

CAPITAL ADVANTAGE ASSURANCE COMPANY, INC.

ACTUARIAL MEMORANDUM

Individual Rates

Effective January 1, 2017

General Information

Company Information

- Company Legal Name: Capital Advantage Assurance Company – CAAC
- State: PA
- HIOS Issuer ID: 45127
- Market: Individual
- Effective Date: 1/1/2017

PID Company Information

- Company Name: Capital Advantage Assurance Company (CAAC)
- NAIC: 14411
- Market: Individual
- On/Off Exchange: On/Off Exchange
- Effective Date: 1/1/2017
- Average Rate Change: 43.3%
- Range of Requested Rate Change: 8.6% to 76.9%
- Product: PPO
- Rating Areas: 6,7,9
- Metal Levels: Gold, Silver
- Current Covered Lives and Policyholders: 38,043/22,830
- Number of Plans: 2
- Contract Form #: CAAC-Ind-PPO-C-v0117
- Form Filing SERFF #: CABC-130533947
- Binder SERFF #: CABC-PA17-125060073
- HIOS Issuer ID: 45127
- HIOS Submission Tracking Number: 45127-687360061172921399

Company Contact Information

- Primary Contact Name: [REDACTED]
- Primary Contact Telephone Number: [REDACTED]
- Primary Contact Email Address: [REDACTED]

Scope and Purpose

By this filing, Capital Advantage Assurance Company (CAAC), a subsidiary of Capital BlueCross (CBC), submits rates for products to be made available to individuals effective January 1, 2017. CAAC will offer individual products on and off the federally-facilitated exchange.

Rate History and Proposed Variations in Rate Changes

Market	Company	Effective Date	SERFF #	Annual Increase
Individual	CAAC	1/1/2014	CABC-129034382	0.00%
Individual	CAAC	1/1/2015	CABC-129635524	-8.00%
Individual	CAAC	1/1/2016	CABC-130076761	1.60%

Proposed Rate Increases

CAAC is proposing an aggregate annual 43.3% rate increase. The rate change does vary by plan. The rate change is calculated in PA Rate Template Part IV, Table 11, cell AZ13.

Reason for Rate Increase

The following are drivers of the requested rate increase, as described in the Pennsylvania Rate Change Request Summary:

- Historical Claim Experience: 20%. Historical claim experience is found on PA Rate Exhibit Table 2. 2015 CAAC results combined with subsidiary Keystone Health Plan Central (KHPC) show a combined loss ratio of 106.5%. Given a target loss ratio of 86.1%, historical claim experience (before trend) justifies a 20% annual rate increase.
- Increased morbidity due to transition from medically-underwritten membership to PPACA membership: 20%.
- Loss of Federal Reinsurance Program: 6.4%. The loss of Federal Reinsurance in 2017 is worth approximately 6 percent of premium. From CAAC's Premium Deficiency Reserve (PDR) calculation, 2016 reinsurance is estimated at \$25 PMPM, or 6.4 percent of premium.
- Trend Components: 8.1%.
- Administrative Expense (AE) Inflation: 0.4%. AE trends approximately 4 percent per year, and is 10 percent of premium.

- Suspension of Health Insurer Tax: -3.6%. CBC applied 3.6% to 2016 rates. This tax is suspended for calendar year 2017.
- Increase in Exchange User Fee: 0.5%.

Membership

Membership is shown in PA Rate Template Part I, Table 1.

Benefit Changes 2016-2017

There are several benefit changes being implemented in 2017. All benefit changes comply with the uniform modification of coverage standards described in 45 CFR 147.106(e). Any plan with a benefit change that did not meet the uniform modification of coverage standard was terminated, and a new plan was created in its place. All terminated plans are listed in Exhibit R, and a summary of proposed 2017 benefits is included in Exhibit A.

Benefit changes by plan are listed in Exhibit A1, highlighted in yellow.

Experience Period Premium and Claims

Base Experience Period: The base experience period (BEP) includes completed fee-for-service paid and incurred claims for dates of service between January 1, 2015 and December 31, 2015.

Paid Through Date: Claims in the BEP are paid through March 31, 2016

Premiums (net of MLR Rebate) in Experience Period: Premiums are calculated on an earned basis in the BEP. MLR rebate adjustments are equal to zero as CAAC does not expect to refund any MLR rebates.

Allowed and Incurred Claims during the Experience Period:

	Incurred	Allowed
Amount of claims processed through the issuer's claim system:	\$45,240,892	\$53,242,444
Amount of claims processed outside of the issuer's claim system:	\$0	\$0
Amount of claims that represent best estimate of incurred but not paid:	\$905,080	\$1,137,423

Allowed claims are developed by combining paid claims with member cost-sharing.

Estimated Incurred but Not Paid Claims: Paid claims by date of service come directly from CBC's data warehouse. The method for calculating incurred claims in the BEP is as follows:

1. Historical fee-for-service claims are viewed by date of service and date of payment in a claims triangle.
2. The claims triangle payments are then accumulated by date of service to develop factors that represent the rate of accumulation or rate of “completion”.
3. Historical rates of completion by duration are used to derive projected rates of completion. Some of the methods used to develop projected completion factors are averages (e.g. harmonic averages, time weighted averages, geometric averages) and regression methods. Numerous items are considered when viewing these averages or regression statistics, such as the impact of high claims on perceived completion patterns.
4. For durations that exhibit a projected completion factor greater than the Valuation Actuary’s chosen threshold (e.g. 80% complete), cumulative paid and incurred claims are divided by the projected completion factor to arrive at ultimate incurred claims. For durations that are less than the chosen threshold, a projection methodology is used. Similar to completion factor development, projection methodologies are worthy of a lengthy discussion. In general, an ultimate incurred claims PMPM is derived by projecting a recent 12-month period to the current month(s) and seasonally adjusting.
5. With all months having both a cumulative paid amount and an estimated ultimate incurred amount, the completion factors used in pricing are calculated by taking the quotient of the two. Allowed completion and incurred completion are assumed to be identical.
6. Both allowed and paid claims in the BEP are completed by applying completion factors by incurred month developed in Step 6.

$$BEP\ Incurred\ Claims = \sum \frac{BEP\ Paid\ Claims\ by\ Incurred\ Month}{Completion\ by\ Incurred\ Month}$$

$$BEP\ Allowed\ Claims = \sum \frac{BEP\ Paid\ Claims + BEP\ Member\ Cost\ Share\ by\ Incurred\ Month}{Completion\ by\ Incurred\ Month}$$

Benefit Categories

Claims in the benefit categories displayed in the URRT come directly from CBC’s data warehouse. See Exhibit C for a description of benefits by benefit category.

Projection Factors

Changes in Morbidity: Found in URRT Worksheet 1, “Pop'l risk Morbidity”. The morbidity adjustment is calculated by measuring the claims experience of transitional policies and single risk pool policies in the experience period. Transitional policies have significantly lower claims PMPM than single risk pool policies, and make up 68 percent of the enrollment in the BEP. Current and projected enrollment show a very different distribution, as CAAC experienced significant enrollment growth in 2016. In the projection period, transitional policies only account for 15% of enrollment. This distribution change leads to higher claim expectations in the projection period. The calculation does adjust the single risk pool claim PMPM as their claim experience should regress toward the mean as enrollment grows. The adjustment also accounts for the impact of risk adjustment. Due to enrollment growth, CAAC is projecting \$0 in risk

adjustment. And because claims and risk are inversely proportional, that assumption translates into a lower single risk pool claims PMPM than in the BEP. See Exhibit G1 – Morbidity Factor Calculation.

Changes in Benefits:

1. Pediatric Dental and Pediatric Vision: The following PMPM charges are added to the projection period claims PMPM:

- Pediatric dental coverage: 5.01 allowed/3.61 incurred
- Pediatric vision coverage 0.46 allowed/0.46 incurred

This was added to the projected allowed claims in Exhibit B by applying a factor to the experience period, “Other Medical” claims. The development of pediatric dental and vision projected claims is described below.

See Exhibit C for the pediatric dental and vision rate development.

Changes in Demographics: CAAC does not expect changes in demographics in its individual population.

Other Adjustments: Found in URRT, Worksheet 1, “Other”.

1. List-Billed Adjustment: CAAC is adjusting the claim experience for the impact of the list-billing rating methodology required under CFR Part 147.102. This section requires that family rates are calculated by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account. This rating rule requires an adjustment to premium.
2. Benefit Adjustment: A benefit adjustment is being applied to measure the impact of discontinuing CAAC’s platinum plan, and the movement of membership into Silver plans. Platinum members are being mapped to a Gold plan, and new enrollment is mostly in Silver. This results in lower incurred and allowed claims in the projection period from the BEP.

Trend Factors: Trend levels reflect our best estimate of changes in utilization, provider reimbursement contracts, the network of facilities and providers, disease management initiatives and the impact of utilization management.

The following is a description of considerations used to determine trend.

1. Base Cost/ Change in hospital and physician contracting: The contracted increase in reimbursements to hospitals and physicians is the basis of cost trends. CAAC uses a hospital and physician contracting model to determine future trends. This model contains all known contracted payment increases, as well as estimated increases in provider payments.
2. Utilization Considerations:

- a. Intensity of medical services rendered
 - b. Changes in place of service (e.g. continued migration of inpatient stays to outpatient setting)
 - c. Further migration from brand prescription drugs to generic prescription drugs
 - d. Favorable impacts of value based benefits designs
3. Intensity: Intensity is defined as the amount of inputs used to provide each unit of service. This can best be seen in an example:

Year 2015

<u>Type of Service</u>	<u>Units</u>	<u>Cost per Unit</u>
X-Ray	1	\$200
MRI	1	\$5,000
Total	2	\$5,200

Year 2016

<u>Type of Service</u>	<u>Units</u>	<u>Cost per Unit</u>
X-Ray	0	\$200
MRI	2	\$5,000
Total	2	\$10,000

Total Annual Trend	92%
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2. Underwriting Cycle: The underwriting cycle is defined as the tendency to swing between profitable and unprofitable periods over time. The underwriting cycle is exacerbated partly by pricing performed with incomplete information as to the level of current experience trends. A reaction delay occurs, as carriers tend to rely on measurements of past experience in developing current pricing assumptions. As a result, carriers are often increasing their pricing trends when actual experience trends have begun to decline, and decreasing their pricing trends actual trends are increasing. CAAC strives to mitigate the underwriting cycle by keeping trends consistent through times of increasing and decreasing claim cost and utilization.

See Exhibit E for CAAC’s pricing trend, as well as cost and utilization components of the pricing trend.

Credibility Manual Rate Development

CAAC individual data was used to develop rates. No credibility manual is used.

Credibility of Experience

Credibility Manual Rate Development: CAAC experience data is given 100% credibility.

Paid to Allowed Ratio

CAAC used the prescribed URRT allowed claim rate development methodology in conjunction with a paid and incurred rate development methodology to determine final premium rates. The URRT projects allowed claims, and uses a paid-to-allowed ratio in order to adjust allowed claims to paid levels. This value is then used to develop premiums. In order to determine the paid-to-allowed ratio, CAAC projected paid and incurred claims, adjusted for benefits, to the experience period.

Projected Paid and Incurred Claims are calculated as follows:

1. Gather claims experience as described in the Data section above.
 - a. Base Experience Period (BEP) Paid Claims, Capitation, and Rx Rebates
 - b. BEP Member Months
2. Develop BEP *Paid and Incurred Claims*:

$$\text{BEP Paid and Incurred Claims} = \frac{\text{BEP Paid Claims}}{\text{Completion Factor}}$$

The development of completion factors is described in Experience Period Premium and Claims above.

3. Develop the *BEP Paid and Incurred Claim PMPM*:

$$\text{BEP Paid and Incurred Claim PMPM} = \frac{\text{BEP Paid and Incurred Claims}}{\text{BEP Member Months}}$$

4. Develop *Trended Claim PMPM*: Using the aggregate trend described in the Projection Factors section above, trend the BEP Paid and Incurred Claim PMPM from the midpoint of the experience period to the midpoint of the rating period.

Trended Claim PMPM

$$= [\text{BEP Paid and Incurred Claim PMPM}] \times (1 + [\text{Trend\%}])^{\text{Trend Months}/12}$$

5. Develop *Projected Paid and Incurred Claim PMPM*:

$$\begin{aligned} \text{Projected Paid and Incurred Claims PMPM} \\ &= [\text{Trended Claim PMPM}] \times [\text{Benefit Adjustment}] \\ &\times [\text{Morbidity Adjustment}] \times [\text{List - Billed Adjustment}] \end{aligned}$$

The *Benefit Adjustment*, *Morbidity Adjustment*, and *List-Billed Adjustment* are discussed in the Projections Factors section above.

6. Develop *Projected Claims PMPM by Benefit* as follows:

- a. CAAC uses an actuarial cost model to measure the impact of cost-sharing designs on cost and utilization amounts by service category. The cost model shows frequency per 1,000 per year by type of service (IP, OP, Professional), and allowed cost per service for each of the same types of service, normalized to a \$0 office visit copayment and a \$25 ER copayment. Given a particular benefit design (for example, \$20 office visit copayment), utilization is adjusted from the benchmark based on assumed utilization change factors, and cost per service is reduced by the copayment or coinsurance per service. Cost and utilization are multiplied together to derive a PMPM by service, summed for all services. The impact of global deductible, coinsurance, and out-of-pocket max is then measured based on cumulative probability distributions (CPDs), where the value of services that apply to the CPDs adjusts the level of the curve, as well as global utilization adjustments.
- b. This actuarial cost model derives a Manual Cost for each benefit design in the experience period, as well as plans being offered in the projection period. The average Manual Cost of the experience is compared to the Manual Cost of the base plan. The projected experience period data is then adjusted to the base plan:

$$\text{Benefit Level Adjustment} = \frac{\text{Average Manual Cost in Projection Period}}{\text{Manual Cost of Base Plan}}$$

- c. The *Projected Paid and Incurred Claim PMPM* (Step 5) is then adjusted to the Base Plan as follows:

$$\begin{aligned} & \text{Base Plan Paid and Incurred Claims PMPM} \\ &= \frac{\text{Benefit Adjusted Paid and Incurred Claims PMPM}}{\text{Benefit Level Adjustment} \times \text{Avg Induced Demand}} \end{aligned}$$

Where Avg Induced Demand is the average premium impact of induced demand rating factor. This factor is discussed in the Plan Adjusted Index Rate section below.

- d. Each additional benefit design has its own unique Manual Cost, which can then be compared to the Base Plan to develop a Benefit Relativity:

$$\text{Benefit Relativity A} = \frac{\text{Manual Cost of Benefit A}}{\text{Manual Cost of Base Plan}}$$

- e. The Benefit Relativity developed in d. above is then used as a gauge to develop a final *Pricing Relativity*. This pricing relativity is developed using actuarial judgment including the following considerations:

- i. Final premium relativities must make sense based on benefits. For example, the annual cost difference between a PPO 2000 and PPO 1000 must be less than \$1000.
 - ii. Adjustments for plan designs that fall outside of the actuarial cost model.
- a. So the *Projected Claims PMPM by Benefit* is:

$$\begin{aligned} & \textit{Projected Claims PMPM Benefit A} \\ & = \textit{Projected Claims PMPM Base Plan} \\ & \times \textit{Pricing Relativity A} \end{aligned}$$

- b. And to arrive at the *Total Projected Claims PMPM*, CAAC assumes a distribution of members across the benefit plans being offered in 2017. The *Total Projected Claims PMPM* :

$$\begin{aligned} = & \textit{Projected Claims PMPM Benefit A} \times \textit{Expected Member Dist of Benefit A} \\ & + \textit{Projected Claims PMPM Benefit B} \\ & \times \textit{Expected Member Dis of Benefit B} + \dots \end{aligned}$$

7. The Paid-To-Allowed Ratio is then:

$$\textit{Paid to Allowed Ratio} = \frac{\textit{Total Projected Claims PMPM}}{\textit{Projected Allowed Claims at Current Benefits}}$$

See Exhibit G for the development of the *Paid-to-Allowed Ratio*.

Risk Adjustment

Projected Risk Adjustments PMPM:

Relevant to 2017 pricing is the impact of Commercial Risk Adjustment (CRA) payment transfers that are expected to be earned in 2017. The 2017 pricing impact is:

$$\begin{aligned} & [\textit{Net Projected Risk Adjustments PMPM}] \\ & = [\textit{Projected CRA Transfer PMPM}] - [\textit{Risk Adjustment Fee PMPM}] \end{aligned}$$

The following items are those that we deem important in generating a CRA payment transfer adjustment:

1. Risk profile of the those enrolled in CRA eligible plans for the market or state (i.e. competitors) relative to risk profile of CRA eligible membership enrolled in our plans
2. Statewide average premiums
3. Current market penetration of this company and competitors in the market and in the state
4. The impact of transitional policies throughout the remainder of 2016 and 2017

Given the uncertainty of the bullets above, it is difficult to determine whether the impact of 2016 earned CRA payment transfers will be positive or negative. Enrollment growth in 2016 further lessens our ability to predict 2017. Therefore, an appropriate estimate of [Projected CRA Transfer PMPM] is \$0.

To fund the HHS-risk adjustment program, issuers will remit to HHS a fee of \$0.13 PMPM. The Risk Adjustment Fee PMPM is included in the URRT Worksheet 1, “Projected Risk Adjustments PMPM”.

$$[\text{Net Projected Risk Adjustments PMPM}] = 0 - 0.13 = -0.13 \text{ PMPM}$$

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

1. **Administrative Expense:** Calculated using an allocation method from CAAC’s finance department, and trended to the rating period. Costs are allocated according to results reported through a company-wide questionnaire. On an annual basis, each cost center within the company completes a questionnaire listing the distribution of costs (in percentage terms) by product as well as by market segment. For example, the questionnaire will ask what percentage of time is spent on PPO versus HMO versus Drug versus Medicare. And separately will ask what percentage of time is spent on large group, small group, individual, and government programs. Using those distributions, all costs needed to perform the business are allocated to the proper market segments and lines of business. The administrative expense applied in the rate development is the total expense allocated to CAAC individual products. Administrative expenses are included in the URRT Worksheet 1, “Administrative Load”.
2. **Broker Expense:** Calculated based on CAAC’s explicit per contract broker fee. Broker Expense is included in the URRT Worksheet 1, “Administrative Load”.
3. **Member Out-Of-Pocket (OOP) and Ways to Save:**
 - a. **Description:** These products offer enhanced transparency to cost savings potential both prospectively and retrospectively. These are new services included in each of CAAC’s plans that work to decrease costs by engaging members in their health care decisions. The Member OOP program will show a member, prospectively, the value of a service and the impact of member cost-sharing when that service is incurred. It allows a member to shop for the best price while introducing transparency related to the member’s expected cost share at the time of service. The “Ways to Save” program allows members to receive alerts, retrospectively, informing them of cost savings that could have been incurred had they have known about competing medical providers in the area. The alerts are retrospective and offer transparency around member’s healthcare options.
 - b. **Costs:** The vendor of these products charge both per contract per year (PCPY) user fees as well as initial implementation fees and annual subscription fees. The PCPY user fees are \$0.115 and \$1.7955 for “Member Out of Pocket” and “Way to

Save” respectively. The vendor also charges a 25% administrative load, annual subscription fee, and a \$100,000 implementation fee. The implementation fee is amortized over 5 years across several hundred thousand members. Using book of business member-to-contract ratios and converting to a per member per month (PMPM), in conjunction with the administrative load and implementation fee yields a PMPM charge of \$0.0128 and \$.20 for Member Out of Pocket and Ways to Save respectively. Annual subscription fees charged yields another \$0.04 PMPM. All of these items combined allow us to arrive at a requested \$0.25 PMPM. These programs are included in the URRT Worksheet 1, “Administrative Load”.

4. Value-Based Benefits (VBB): Standard with each plan, Capital BlueCross includes wellness incentives to maximize the likelihood that consumers make positive behavioral changes, which lead to better health, and curbed health care costs for employers and employees alike. The incentive is as follows:
 - a. Complete CBC Personal Profile and receive a gift card reward.
 - b. Complete one online coaching program and receive a gift card reward.
 - c. The wellness program is administered through a vendor and costs are based on vendor fees.
5. Identity Theft Coverage: Identity protection offering will include the following components:
 - a. Credit monitoring – Monitors activity that may affect credit
 - b. Fraud detection – Identifies potentially fraudulent use of identity or credit
 - c. Fraud resolution support – Assists members in addressing issues that arise in relation to credit monitoring and fraud detection

Profit (or Contribution to Surplus) & Risk Margin:

6. Contingency: Contingency is included in the URRT Worksheet 1, “Profit and Risk”.

Taxes and Fees:

1. Fee for Patient-Centered Outcomes Research Trust Fund (PCOR): As per the Notice of Proposed Rulemaking for Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund (REG-136008-11), 77 Fed. Reg. 22691: For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is \$2 per member per year (\$0.17 PMPM), trended annually. At an estimated trend of 4%, the 2017 projected fee is \$0.18 PMPM. PCOR is included in the URRT Worksheet 1, “Taxes and Fees”.
2. Health Insurer Fee (HIF) – Section 9010 of PPACA and Section 1406 of the Reconciliation Act (which modified PPACA) refer to HIF. The fee is a fixed-dollar amount distributed across health insurance providers: \$8 billion in 2014, \$11.3 billion in 2015-2016, suspended in 2017, and \$14.3 billion in 2018. Because HIF is suspended in 2017, it is not included in 2017 individual rates.
3. Exchange Fee – All issuers participating in a federally-facilitated exchange will remit 3.5% of premium to HHS. CAAC expects 52% of its membership to purchase on-exchange. This translates into a projected \$10.42 PMPM. The Exchange fee is included

in the URRT Worksheet 1, “Taxes and Fees”. The exchange user fee is applied as an adjustment to the Index Rate at the market level.

4. Federal Income Tax: Projected that Federal Income Tax will be collected on the 2% contingency built into the premium. The projected Federal Income Tax is included in the URRT Worksheet 1, “Taxes and Fees”.

See Exhibit H for all retention values.

Projected Loss Ratio

See Exhibit I for the projected loss ratio calculation. The projected loss ratio is calculated using the federally prescribed MLR methodology.

Single Risk Pool

The data used to develop rates and shown in the URRT abides by 45 CFR part 156.80(d) single risk pool requirements. The single risk pool reflects all covered lives for every non-grandfathered product/plan combination for CAAC in the individual market. The single risk pool includes transitional products/plans for purposes of base rate experience. The projection period reflects experience of transitional policies as those members are expected to enroll in single risk pool policies in 2016. The impact of transitional policies is discussed in Projection Factors section above.

Index Rate

The experience period index rate is CAAC’s allowed claims PMPM, set in accordance with the single risk pool provision. All CAAC covered benefits are categorized as Essential Health Benefits (EHBs), therefore no adjustment was made to the experience period index.

Projected Allowed Claims: The CAAC experience period allowed claims, benefit-adjusted, trended to the projection period (See Projection Factors section above), and credibility adjusted, is the *Projected Allowed Claims at Current Benefits*. This number is reflected in Worksheet 1 of the URRT (“Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable)”).

To calculate the projected index rate:

1. Start with *Projected Allowed Claims at Current Benefits*
2. The *Projected Allowed Claims at Current Benefits* reflect EHBs 100 percent, so no adjustment needs to be made to add EHBs and remove non-EHB claim cost. This is the index rate for individuals renewing January – December.

See Exhibit J for the Index Rate.

Market Adjusted Index Rate

The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156.80(d)(1). So,

$$\begin{aligned} & [\textit{Market Adjusted Index Rate}] \\ & = ([\textit{Index Rate}] \times [\textit{Paid to Allowed Ratio}] \\ & \quad - [\textit{Net Projected ACA Reinsurance Recoveries}] \\ & \quad - [\textit{Net Projected Risk Adjustments PMPM}] + [\textit{Exchange Fees PMPM}]) \\ & \div [\textit{Paid to Allowed Ratio}] \end{aligned}$$

See Exhibit K for the development of the Market Adjusted Index Rate.

Plan Adjusted Index Rate

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the URRT.

The following adjustments were used to derive the Plan Adjusted Index Rate:

1. Actuarial Value and Cost Sharing adjustment: The Actuarial Value and Cost Sharing Adjustment is determined using CAAC's actuarial cost model. CAAC uses an actuarial cost model to measure the impact of cost-sharing designs on cost and utilization amounts by service category. The cost model shows frequency per 1,000 per year by type of service (IP, OP, Professional), and allowed cost per service for each of the same types of service, normalized to a \$0 office visit copayment and a \$25 ER copayment. Given a particular benefit design (for example, \$20 office visit copayment), utilization is adjusted from the benchmark based on assumed utilization change factors, and cost per service is reduced by the copayment or coinsurance per service. Cost and utilization are multiplied together to derive a claim PMPM by service, summed for all services. The impact of global deductible, coinsurance, and out-of-pocket max is then measured based on CPDs, where the value of services that apply to the CPDs adjusts the level of the curve, as well as global utilization adjustments.
2. Induced Demand: Higher than average utilization due to benefit richness.
3. Provider Network: The Provider network varies across plans. All "Narrow Network" plans have a smaller provider network than "Broad Network" plans. The provider network factor for those plans is shown in Exhibit L. Development of provider network factors is discussed in Geographic Rating Factors and Network Analysis
4. Adjustment for benefits in addition to EHBs: No benefits other than EHBs are included in the plans, so no adjustment is necessary.
5. Catastrophic Plans: Applied to catastrophic plans to reflect lower morbidity.
6. Adjustment for distribution and administrative costs: Described in Non-Benefit Expenses and Profit & Risk section above.
7. Tobacco Adjustment: Calculated as the average tobacco factor applied across the risk pool.

The development of the Plan Adjusted Index rate is found in Exhibit L, and summarized in Exhibit M.

Calibration

A calibration must be performed in order to apply the allowable rating factors (age and geography) to the Plan Adjusted Rate in order to calculate the Consumer Adjusted Premium Rates.

Age Curve Calibration: The projected average age factor is 1.64. This is calculated by taking the member-weighted average of current individual enrollment by age in CAAC. Age factors are applied in accordance with CMS’s Standard Age Curve.

Geographic Factor Calibration: The projected average geographic factor is 1.003. This is calculated by taking the CAAC member-weighted average by region.

Geographic Factors: CAAC performed regional analysis to quantify the cost difference between the three regions in our service area. The analysis gathered allowed claims in a 12-month period by region, normalized for demographics. We then compared the claim cost for each of the three regions, and found cost differentials between the regions, mostly due to differences in hospital contracting between regions. The data from the analysis is found in Exhibit Q.

The calibration is:

$$[\textit{Calibrated Plan Adjusted Index Rate}] = [\textit{Plan Adjusted Index Rate}] \div ([\textit{Age Curve Calibration}] \times [\textit{Geographic Factor Calibration}])$$

All consumer-level adjustments are applied uniformly to all plans in the Single Risk Pool. These adjustments do not vary by plan. The calibration factors and development are found on Exhibit N. Age and Geographic factors are displayed in Exhibits O.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed as follows:

1. Member-Level Consumer Adjusted Premium Rate:

$$\begin{aligned} [\textit{Member – Level Consumer Adjusted Premium Rate}] \\ &= [\textit{Calibrated Plan Adjusted Index Rate}] \times [\textit{Age Factor}] \\ &\times [\textit{Geographic Factor}] \end{aligned}$$

2. $[\textit{Family Consumer Adjusted Premium Rate}] = \sum[\textit{Member – Level Consumer Adjusted Premium Rate}]$

With no more than three child dependents under age 21 taken into account

Base Rates, i.e. Calibrated Plan Adjusted Index Rates, are found on Exhibit P.

AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based on the federally issued AV Calculator. Plan 45127PA0020015 used Approach 1 under CFR 156.135(b)(2). All other plans fit into the calculator.

AV Pricing Values

All AV Pricing values were developed using CAAC's actuarial cost model and actuarial judgment as described in section Paid to Allowed above. Differences in health status are not included.

Membership Projection

The membership projections found in Worksheet 2 of the URRT were developed by assuming that moderate growth and similar distribution to current.

Terminated Products

See Exhibit R for a list of terminated products.

Attachments and Examples

The following is a list of Exhibits and Data to support this filing:

Exhibit A – Benefit Summary
Exhibit A1 – Benefit Change Summary
Exhibit B – Benefit Categories
Exhibit C – Pediatric Dental and Vision Rate Development
Exhibit D – Benefit Changes
Exhibit E – Trend
Exhibit F – URRT
Exhibit G – Paid-to-Allowed Development
Exhibit H – Retention
Exhibit I – Projected Loss Ratio
Exhibit J – Index Rate
Exhibit K – Market Adjusted Index Rate
Exhibit L – Rate Development by Plan
Exhibit M – Plan Adjusted Index Rates
Exhibit N – Calibration
Exhibit O – Rating Factors
Exhibit P – Quarterly Base Rates
Exhibit Q – Regional Analysis
Exhibit R – Terminated Products

PA Rate Template Part I through Part V

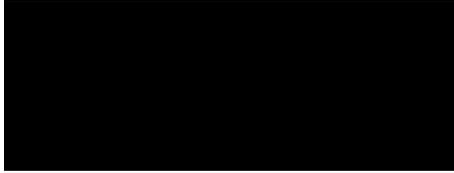
Actuarial Statement

I, [REDACTED], ASA, MAAA, am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

I, [REDACTED], ASA, MAAA, do hereby certify that:

1. This filing has been prepared in accordance with the following:
 - a. Actuarial Standard of Practice No. 5, “Health and Disability Claims”
 - b. Actuarial Standard of Practice No. 8, “Regulatory Filings for Rates and Financial Projections for Health Plans”
 - c. Actuarial Standard of Practice No. 12, “Risk Classification”
 - d. Actuarial Standard of Practice No. 23, “Data Quality”
 - e. Actuarial Standard of Practice No. 25, “Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage”
 - f. Actuarial Standard of Practice No. 26, “Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans”
 - g. Actuarial Standard of Practice No. 41, “Actuarial Communications”.
2. The index rate is:
 - a. Projected in compliance with all applicable state and federal statutes and regulations (45 CFR 156.80(d) (1)).
 - b. Developed in compliance with the applicable Actuarial Standards of Practice.
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered.
 - d. Neither excessive nor deficient.
 - e. Adjusted by only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) to generate plan level rates.
3. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
4. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans, and in accordance with CFR 156.135(b)(2) as necessary. For any plan requiring an alternative method, the development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for benefits that deviate substantially from the parameters of the AVC and have a material impact on the actuarial value.
 - a. The analysis was
 - i. conducted by a member of the American Academy of Actuaries, and
 - ii. performed in accordance with generally accepted actuarial principles and methods.

5. All factor, benefit and other changes from the prior approved filing have been disclosed in the actuarial memorandum.
6. New plans cannot be considered modifications of existing plans under the uniform modification standards in 45 CFR 147.106.
7. The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2017 Rate Filing Justification.



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