

Kaiser Foundation Health Plan, Inc.
(HIOS Issuer ID: 40513)
January 2017 Rate Filing for CA Individual
ACA-Compliant HMO Plans

Actuarial Memorandum

General Information

This Memorandum is a part of the Kaiser Foundation Health Plan, Inc. (KFHP) rate filing for the individual HMO plans available on and off Covered California Exchange. The rates will be effective January 1, 2017, and will be paid by the plan members throughout CY 2017.

This rate filing does not cover the pre-ACA individual plans, in which grandfathered members will continue to be enrolled in 2017.

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Proposed Rate Changes

We estimate that implementation of the proposed 2017 rates will result in a 5.8% increase in member dues paid by an average member enrolled in a KFHP individual plan. The actual rate changes will vary in a 0.4% to 7.5% range depending on the benefit plan. These changes are prior to the impact of members moving to the next age band at renewal.

The rate changes are affected by the following:

- (a) medical and administrative cost trends;
- (b) benefit adjustments affecting pricing actuarial values;
- (c) projections of risk adjustment amounts and expiration of reinsurance recovery program;
- (d) change in membership demographics due to newly established eligibility of some child members for Medi-Cal; and
- (e) target margin.

These factors are discussed in detail in specific sections of this memorandum.

Experience Period Premium and Claims

This section is related to the information reported in Worksheet 1, Section I of the URRT. As indicated on the worksheet, the experience period for this filing is CY 2015.

Paid Through Date: December 31, 2015.

Premiums (Net of MLR Rebate) in Experience Period.

Premiums are reported for all KFHP non-grandfathered individual plan members using the data in the KFHP system of record. The amount shown reflects the risk adjustment amount to be paid by KFHP according to the CCIIO report dated June 30, 2016. No rebates are expected to be paid based on the CY 2015 results.

Allowed and Incurred Claims Incurred During the Experience Period:

It should be noted that KFHP is a part of the Kaiser Permanente (KP) integrated delivery system. Members covered by KFHP benefit plans receive the vast majority of healthcare services within this system. KFHP does not reimburse providers based on fees for each specific service but rather buys care “by the month”. As a result, there is no need to generate claims.

KFHP does track the costs of services provided and has developed a methodology for allocating these costs among the members based on cost accounting algorithms. In particular, this methodology allows the Plan to allocate the costs to business lines such as individual plans. These costs are reported in Worksheet 1 as “Allowed Claims”. The Allowed Claims reduced by the amounts collected from the members are presented as “Incurred Claims”. The data source is the KFHP system of record.

No adjustment was made for incurred but not reported costs as such adjustment would not be material.

Benefit Categories

The Pharmacy Utilization and Unit Cost data in Worksheet 1, Section II of the URRT are based on the KFHP system of record. In 2015, pharmacy utilization by the members in the KFHP individual plans was 4,788 scripts per 1,000. For non-CHP population, (see the Changes in Demographics subsection below), the utilization is 5,270 per 1,000.

Utilization and Cost data for certain non-pharmacy service categories within the KP integrated delivery system are not available. As noted above, the system of record for reporting costs is KFHP’s cost accounting system. This system does not employ (or require) claim-like level of detail. One consequence of this approach is that we are unable to report service category-level utilization (and, hence, unit costs) that conform to insurance industry norms. For example, there is no clear line in our reporting system between Hospital Outpatient services and services provided in physicians’ offices or in an Inpatient Hospital setting. In the Worksheet 1, Section II the costs of Outpatient Hospital services are combined with Inpatient costs. The CY 2015 utilization of Inpatient Hospital services was 149 days per 1,000 members enrolled in KFHP individual plans (160 days for non-CHP members).

During an office visit, a KFHP member usually receives multiple professional services, which may be recorded as one utilization unit in the KFHP database. This creates problems with tracking utilization for ancillary services such as Radiology and Pathology. Based on our data, the CY 2015 Office Visit utilization by the KFHP individual members was 4,406 per 1,000 (4,553 for non-CHP members).

Finally, Other Medical benefit category includes Pediatric Dental and Vision as well as DME, Home Health, Ambulance and some other services.

For the reasons discussed above, we populated the template with annual utilization for Hospital, Professional and Other Medical categories at 12,000 per thousand members, which turned the Unit Cost amounts into monthly capitation amounts.

Projection Factors

Changes in the Morbidity of the Population Insured:

We used prospective DxCG risk scores to estimate the change in age-adjusted morbidity of the KFHP non-grandfathered members between 2015 and 2017. The data showed that age adjusted prospective risk scores for non-CHP population (see the Changes in Demographics subsection below) increased by 3.4% from mid-2015 to February 2016 (the most recent data we have). Since the reasons behind the morbidity deterioration are not clear yet, we dampened the increase for our projections and used a factor of 1.019 to estimate the morbidity change for the two-year period from 2015 to 2017.

Changes in Benefits:

As a result of introduction of a revised HHS Calculator, many of the 2015 plans required benefit adjustments to keep them within the metallic Actuarial Value ranges in 2017. In addition, Covered California Exchange and KFHP made other benefit changes to standard and non-standard plans, respectively, to make the plans more affordable and attractive to consumers. These changes made the 2017 portfolio slightly leaner, by 0.4%, on average.

Changes in Demographics:

During CY 2015 more than 70,000 former KP Child Health Plan (CHP) members, all of age 18 or younger, were enrolled in Platinum Plan. This had a material impact on demographic characteristics of KFHP’s individual membership pool as well as on pool morbidity. In September 2016, the vast majority of the CHP members will be transferred to Medi-Cal due to new state eligibility rules. By comparing the average costs for CHP and non-CHP members, we concluded that as a result of this transfer, the average 2017 medical cost PMPM for the pool will increase by 9.6% (before medical inflation) compared to the 2015 cost. At the same time, the average pediatric dental cost PMPM for the pool will drop by 55.4% due to significant

reduction in the percentage of children. This translates in a 13.2% PMPM reduction for the Other Medical benefit category.

Other:

We did not make any adjustments in addition to changes in benefits and demographics. Thus the factors in the Other column of Worksheet 1, Section II of the URRT are the Benefit and Demographic factors compounded. For all benefit categories but Other Medical the factors are: $0.996 \times 1.096 = 1.092$, while for Other Medical, the factor is $1.092 \times 0.868 = 0.947$

Trend Factors (cost / utilization):

Trend assumptions for the KP integrated delivery system are based on the projected costs of providing medical care to the KFHP membership. Rather than focusing on cost and utilization estimates at the service category level, our expense targets reflect items like number of employees, changes in the cost of wages and benefits, etc. We then take these overall targets and adjust them to a specific business line based on historical relationships and judgment. The projections are part of the overall financial planning process for the KP organization.

It should be noted that KP does not develop forward looking trend expectations at the medical category level (other than Prescription Drugs). Also, due to the KP integrated delivery model, trend projections are not easily separated into unit cost and utilization components. 1.7% is the average medical (non-pharmacy) cost trend largely attributable to the implied increases in unit costs. The trend is for the period of 2015-17 annualized.

A higher annual Pharmacy trend of 6.0% is driven by introduction of new expensive drugs, including Specialty drugs. The trend projection was developed by the KFHP Pharmacy department. It reflects discounts negotiated with drug manufacturers.

The trends entered in the Cost column are the overall trends covering utilization as well. (In general, integrated delivery systems help keep utilization of services under control, which has a dampening impact on utilization trends.) Moreover, we do not anticipate that changes in non-CHP membership distribution by metallic tier or plan in 2015-17 will have a material impact on the average PMPM cost for the pool (the projected membership distribution by plan is displayed in Worksheet 2 of the URRT), while the impact of the CHP members exiting the pool was accounted for in the Changes in Demographics subsection above. Thus, we entered factors of 1.000 in the Utilization column.

Credibility Manual Rate Development

Not applicable as manual rates were not used.

Credibility of Experience

The experience period data are based on 6.4 million member months. We believe that the data are fully credible for purposes of rate-making.

Paid to Allowed Ratio

Based on the data displayed in Worksheet 1, Section I, the Paid to Allowed ratio for the experience period was 0.901. It should be noted that while for a traditional health plan the ratio is expected to be close to (albeit not the same as) the average Actuarial Value (AV) of the plan portfolio, this is not a reasonable expectation for an integrated delivery system. (In this section, under AV we mean an actuarial value generated by the pricing model rather than the HHS Calculator.)

For traditional health plans that process claims, the paid amount is calculated based on the coverage provisions of the benefit plan. These amounts implicitly assume that all member cost-sharing amounts are paid by the member. The providers are responsible for collecting these member cost sharing amounts and any uncollected member cost-sharing (i.e., bad debt) is ultimately included in the provider contracted rates (i.e. the allowed amounts) and distributed evenly over all plan products.

In contrast to this “norm”, an integrated delivery system (such as KP) does not generate claims and, thus, there are no paid amounts for internal services in the KFHP system of record. What we call a “paid” amount is the difference between the actual cost of providing the service (the allowed amount) and the cost sharing amount collected from the member. Differences in effective collection ratios from one benefit plan to the next are thus reflected in KP’s paid to allowed ratios.

The table below reflects the actual 2015 experience. In particular, the table demonstrates that in reality the KFHP “Paid” to Allowed ratios do not closely follow the AVs. (We excluded the experiences of CHP and CSR members, because demographics of the former members and utilization of the latter are materially different from the rest of the population in the same tier.)

Product	% of Membership	% of Allowed Costs	Average AV	Paid to Allowed Ratio
Platinum (non-CHP)	12.8%	32.7%	0.868	0.968
Gold	9.8%	12.8%	0.784	0.937
Silver (non-CSR)	23.8%	24.3%	0.647	0.912
Bronze	52.1%	29.4%	0.491	0.891
Catastrophic	1.5%	0.8%	0.507	0.835
All	100.0%	100.0%	0.690	0.927

If Paid to Allowed values reported by other issuers were adjusted to reflect benefit plan-specific collection ratios, the results would be much closer to those shown above. (We would also note that Paid to Allowed ratios do not capture differences in induced utilization that would be expected of different plan designs. As a result, even when cost sharing is fully collected, these ratios are higher than the corresponding pricing actuarial values.)

The projected 2017 Paid to Allowed factor is shown in Worksheet 1, Section III. It was developed by trending the allowed and member paid PMPM amounts from the experience period to the projection period. The factors impacting the allowed amounts are displayed on Worksheet 1. The member paid amounts were adjusted for the change in membership distribution by plan and assumed to trend at 1.0% for no-deductible copay plans and at 1.5% for all other plans.

Risk Adjustment and Reinsurance

Projected Risk Adjustment PMPM:

We used results of an individual insurance market study commissioned by major CA carriers to estimate risk adjustment payments for future years. The results of the study were recalibrated after the CCIIO reported the actual 2015 risk adjustment transfers. Our 2017 projections are based on an assumption that since the Keep Your Plan option was not available for individual members in the state, the 2015 CA market was stable enough and material changes in morbidity of members choosing a certain metallic plan from a particular carrier should not be anticipated in future years. So in order to project the 2017 risk adjustment results, we combined the specific risk adjustment PMPM amounts for metallic and catastrophic products with the 2017 product specific member months projections. The resultant risk adjustment payment was converted into PMPM amount, reduced by a per member risk adjustment fee of \$0.13 and entered in Worksheet 1, Section III of the URRT.

We recognize that there is significant uncertainty around our assumptions supporting the projection. However, based on our understanding of the current individual market dynamics and the data available to us, we believe the result is reasonable.

The total risk adjustment amount was applied to the projected Index Rate as part of the Market Adjusted Index Rate calculation (see the Market Adjusted Index Rate section below) and was allocated proportionally based on plan premiums for all plans within the pools on Worksheet 2 of the URRT.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:

No recoveries will be collected in the experience period because the reinsurance program will expire in 2016.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

The amount displayed in Worksheet 1, Section III is a 2015 Administrative Cost PMPM amount trended to the projection period at 1.8% annually. The projected cost was combined with a PCORI fee (see Taxes and Fees subsection below) and then allocated by plan on PMPM and percentage of premiums basis, which reflects KFHP financial reporting methodology. (See the Plan Adjusted Index Rates section below.)

Contribution to Surplus & Risk Load:

The CY 2017 target margin for the KFHP non-grandfathered portfolio of individual plans is 0.5%. The target margin in the 2016 rate filing was 0.3%.

The KFHP individual rates do not include loads for risk.

Taxes and Fees:

The amount displayed in Worksheet 1, Section III covers the PCORI fee of \$0.20 PMPM and the Covered California exchange user fee, whose PMPM amount is calculated as 4.0% of the 2017 projected member dues for all on-exchange members divided by the total on- and off-exchange member months counts. (No provisions were made for Health Insurer Fee as this fee will not be collected in 2017.)

For the plan specific rate calculation purposes, the exchange fee was included as an adjustment to the Index Rate at the market level (see the Market Adjustment Index Rate section below.)

Projected Loss Ratio

The ratio of the Projected Incurred Claims to the Single Risk Pool Gross Premium Avg. Rate PMPM from Worksheet 1, Section III is 89.4%. The ACA allowed adjustments will result in a higher number for the KFHP non-grandfathered individual plans in 2017.

Our best estimate of the 2017 projected loss ratio based on the federally-prescribed MLR methodology (a 3-year average for grandfathered and non-grandfathered plans combined) is presented in the following table:

	(Estimated) 2015	(Projected) 2016	(Projected) 2017	Total
Claims	\$2,416.3M	\$2,547.6M	\$2,639.5M	\$7,603.4M
Quality Improvement	\$5.1M	\$5.3M	\$5.0M	\$15.4M
Risk Corridors	\$0.0M	\$0.0M	\$0.0M	\$0.0M
Reinsurance Recoveries	(\$193.6M)	(\$107.9M)	\$0.0M	(\$301.5M)
Risk Adjustment	\$82.1M	\$46.9M	\$23.3M	\$152.3M
Adjusted Claims	\$2,309.9M	\$2,491.9M	\$2,667.8M	\$7,469.6M
Premium	\$2,773.2M	\$2,896.6M	\$3,006.3M	\$8,676.1M
Taxes and Fees	(\$105.5M)	(\$97.3M)	(\$63.1M)	(\$266.0M)
Adjusted Premium	\$2,667.7M	\$2,799.3M	\$2,943.1M	\$8,410.1M
MLR	86.6%	89.0%	90.6%	88.8%

The Projected Adjusted Premium for 2017 in the above table will be adjusted further for Charitable Contributions, which will result in a slightly higher total MLR. Based on these data, we believe that it is highly unlikely that KFHP's ACA-adjusted individual product MLR will drop below 80%.

Single Risk Pool

The 2017 rates for KFHP ACA-compliant plans were developed within the single risk pool framework. The details are provided on the California Rating Factor Exhibit of the Supplemental Rate Review Template (SRRT), which is part of this submission. (The template was developed by the Covered California exchange.) These details are discussed in the next five sections of this memorandum.

Index Rate

Only Essential Health Benefits (EHBs) were covered by the KFHP non-grandfathered individual policies in 2015. Thus, the Index Rate of Experience Period in Worksheet 1, Section I of the URRT is the Allowed Claims PMPM amount for all these policies rounded to the nearest \$1 as required by the URRT instructions.

Non-EHBs will not be covered in the Projection Period either. The Index Rate for this period is the projected Allowed Claims PMPM amount. It appears in Worksheet 1, Section III of the URRT.

KFHP did not issue transitional policies for individual plan members.

Market Adjusted Index Rate

The Index Rate for the Projection Period developed in Worksheet 1, Section III of the URRT was transferred to the California Rating Factor Exhibit in the SRRT. In order to arrive at the Market Adjusted Index Rate, the market-wide risk and exchange user fee adjustments were applied. These adjustments are different from the corresponding URRT numbers, because the SRRT numbers apply to the Index Rate before it is converted into the claim PMPM amount, while the URRT adjustments were made after the conversion. Thus, these adjustments can be restored from the SRRT numbers by applying the Paid to Allowed Ratio of 0.899.

The Market Adjusted Index Rate is the same for all benefit plans and reflects the average demographic characteristics of the single risk pool.

Plan Adjusted Index Rates

For each plan, the 2017 Plan Adjusted Index Rate is calculated in the California Rating Factor Exhibit of the SRRT by multiplying the Market Adjusted Index Rate by Actuarial Value and Cost Sharing Factor and Distribution and Administrative Costs Factor. In case of the Minimum Coverage (a.k.a. Catastrophic) Plan an additional adjustment reflecting the impact of the specific eligibility categories for this plan is applied. The three adjustment factors are discussed in subsections below.

The Plan Adjusted Index Rates for the Experience Period in Worksheet 2, Section III were calculated similarly but using the Index Rate and allowable adjustments developed in the 2015 rate filing.

Plan Adjusted Index Rates for the Projection Period were transferred from the SRRT to Worksheet 2, Section IV of the URRT.

Actuarial Value and Cost Sharing Adjustment:

This factor is based on the actuarial value generated by a model from a national actuarial consulting firm. The model is calibrated to the KFHP individual plan experience data in CA. It has a built-in capability to adjust the factors for induced utilization triggered by a specific plan design. The model does not adjust factors for differences due to the member health status.

The Market Adjusted Index Rate derived in the previous step reflects the projected average utilization in the non-grandfathered products in the portfolio, which is different from the utilization in the no-cost sharing plan. Thus, actuarial values should not be applied to the index rate without an adjustment. They need to be adjusted further to produce realistic paid claims amounts (see Paid to Allowed section above).

The factors displayed in the Rating Factor Exhibit are after such adjustments. The adjustments are market averages rather than plan specific. They are multipliers that uniformly apply to the plan specific AVs generated by the model and do not impact plan premium relativities.

Impact of Specific Eligibility Categories for the Catastrophic Plan:

This factor remained unchanged from the previous year.

Adjustment for Distribution and Administrative Costs:

As discussed in the Administrative Expense Load section above, the projected administrative costs and the PCORI fee were allocated by plan on PMPM and percentage of premiums basis, which reflects KFHP financial reporting methodology. As a result, the factors displayed in the California Rating Factor Exhibit of the SRRT are higher for leaner plans and lower for richer plans.

Calibration

For each benefit plan, a Calibrated Plan Adjusted Index Rate is calculated in the California Rating Factor Exhibit of the SRRT as a product of the Plan Adjusted Index Rate and Age Curve and Geographic Calibration Factors. Each of these factors is the same for all plans and is discussed below.

Age Curve Calibration Factor:

This factor is a reciprocal of the weighted average of standard CMS age curve rate factors. The weights are the 2017 projected member counts for each age (or age band) on the curve. (We are making an assumption that the membership distributions by age and benefit plan are the same for all rating areas, which allows us to separate age calibration from geographic calibration.) The projected membership demographics are based on the 2016 non-CHP emerging experience. The same

demographics were assumed in the projection period Index Rate development in Worksheet 1 of the URRT.

The 2017 projected weighted average age for the entire individual membership pool is 40 years. The average age of the membership pool is provided to satisfy an Actuarial Memorandum and Certification Instructions requirement. The number was not used for calibration.

Geographic Factor Calibration:

In California, KP’s health plan and hospital operations are integrated. As well, we enjoy exclusive arrangements with TPMG and SCPMG in Northern and Southern California regions, respectively. One result of this operating model is that reported costs within a region tend to be relatively flat from one service (or rating) area to the next, although such costs are also affected by care delivered out of network and delivery system capacity. In particular, the reported internal costs for KP do not reflect several of the drivers of cost difference for the market in which we compete and our approach to the challenge of determining appropriate rating area factors for KP involves seeking a balance between actual internal costs and the expected competitive environment.

In the past, in order to remain competitive and continue to offer affordable coverage to individual plan members, we lowered Geographic Adjustment Factors (GAFs) in certain areas, especially in the areas where our competitors deliver healthcare using narrow provider networks. We are not making GAF changes in 2017 with the following exception.

Prior to 2017, KFHP did not provide coverage in Rating Area 9. In Jan-17, pending regulatory approval, KFHP’s service area will be expanded to Santa Cruz County, which is a part of the area. Area 9 rates are included in this submission. Some referral services for Santa Cruz residents will be provided in Santa Clara. Thus, we set the Area 9 GAF at the Area 7 GAF level.

The 2017 GAFs are displayed at the bottom of the California Rating Factor Exhibit in the SRRT. The Geographic Calibration Factor of 1.113 is a reciprocal of the average geographic factor weighted by the 2017 projected membership distribution by rating area. The latter factor is 0.898 and is calculated in the table below:

Rating Area	Area Factor	% of 2017 Non-GF Membership	Rating Area	Area Factor	% of 2017 Non-GF Membership
1	0.950	0.1%	11	0.810	2.2%
2	1.000	8.4%	12	0.911	2.0%
3	0.950	9.2%	13	0.865	0.0%
4	1.050	4.0%	14	0.828	0.8%
5	0.950	6.6%	15	0.758	7.1%
6	0.975	10.0%	16	0.793	11.7%
7	0.975	7.0%	17	0.801	8.1%
8	1.050	3.9%	18	0.865	6.0%
9	0.975	0.2%	19	0.837	8.6%
10	0.850	4.2%			
All				0.898	100.0%

Finally, it should be noted that although, as explained above, KFHP’s geographic factors do not solely reflect delivery cost differences (these costs are mostly flat throughout Northern and Southern California), the factors are not affected by differences in population morbidity.

Consumer Adjusted Premium Rate Development

For each benefit plan, member age and rating area combination, the premium rate is a product of:

- Plan Adjusted Index Rate;
- Age Factor for the member age on the standard federal age curve;

- Age Curve Calibration Factor;
- Geographic Adjustment Factor for the area; AND
- Geographic Calibration Factor.

AV Metal Values

The AV Metal Values included in Worksheet 2 are entirely based on the HHS AV Calculator with an exception of the plans with fixed copays for Outpatient Facility services, which the calculator does not support. For these plans, the alternate method of calculation described in 45 CFR Part 156, §156.135 (b)(2) was used. In particular, the fixed copay was converted into a coinsurance percentage by dividing it by the national average allowed amount for outpatient facility service costs in 2014 trended to 2017. The 2014 amount was provided by a major national consulting firm.

Since the above type of plans is widely used while the proposed method is straightforward and hardly ever controversial, CMS clarified that the calculation does not require actuarial certification.

AV Pricing Values

Each AV Pricing Value in Worksheet 2 of the URRT is a product of three adjustment factors discussed in the Plan Adjusted Index Rate section above and displayed in the SRRT California Rating Factor Exhibit. As clarified in that section, the model used to derive the Actuarial Value and Cost Sharing Adjustment Factor does adjust it for induced utilization based on the benefit plan design but not for the member health status.

Membership Projections

The membership projections found in the URRT and elsewhere in this submission were developed by the KFHP Market Planning department. The projections reflect the results of the 2016 open enrollment. They track monthly membership counts by benefit plan. In particular, these projections break down the on-exchange Silver plan membership among the regular (Base) plan and its CSR versions as shown in the table below:

Plan	Base	CSR 73%	CSR 87%	CSR 94%	All
%	26.4%	16.2%	39.0%	18.5%	100.0%

For each CSR version, an estimate of the allowed claims payable by HHS’s funds PMPM is calculated by applying the difference between the Metal AVs of the CSR and Base plans to the EHB portion of the Silver plan premium PMPM. (In case of CSR 87% and CSR 94% plans, the difference is adjusted for induced utilization as prescribed by CMS.) The Silver plan membership breakdown from the above table is used to convert the PMPM amounts to total projected amount of the HHS payment in Worksheet 2, Section IV of the URRT.

The projections cover members of Standard Gold Coinsurance Plan, which KFHP will start offering on the Covered California exchange in 2017.

Terminated Products

None of the standard plans sold on- and off-exchange in 2015-16 will be terminated in 2017. Due to a HHS AV Calculator revision, the plans were modified by the Covered California exchange and KFHP to keep their Actuarial Values within the allowed metal tier ranges.

Warning Alerts

The warning displayed on Line 57 in Worksheet 2 of the URRT is due to the fact that the 2015 membership demographics of Platinum Plan was significantly different from the total portfolio membership demographics (a significant percentage of this plan’s members were children formerly enrolled in the KP Child Health Plan), and, as a result, its premium PMPM is materially different from its Plan Adjusted Index Rate. This situation is specifically addressed in the URRT instructions.

Plan Type

The type of all plans in this submission is HMO.

Reliance

In preparing this memorandum I have relied upon information and data provided by others. These include the experience period data (provided by KFHP Management Information and Analysis department), medical and pharmacy trend projections by KFHP financial actuaries and Pharmacy department, respectively, membership projections by KFHP Market Planning department and proprietary forecasts of California risk adjustment results by actuarial consultants.

While I reviewed the information for reasonableness, I did not audit the underlying data for correctness.

Actuarial Certification

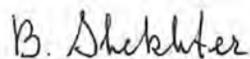
I, Boris Shekhter, Actuarial Director for Kaiser Foundation Health Plan, Inc. (KFHP), am a member of the American Academy of Actuaries and meet its qualification standards for issuing statements of actuarial opinion in the United States.

This statement of opinion complies with the Actuarial Standards of Practice No. 8 and No. 41 as well as with the other applicable standards.

In my opinion:

1. The projected Index Rate is:
 - 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 to be covered,
 - neither excessive nor deficient.
2. The Index Rate and only 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.
3. The percent of total premium that represents Essential Health Benefits (EHB) included in Worksheet 2, Sections III and IV of the Unified Rate Review Template was calculated in accordance with applicable Actuarial Standards of Practices.
4. The geographic rating factors do not solely reflect the differences in cost of KFHP's healthcare delivery **but** they are not affected by differences in population morbidity by geographic area.
5. The AV Calculator was used to determine AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans as described in the AV Metal Values section above.

It should be noted that the Unified Rate Review Template does not demonstrate the process used by KFHP 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 and for certification that the Index Rate is developed and used in accordance with regulation and only adjusted by allowable modifiers.



Boris Shekhter, MAAA, FSA
July 7, 2016