Part III Actuarial Memorandum

Blue Cross and Blue Shield of Oklahoma
Individual Rate Filing
Effective January 1, 2019

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.

This actuarial memorandum and certifications do not guarantee the adequacy of the proposed rates. Rather, they are subject to the qualifications and/or assumptions of the actuarial memorandum and certify that the proposed rates would be adequate if the assumptions were realized. This actuarial memorandum (and any related Rate Filing Justifications (Parts I and II), proposed and/or approved rates, other rate filing documentation, attestations and/or certifications) are subject to amendment, revision and/or withdrawal (in whole or in part), if determined necessary or appropriate by BCBSOK, the attestor(s), and/or the certifying actuary.

This would include, but would not be limited to, any amendment, revision and/or withdrawal necessary (in whole or in part) to address any change to and/or modifications of the premium tax credits (26 U.S.C. 36B), risk adjustment (42 U.S.C. 18063), cost-sharing reductions (42 U.S.C. 18071) and/or medical loss ratios (42 U.S.C. 300gg-18) by statute, regulation, court decision, and/or agency sub-regulatory guidance, implementation, administration, and/or interpretation, as well as any department or agency decision regarding BCBSOK's product, plan and/or rate filings (in whole or in part).

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.

4.2 General Information:

Company Identifying Information:

Company Legal Name	Blue Cross and Blue Shield of Oklahoma
State	Oklahoma
HIOS Issuer ID	87571
Market	Individual
Effective Date	January 1, 2019

Company Contact Information:

Primary Contact Name	[redacted]

Primary Contact Telephone	312-653-5181
Primary Contact Email	RateFiling@hcsc.net

4.3 Proposed Rate Increase(s):

The proposed increase is -2.0% across the entire block of BCBSOK Individual ACA-compliant plans effective January 1, 2019, and reflects the expected migration to available plans. The premium rate changes will vary by plan.

The average rate increase is calculated using the 2018 rate tables, the proposed 2019 rate tables, the mapping of terminated plans to existing or new plans, and the membership distribution by plan, age, tobacco user status, and area for 2018 members in our membership system as of March 31, 2018.

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, which includes the repeal of the individual mandate penalty and the sale of short term limited duration products up to 364 days,
- Anticipated changes in demographics,
- Anticipated changes in provider networks,
- Anticipated changes associated with the final Market Stabilization rule,
- Permitted rating factors (geographic area, age, and tobacco use),
- Anticipated administrative expenses including taxes and fees imposed on the insurer, and
- Changes in anticipated costs associated with the lack of direct federal reimbursement for members enrolled in Cost-Sharing Reduction (CSR) plans.

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.

4.4 Market Experience:

4.4.1 Experience Period Premium and Claims:

Paid Through Date:

Payments have been made through March 31, 2018, on claims incurred during the experience period calendar year 2017.

Premiums (net of MLR Rebate) in Experience Period:

Earned premiums were determined using corporate earned premium records. After determining earned premiums, the 2017 accrual for MLR rebates, if any, was backed out.

We do not anticipate refunding premiums through MLR rebates for 2017. The earned premiums and MLR rebates accrued are:

- Total Earned Premium in the Experience Period = $961,943,433
- MLR Rebates Accrued = $0
- Earned Premium (net of MLR rebates accrued) = $961,943,433

The 2017 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 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.

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 is the same. The methodology incorporates estimates based upon developed completion factors. Consideration is given to additional relevant information not fully reflected in the pricing model. 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.

4.4.2 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, ICD-10, Revenue Codes, CPT4, HCPCS, and NDCs) to determine into which category each claim in the experience period falls.

Benefit Category	Category Description
Inpatient Hospital (Units = Days)	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 (Units = Visits)	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 (Units = Services)	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 (Units = See Below)	Includes non-capitated ambulance, DME, prosthetics, supplies, and other services.
Capitation (Units = See Below)	Includes all services provided under one or more capitated arrangements.

Prescription Drug (Units = Prescriptions)	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, 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.

4.4.3 Projection Factors:

Changes in the Morbidity of the Population Insured:

[redacted]

Changes in Benefits:

[redacted]

Change in Covered Services:

[redacted]

[redacted]

Change in Benefit Richness:

[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/gender and area cost relativities were separately developed using internal claims data normalized for other demographic characteristics and applied to each of the 2017 single risk pool and 2019 expected population to determine the expected change in cost due to age/gender and area mix.

Other Adjustments:

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Trend Factors (Cost/Utilization):

[redacted]

The source data has adjustments applied:

- to normalize for age and gender,
- to complete the data,
- for number/type of days of the week, holidays,
- 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, unit cost, and utilization.

[redacted]

4.4.4 Credibility Manual Rate Development:

No manual rate was needed as the experience period claims are deemed fully credible as discussed in section 4.4.5 Credibility of Experience.

4.4.5 Credibility of Experience:

Full credibility has been assigned to the base period experience, appropriately adjusted to reflect the material changes anticipated between the experience period and the projected period.

This assignment of full credibility is consistent relative to:

(1) Actuarial Standard of Practice No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages, specifically section 3.4, "Professional Judgment," the ASOP states, "...in some situations, an acceptable procedure for blending the subject experience with the relevant experience may be based on the actuary assigning full, partial, or zero credibility to the subject experience without using a rigorous mathematical model," and

(2) A review of the MLR credibility standards, as described in 45 CFR Part 158, §158.230(c)(1). An MLR calculation is fully credible if it is based on the experience of 75,000 or more life-years. [redacted] As such, we felt that applying 100% credibility was appropriate.

There are no material changes from the prior credibility procedures.

4.4.6 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.

We have made an adjustment to our projected paid claims for the members expected to enroll in a cost sharing reduction (CSR) variant plan to account for the lack of direct federal reimbursement for these subsidies.

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 F94)

Allowed Amount = Total Allowed Claims (cell F87)

Worksheet 2 Paid to Allowed Ratio = [redacted]

The ratio for each plan is relatively consistent with the corresponding metallic actuarial value, but may differ due to:

- [redacted]

[redacted]

4.4.7 Risk Adjustment and Reinsurance:

Please note that the 2016 benefit year was the final year of the Federal Reinsurance Program, as stated in the 2019 Notice of Benefit and Payment Parameters. As a result, neither the Experience Period nor the Projection Period include Reinsurance payments/contributions.

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

[redacted]

Projected Risk Adjustments PMPM:

Estimates of the risk adjustment revenue in the projection period were developed using information from the process 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.

[redacted]

Market and plan level inputs to the risk adjustment transfer formula are shown in the following table:

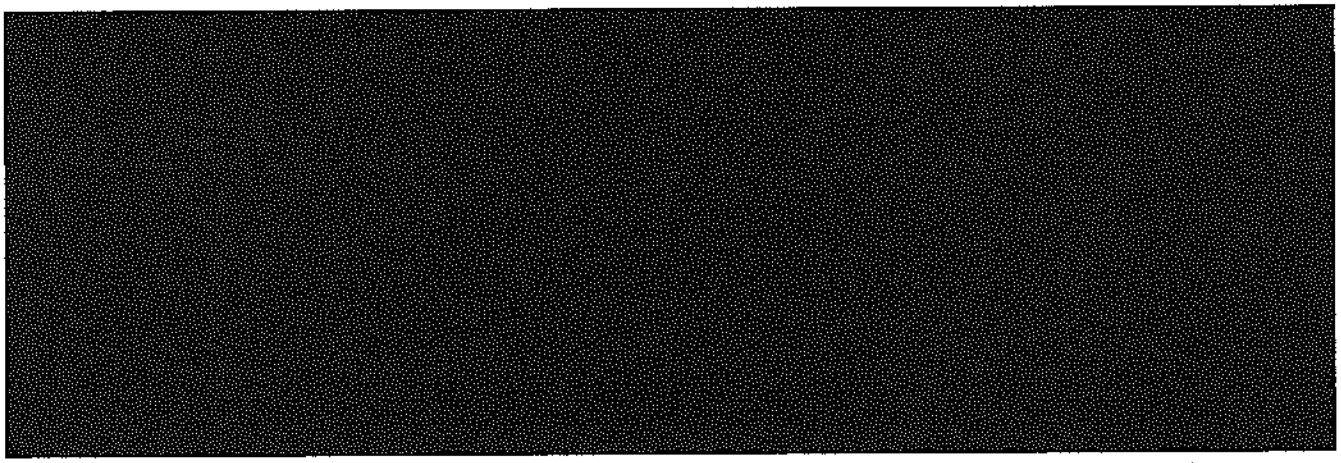
[redacted]

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 as follows:

- PLRS (Plan Liability Risk Score): The baseline is estimated from the process described in the Changes in the Morbidity of the Population Insured section, 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.
- IDF (Induced Demand Factor): This is tied to the metallic plan a member is enrolled in. Metallic distribution is sourced from the process described in the Changes in the Morbidity of the Population Insured section.
- GCF (Geographic Cost Factor): This is sourced from the process described in the Changes in the Morbidity of the Population Insured section and calculated as prescribed by HHS regulations.
- ARF (Allowable Rating Factor): The ages of enrollees are sourced from the process described in the Changes in the Morbidity of the Population Insured section, and the standard CMS age curve is applied to determine the ARF.
- AV (Actuarial Value): This is tied to the metallic plan a member is enrolled in. Metallic distribution is sourced from the process described in the Changes in the Morbidity of the Population Insured section.
- Market share: This is sourced from the process described in the Changes in the Morbidity of the Population Insured section.
- For purposes of developing the final projected risk adjustment PMPM, the market average premium has been reduced by 14% to account for the proportion of administrative costs that do not vary with claims in accordance with the final 2019 Notice of Benefit and Payment Parameters. This is reflected in the formula below.

The final calculation of risk adjustment as a percent of premium estimate for 2018 or later is below. Note that the risk transfer calculation is actually applied at the level of carrier/plan combination as per HHS regulations.

Net Plan Average Risk Adjustment as % of BCBSOK Premium =



Please note that the risk adjustment modeling is completed before final rates are set, which causes the final BCBSOK premium to be different from premium used in this process. This difference does not materially impact rate development. The above exhibit has been slightly adjusted from the original analysis in order to be consistent with the final projected risk adjustment PMPM and BCBSOK premium PMPM.

The pool that buys insurance and the risk of this pool was generated by the process described in the Changes in the Morbidity of the Population Insured section. To the extent that purchasing decisions and risk scores are different from the BCBSOK modeling results, then this could have an impact on the transfers.

The difference between BCBSOK average premium and market average premium is sourced from the process described in the Changes in the Morbidity of the Population Insured section. This difference is the basis for the Net Plan Average Risk Adjustment as % of Market Premium shown in the table above. To the extent that Market Premium differs from BCBSOK premium other than this assumption, then this could have a significant impact on transfers.

The estimated risk adjustment transfers net of the risk adjustment user fee 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].

4.4.8 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 2019 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 Marketplace User Fees.

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 2019, and changes in operations as a result of the Marketplace. Membership in 2019 is aligned with the projected membership 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. [redacted]

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 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:

State Premium Tax	[redacted]
Annual Fee on Health Insurers	[redacted]
High Risk Pool Assessments	[redacted]
PCORI Fee	[redacted]
Marketplace User Fee	[redacted]
Miscellaneous Taxes	[redacted]
Federal Income Tax	[redacted]

As described in the Changes in the Morbidity of the Population Insured section, the anticipated membership was allocated to networks, Marketplace participation, and metallic level using internal assumptions. The allocations were based on members' presumed income levels, prior insured status, and the number of networks available in the insured geographic location. From this allocation, assumed premium levels were assigned to each member based on their demographic characteristics and allowable rating variables so that the market level Marketplace User Fee was determined as [redacted] of total Marketplace participation premium divided by total premium for on and off Marketplace business.

The Miscellaneous Taxes item of [redacted] is assumed to be included in the Core Administrative Expenses. This assumption is only used for purposes of determining the projected loss ratio using the Federally prescribed MLR methodology and has no impact on the 2019 rate level and is based on guidance from Health Care Service Corporation's Cost Accounting Department.

4.5 Projected Loss Ratio:

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

$$MLR = \left[\frac{(i+q+n-r)}{\{(p-n+r)-t-f-(-n+r)\}}\right] + c$$

Which simplifies to,

$$MLR = \left[\frac{(i+q+n-r)}{\{p-(t+f)\}}\right] + c$$

Where,

- i = incurred claims
- q = expenditures on quality improving activities
- p = earned premiums
- t = Federal and State taxes and assessments
- f = licensing and regulatory fees,
- n = issuer's risk corridors and risk adjustment related payments
- r = issuer's risk corridors and risk adjustment related receipts
- c = credibility adjustment, if any

The following are the values for each component listed above stated as a percentage of premium:

- i = [redacted]

- q = [redacted]
- p = [redacted]
- t = [redacted]
- f = [redacted]
- n = [redacted]
- r = [redacted]
- c = [redacted]

[redacted]

The projected MLR is greater than 80%.

4.6 Application of Market Reform Rating Rules:

4.6.1 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.

4.6.2 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.

[redacted]

[redacted]

[redacted]

The Index Rate is then adjusted for:

- Expected payments and charges under the Risk Adjustment program including the Risk Adjustment User Fee,
- 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]
- [redacted]

4.6.3 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 Risk Adjustment and Marketplace user fees.

The Market Adjusted Index Rate is calculated as follows:

MAIR = IR - RA + MUFA

Where,

- MAIR = Market Adjusted Index Rate
- IR = Index Rate
- RA = Risk Adjustment
- MUFA = Marketplace User Fee Adjustment

MAIR = [redacted]

The Payments and Contributions for the Risk Adjustment program are described in the Risk Adjustment and Reinsurance section. The Marketplace User Fee is described in the Taxes and Fees section.

4.6.4 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]

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.

For catastrophic plans, an adjustment was made to reflect the differences in anticipated demographics and morbidity of the catastrophic plans as compared to the Single Risk Pool. [redacted]

4.6.5 Calibration:

Age Curve Calibration:

The approximate weighted average age associated with the projected 2019 Single Risk Pool is [redacted]. The approximate average age factor associated with the projected Single Risk Pool is [redacted].

This factor was developed using the projected membership for the Single Risk Pool in conjunction with the CMS standard age curve. The member-weighted average age factor for the expected 2019 population is calculated as follows: ∑(CMS Age Factor x 2019 Rated Member Months) / ∑(2019 Total Member Months).

According to the 2019 Unified Rate Review instructions, CMS will allow for the application of a factor of zero (0) for the distribution of members expected to pay no premium when developing the approximate weighted average age to account for the lost revenue due to the three under age 21 child dependent cap. Therefore, a distribution of 2019 projected membership for the Single Risk Pool expected to pay no premium was developed and used in the development of member-weighted average age factor.

The following table below shows the projected 2019 membership distribution by age.

Age	Age Factor	Projected Rated Member Months	Projected Non-Rated Member Months	Age	Age Factor	Projected Rated Member Months	Projected Non-Rated Member Months
0	[redacted]			33	[redacted]		
1				34			
2				35			
3				36			
4				37			
5				38			

Age	Age Factor	Projected Rated Member Months	Projected Non-Rated Member Months	Age	Age Factor	Projected Rated Member Months	Projected Non-Rated Member Months
6	[redacted]			39	[redacted]		
7				40			
8				41			
9				42			
10				43			
11				44			
12				45			
13				46			
14				47			
15				48			
16				49			
17				50			
18				51			
19				52			
20				53			
21				54			
22				55			
23				56			
24				57			
25				58			
26				59			
27				60			
28				61			
29				62			
30				63			
31				>=64			
32							

The age calibration adjustment is not plan specific, and the same factor is applied for all plans in the projected Single Risk Pool.

Geographic Factor Calibration:

[redacted]

[redacted]

The following table shows the 2019 geographic area factors and the projected membership distribution used to develop the geographic area calibration adjustment.

Rating Area	Geographic Factor	Projected Member Months
Rating Area 1: Fort Smith, AR-OK	[redacted]	
Rating Area 2: Lawton, OK		
Rating Area 3: Oklahoma City, OK		
Rating Area 4: Tulsa, OK		
Rating Area 5: Non MSA		

The geographic area calibration adjustment is not plan specific, and the same factor is applied for all plans in the projected Single Risk Pool.

Tobacco Use Rating Factor Calibration:

The average tobacco use rating factor associated with the projected Single Risk Pool only reflects the expected surcharge collected for tobacco users and is equal to [redacted]. It is calculated as follows:

[redacted]

where non-tobacco users are assigned a factor of [redacted].

The tobacco use rating factors by age are identical to the factors used for 2015 through 2018. The tobacco use rating factors were developed by comparing individual claims costs by age for tobacco and non-tobacco users after normalizing for other variables such as rating area, gender, and underwriting duration.

The following table shows the 2019 tobacco use rating factors by age and the projected membership distribution used to develop the tobacco use rating factor calibration. Note that non-tobacco users have a factor of [redacted].

Age	Age Factor	Tobacco Use Rating Factor	Projected Tobacco User Member Months	Projected Non Tobacco User Member Months	Projected Total Member Months
0	[redacted]				
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					

Age	Age Factor	Tobacco Use Rating Factor	Projected Tobacco User Member Months	Projected Non Tobacco User Member Months	Projected Total Member Months
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					
53					
54					
55					
56					
57					
58					
59					
60					
61					
62					
63					
>= 64					

The tobacco use rating factor calibration adjustment is not plan specific, and the same factor is applied for all plans in the projected Single Risk Pool.

4.6.6 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, the geographic calibration factor, and the tobacco use rating factor 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 (CAPR). 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.

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

Example calculation for age 40 non-tobacco user in Rating Area 1

Plan: Blue Preferred Gold PPO 205, 87571OK0320088
Plan Adjusted Index Rate = [redacted]
Age Calibration = [redacted]
Geographic Calibration = [redacted]
Tobacco Calibration = [redacted]
Age 40 Factor = [redacted]
Non-Tobacco Factor = [redacted]
Rating Area 1 Factor = [redacted]

CAPR = [redacted]

The Premium Rate listed in the Rates Template is [redacted]. Any differences are due to rounding.

4.7 Plan Product Info

4.7.1 AV Metal Values:

The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template are based entirely on the AV Calculator results. While certain member cost-sharing features may not be fully compatible with the AV Calculator parameters and potentially remain unaccounted for, the impact of these features is likely small enough that no plan's metallic status would be impacted.

4.7.2 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	AV Pricing Value	Provider Network	Cost-Sharing	Benefits in Addition to EHBs	Catastrophic Plan Eligibility	Administrative Costs
87571OK0320078						
87571OK0320080						
87571OK0320081						
87571OK0320082						
87571OK0320083						
87571OK0320079						
87571OK0320084						
87571OK0320085						
87571OK0320086						
87571OK0320087						
87571OK0350068						
87571OK0350083						
87571OK0350084						
87571OK0350085						
87571OK0350086						
87571OK0350069						
87571OK0350087						
87571OK0350088						
87571OK0350089						
87571OK0350090						
87571OK0350070						
87571OK0350091						
87571OK0350092						
87571OK0350093						
87571OK0350094						
87571OK0320088						
87571OK0320089						
87571OK0320090						
87571OK0320091						
87571OK0320092						
87571OK0320093						
87571OK0320094						
87571OK0320095						
87571OK0320096						
87571OK0320097						
87571OK0320099						
87571OK0320105						
87571OK0320106						
87571OK0320107						

Standard Component ID	AV Pricing Value	Provider Network	Cost-Sharing	Benefits in Addition to EHBs	Catastrophic Plan Eligibility	Administrative Costs
87571OK0320108						
87571OK0320098						
87571OK0320101						
87571OK0320102						
87571OK0320103						
87571OK0320104						
87571OK0350097						
87571OK0350106						
87571OK0350107						
87571OK0350108						
87571OK0350109						
87571OK0350096						
87571OK0350102						
87571OK0350103						
87571OK0350104						
87571OK0350105						

The following table shows the breakdown of the AV and Cost-Sharing Design adjustments factors for each plan.

AV and Cost-Sharing Design Adjustment Factors

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	AV and Cost-Sharing Design
87571OK0320078			
87571OK0320080			
87571OK0320081			
87571OK0320082			
87571OK0320083			
87571OK0320079			
87571OK0320084			
87571OK0320085			
87571OK0320086			
87571OK0320087			
87571OK0350068			
87571OK0350083			
87571OK0350084			
87571OK0350085			

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	AV and Cost-Sharing Design
87571OK0350086	[redacted]		
87571OK0350069			
87571OK0350087			
87571OK0350088			
87571OK0350089			
87571OK0350090			
87571OK0350070			
87571OK0350091			
87571OK0350092			
87571OK0350093			
87571OK0350094			
87571OK0320088			
87571OK0320089			
87571OK0320090			
87571OK0320091			
87571OK0320092			
87571OK0320093			
87571OK0320094			
87571OK0320095			
87571OK0320096			
87571OK0320097			
87571OK0320099			
87571OK0320105			
87571OK0320106			
87571OK0320107			
87571OK0320108			
87571OK0320098			
87571OK0320101			
87571OK0320102			
87571OK0320103			
87571OK0320104			
87571OK0350097			
87571OK0350106			
87571OK0350107			
87571OK0350108			
87571OK0350109			
87571OK0350096			
87571OK0350102			
87571OK0350103			
87571OK0350104			

Standard Component ID	Paid/Allowed Ratio	Benefit Richness	AV and Cost-Sharing Design
87571OK0350105	[redacted]		

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

4.7.3 Membership Projections:

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

Projected Member Months by Standard Component ID and Cost-Sharing Reduction Variant

Standard Component ID	0	1	2	3	4	5	6	Total
87571OK0320078	[redacted]							
87571OK0320080								
87571OK0320081								
87571OK0320082								
87571OK0320083								
87571OK0320079								
87571OK0320084								
87571OK0320085								
87571OK0320086								
87571OK0320087								
87571OK0350068								
87571OK0350083								
87571OK0350084								
87571OK0350085								
87571OK0350086								
87571OK0350069								
87571OK0350087								
87571OK0350088								
87571OK0350089								
87571OK0350090								
87571OK0350070								

Standard Component ID	0	1	2	3	4	5	6	Total
87571OK0350091								
87571OK0350092								
87571OK0350093								
87571OK0350094								
87571OK0320088								
87571OK0320089								
87571OK0320090								
87571OK0320091								
87571OK0320092								
87571OK0320093								
87571OK0320094								
87571OK0320095								
87571OK0320096								
87571OK0320097								
87571OK0320099								
87571OK0320105								
87571OK0320106								
87571OK0320107								
87571OK0320108								
87571OK0320098								
87571OK0320101								
87571OK0320102								
87571OK0320103								
87571OK0320104								
87571OK0350097								
87571OK0350106								
87571OK0350107								
87571OK0350108								
87571OK0350109								
87571OK0350096								
87571OK0350102								
87571OK0350103								
87571OK0350104								
87571OK0350105								

The following is the definition of each cost sharing reduction (CSR) variant:

- 00 = Off Marketplace
- 01 = On Marketplace with no CSR
- 02 = Zero Cost Sharing Plan

- 03 = Limited Cost Sharing Plan
- 04 = 73% AV Level Silver Plan CSR (200% to 250% of FPL)
- 05 = 87% AV Level Silver Plan CSR (150% to 200% of FPL)
- 06 = 94% AV Level Silver Plan CSR (100% to 150% of FPL)

4.7.4 Terminated Products:

The following products will be terminated prior to January 1, 2019. The 2019 Standard Component ID listed is the plan to which the terminated plan will be mapped.

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0320006	[redacted]				
87571OK0320006					
87571OK0320030					
87571OK0320030					
87571OK0320031					
87571OK0320031					
87571OK0320032					
87571OK0320032					
87571OK0320033					
87571OK0320033					
87571OK0320046					
87571OK0320046					
87571OK0320047					
87571OK0320047					
87571OK0320048					
87571OK0320048					
87571OK0320049					
87571OK0320049					
87571OK0320062					
87571OK0320062					
87571OK0320063					
87571OK0320063					
87571OK0320064					
87571OK0320064					
87571OK0320065					
87571OK0320065					

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0320066	[redacted]				
87571OK0320066					
87571OK0320067					
87571OK0320067					
87571OK0320068					
87571OK0320068					
87571OK0320069					
87571OK0320069					
87571OK0320070					
87571OK0320070					
87571OK0320071					
87571OK0320071					
87571OK0320072					
87571OK0320072					
87571OK0320073					
87571OK0320073					
87571OK0320074					
87571OK0320074					
87571OK0320075					
87571OK0320075					
87571OK0320076					
87571OK0320076					
87571OK0320077					
87571OK0320077					
87571OK0320078					
87571OK0320078					
87571OK0320079					
87571OK0320079					
87571OK0320080					
87571OK0320080					
87571OK0320081					
87571OK0320081					
87571OK0320082					
87571OK0320082					
87571OK0320083					
87571OK0320083					
87571OK0320084					
87571OK0320084					
87571OK0320085					
87571OK0320085					

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0320086	[redacted]				
87571OK0320086					
87571OK0320087					
87571OK0320087					
87571OK0320088					
87571OK0320088					
87571OK0320089					
87571OK0320089					
87571OK0320090					
87571OK0320090					
87571OK0320091					
87571OK0320091					
87571OK0320092					
87571OK0320092					
87571OK0320093					
87571OK0320093					
87571OK0320094					
87571OK0320094					
87571OK0320095					
87571OK0320095					
87571OK0320096					
87571OK0320096					
87571OK0320097					
87571OK0320097					
87571OK0350006					
87571OK0350006					
87571OK0350022					
87571OK0350022					
87571OK0350023					
87571OK0350023					
87571OK0350024					
87571OK0350024					
87571OK0350025					
87571OK0350025					
87571OK0350026					
87571OK0350026					
87571OK0350027					
87571OK0350027					
87571OK0350028					
87571OK0350028					

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0350029	[redacted]				
87571OK0350029					
87571OK0350030					
87571OK0350030					
87571OK0350031					
87571OK0350031					
87571OK0350032					
87571OK0350032					
87571OK0350033					
87571OK0350033					
87571OK0350034					
87571OK0350034					
87571OK0350035					
87571OK0350035					
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87571OK0350039					
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87571OK0350041					
87571OK0350041					
87571OK0350042					
87571OK0350042					
87571OK0350043					
87571OK0350043					
87571OK0350044					
87571OK0350044					
87571OK0350046					
87571OK0350046					
87571OK0350051					
87571OK0350051					
87571OK0350052					
87571OK0350052					
87571OK0350053					

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0350053					
87571OK0350057					
87571OK0350057					
87571OK0350058					
87571OK0350058					
87571OK0350059					
87571OK0350059					
87571OK0350060					
87571OK0350060					
87571OK0350061					
87571OK0350061					
87571OK0350062					
87571OK0350062					
87571OK0350064					
87571OK0350064					
87571OK0350068					
87571OK0350068					
87571OK0350069					
87571OK0350069					
87571OK0350070					
87571OK0350070					
87571OK0350083					
87571OK0350083					
87571OK0350084					
87571OK0350084					
87571OK0350085					
87571OK0350085					
87571OK0350086					
87571OK0350086					
87571OK0350087					
87571OK0350087					
87571OK0350088					
87571OK0350088					
87571OK0350089					
87571OK0350089					
87571OK0350090					
87571OK0350090					
87571OK0350091					
87571OK0350091					

Original Standard Component ID	CSR Variant	Original Plan Name	Rating Area	Mapped Standard Component ID	Status
87571OK0350092					
87571OK0350092					
87571OK0350093					
87571OK0350093					
87571OK0350094					
87571OK0350094					
87571OK0460001					
87571OK0460002					
87571OK0460003					
87571OK0460004					
87571OK0460005					
87571OK0460006					
87571OK0460007					
87571OK0460008					
87571OK0460009					
87571OK0460010					
87571OK0460011					
87571OK0460012					
87571OK0460013					
87571OK0460014					
87571OK0460015					
87571OK026*					
87571OK027*					

*The product ID is listed for terminated transitional plans.

4.7.5 Plan Type:

All health plans fit the plan types listed in the drop-down box in Worksheet 2, Section I of the URRT.

4.7.6 Warning Alerts:

All warning alerts in the URRT are indicated as "OK".

4.8 Miscellaneous Instructions:

4.8.2 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.

4.8.3 Actuarial Certification:

I, [redacted], am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries in good standing, 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
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

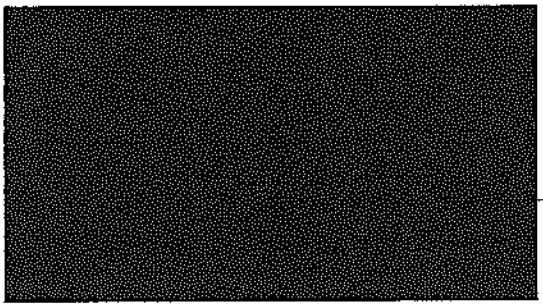
I hereby certify to the best of my knowledge that:

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 and 45 CFR 147.102),
    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 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.
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.

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,



Date: July 25, 2018