redacted]	[redacted]
87% AV Level Silver Plan	[redacted]	[redacted]
73% AV Level Silver Plan	[redacted]	[redacted]
Limited Cost Sharing	[redacted]	[redacted]
Zero Cost Sharing	[redacted]	[redacted]
Total	[redacted]	[redacted]

7.3 Terminated Products

Exhibit J summarizes any discontinued plans that were included in the single risk pool during the experience period or made available thereafter and the corresponding mapped plans.

7.4 Plan Type

Not Applicable. The plan types listed in Worksheet 2, Section I of the URRT appropriately describe Medica's plans.

7.5 Warning Alerts

Not applicable. No warning alert appear in Worksheet 2, Section III of the URRT.

8. Miscellaneous Instructions

8.1 Effective Rate Review Information

Medica believes all information specific to Iowa Insurance Division's (IID)'s filing requirements are reflected elsewhere in this filing.

8.2 Reliance

In developing this rate filing, I have relied on several internal departments for information. This information includes Corporate Actuarial providing rating factors, projections of claim trend and Corporate Finance providing non-benefit expenses. I have performed a limited review of this information, and have deemed it to be reasonable.

8.3 Actuarial Certification

I, Christopher Juhlke, am a Director of Actuarial Services for Medica. 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.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable state and federal statutes and regulations (45 CFR 156.80 and 147.102),
- 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
- Neither excessive nor deficient.

I further certify that:

- 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,
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area, and
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I URRT for all plans except as noted in Section 7.

The Part I 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.

[REDACTED]

Christopher Juhlke
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June 11th, 2021

Exhibit A
Rate Manual

Sample Rate Calculation

Rate Formula:

= Plan-Adjusted Index Rate x Age Factor x Geographic Factor x Tobacco Factor x Calibration Factor

Sample Member Information:	Description	Factor	Source
[redacted]	[redacted]	[redacted]	[redacted]

Sample Rate Calculation:

[redacted]

Exhibit A (continued)
Rate Manual

Table 1 - Plan-Adjusted Index Rates and Actuarial Values				
Plan Name	HIOS Plan ID	Metal Level	Actuarial Value	Plan-Adjusted Index Rate
[redacted]				

Exhibit A (continued)
Rate Manual

Table 2 – Age	
Age	Factor
0-14	0.765
15	0.833
16	0.859
17	0.885
18	0.913
19	0.941
20	0.970
21	1.000
22	1.000
23	1.000
24	1.000
25	1.004
26	1.024
27	1.048
28	1.087
29	1.119
30	1.135
31	1.159
32	1.183
33	1.198
34	1.214
35	1.222
36	1.230
37	1.238
38	1.246
39	1.262
40	1.278
41	1.302
42	1.325
43	1.357
44	1.397
45	1.444
46	1.500
47	1.563
48	1.635
49	1.706
50	1.786
51	1.865
52	1.952
53	2.040
54	2.135
55	2.230
56	2.333
57	2.437
58	2.548
59	2.603
60	2.714
61	2.810
62	2.873
63	2.952
64+	3.000

Table 3 - Geographic	
Rating Area	Area Factor
1	
2	
3	
4	
5	
6	
7	

Table 4 - Tobacco
Tobacco Factor

Table 5 – Calibration
Calibration Factor

Exhibit B
Rate Change, Membership, and Loss Ratio History

State			
Plan Year	Rate Change	Member Months	Loss Ratio[1]
			

[1] Loss ratio is defined as incurred claims over premium.

Nationwide			
Plan Year	Rate Change	Member Months	Loss Ratio[1]
			

[1] Loss ratio is defined as incurred claims over premium.

Exhibit C
Paid-to-Allowed Ratio

Paid-to-Allowed Average Factor				
Plan	Projected Member Months	Allowed Claims PMPM[1]	Paid Claims PMPM[1]	Paid / Allowed
[redacted]				

[1] Before risk adjustment.

Exhibit D
Medical Loss Ratio (MLR)

Projected MLR for 2022		
Incurred Claims	[redacted]	A
Risk Adjustment	[redacted]	B
Reinsurance	[redacted]	C
HCQI	[redacted]	D
MLR Numerator	[redacted]	E = A + B + C + D
Revenue	[redacted]	F
Exchange Fees	[redacted]	G
ACA Health Insurer Fees	[redacted]	H
Federal PCORI Fees	[redacted]	I
Risk Adjustment Fees	[redacted]	J
State Premium Tax	[redacted]	K
Federal Income Tax	[redacted]	L
MLR Denominator	[redacted]	M = F - G - H - I - J - K - L
Projected MLR	[redacted]	N = E / M

Exhibit E
Plan-Adjusted Index Rates

Market-Adjusted Index Rates, AV Pricing Values, and Plan-Adjusted Index Rates					
Plan Name	HIOS Plan ID	Metal Level	Market-Adjusted Index Rate	Actuarial Value	Plan-Adjusted Index Rate
[redacted]					

Exhibit F
Provider Network Adjustments

Network	Member Distribution	Current Adjustment	Proposed Adjustment
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Exhibit G
Geographic Rating Factors

Rating Area	Member Distribution	Current Adjustment	Proposed Adjustment
[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]

Exhibit H
Calibration Development

Age Calibration		
Age	Member Distribution	Age Factor
0-14	[redacted]	0.765
15		0.833
16		0.859
17		0.885
18		0.913
19		0.941
20		0.970
21		1.000
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
35		1.222
36		1.230
37		1.238
38		1.246
39		1.262
40		1.278
41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64+		3.000
Average	100.0%	[redacted]

Geographic Calibration		
Rating Area	Member Distribution	Area Factor
1	[redacted]	[redacted]
2		
3		
4		
5		
6		
7		
Average	[redacted]	[redacted]

Tobacco Factor Calibration		
Smoking Status	Member Distribution	Tobacco Factor
Yes	[redacted]	[redacted]
No		
Average	[redacted]	[redacted]

Exhibit I
AV Pricing Values

Plan Name	HIOS Plan ID	Metal Level	AV/Cost-Sharing Adjustment	CSR Load	Benefit Induced Utilization	Provider Network	EHB Adjustment	Catastrophic Eligibility	Administrative Costs	AV Pricing Value
			A	B	C	D	E	F	G	H
[redacted]										

AV Pricing Value = A x B x C x D x E x F x G

Exhibit I (cont.)
CSR Load

[REDACTED]

Exhibit J
Terminated Plan Cross-Walk

Terminated Plan Name	Terminated HIOS ID	Mapped Plan Name	Mapped HIOS ID
Plans offered during the 2020 plan year and terminated prior to the 2021 plan year.			
[redacted]	[redacted]	[redacted]	[redacted]
Plans offered during the 2021 plan year and terminated prior to the 2022 plan year.			
[redacted]	[redacted]	[redacted]	[redacted]