Part III Actuarial Memorandum

Evergreen Health Cooperative Inc.
Individual market 2017

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A. GENERAL INFORMATION

Overview

This document contains the Part III Actuarial Memorandum for Evergreen Health Cooperative's (EHC) individual block of business, effective January 1, 2017. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This information is intended for use by the Maryland Insurance Administration, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of EHC's individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Milliman under any theory of law.

Company identifying information

Company Legal Name:	Evergreen Health Cooperative Inc.
State:	Maryland
HIOS Issuer ID:	72564
Market:	Individual
Effective Date:	January 1, 2017

Company contact information

Primary Contact Name:	Elliot Hooper
Primary Contact Telephone Number:	(443) 451-4976
Primary Contact Email Address:	meh@evergreenmd.org

HIOS IDs

The HIOS IDs listed in this memorandum are for plans available on the Exchange. EHC also uses a separate set of HIOS IDs for off-exchange members. There are no differences in plan designs or premiums between the on-exchange and off-exchange HIOS IDs, other than the absence of CSR variants for off-exchange-only HIOS IDs. Appendix A provides a crosswalk.

B. PROPOSED RATE INCREASE

Description of rate increase

EHC is proposing the following rate increases effective January 1, 2017.

Table B.1 – Proposed 2017 rate increases

Product Name	Plan Name	HIOS	Metal	Rate Increase (Plan)	Rate Increase (Product)
HMO Open-Access	Evergreen Health HMO Open-Access Gold 750	72564MD0090020	Gold	23.62%	19.45%
HMO Open-Access	Evergreen Health HMO Open-Access HSA Silver 2250	72564MD0090021	Silver	18.77%	
HMO Open-Access	Evergreen Health HMO Open-Access Bronze HSA 6850	72564MD0090022	Bronze	16.23%	
HMO Open-Access	Evergreen Health HMO Open-Access The Basics 7150	72564MD0090023	Catastrophic	18.45%	
POS	Evergreen Health POS Gold 1000	72564MD0110020	Gold	25.24%	22.29%
POS	Evergreen Health POS Silver 5000	72564MD0110021	Silver	19.78%	
POS	Evergreen Health POS Bronze 5000	72564MD0110022	Bronze	23.34%	
Select	Evergreen Health Select Gold 850	72564MD0190010	Gold	23.71%	19.00%
Select	Evergreen Health Select Silver 4400	72564MD0190011	Silver	17.55%	

Reason for rate increase

The rates for these products are being adjusted for the reasons outlined in this section.

ESTIMATED RISK ADJUSTMENT TRANSFER PAYMENTS

[Redacted]

MEDICAL TREND

The claim cost assumptions have been adjusted to reflect expected increases in unit cost and utilization. These trends reflect the Maryland state facility fee schedule, set by the Health Services Cost Review Commission (HSCRC), which dictates the facility fees paid by all payers in the state and keeps the facility trends lower that what is seen in other states. Below are the assumed annual rates of increase by service category.

Table B.2 – Trend assumptions

Service Category	In-network Unit Cost Trend (Annual)	In-network Utilization Trend (Annual)	Out-of-network Unit Cost Trend (Annual)	Out-of-network Utilization Trend (Annual)
Inpatient facility	2.0%	0.0%	2.0%	0.0%
Outpatient facility	1.0%	1.0%	1.0%	1.0%
Professional	0.5%	1.0%	5.5%	1.5%
Prescription drugs	6.0%	2.4%	6.0%	2.4%
Other	0.5%	1.0%	0.5%	1.0%

BENEFIT DESIGN CHANGES

There were no changes in the scope of covered benefits between 2016 and 2017. Some cost sharing details were changed, as described more fully in EHC's form filing for 2017.

CHANGES IN NON-CLAIM COSTS

The projected administrative expenses have changed; please see Table C.3 below for detailed values.

TRANSITIONAL REINSURANCE

The federal transitional reinsurance program authorized by Section 1341 of the ACA ends after 2016, as does the supplemental Maryland state transitional reinsurance program. The 2016 premiums reflected savings due to reimbursements from these programs (which, for the individual market, tend to significantly exceed contributions). Starting in 2017, these programs are no longer in place and EHC is responsible for paying high-cost claims that previously would have been partially reimbursed through transitional reinsurance programs. EHC will also no longer have to pay the $2.25 PMPM charge for federal transitional reinsurance, but as noted above, the removal of the charge is less significant than the removal of the reimbursements.

C. MARKET EXPERIENCE

Experience period premium and claims

PAID-THROUGH DATE

The experience in the URRT reflects claims paid through March 31, 2016. Completion factors have been applied to account for expected claims run-out after that date.

PREMIUMS (NET OF MLR REBATE) IN EXPERIENCE PERIOD

The experience period premiums shown on Worksheet 1 of the URRT were provided by EHC. They represent gross premium collected from policy holders, plus EHC's estimated risk adjustment payable for 2015. EHC does not anticipate owing MLR rebates for its individual market business in 2015.

The premiums do not include any adjustment for reinsurance ceded or risk corridor transfers.

ALLOWED AND INCURRED CLAIMS DURING EXPERIENCE PERIOD

Worksheet 1, Section 1 of the URRT shows a total of $12,881,308 of incurred claims in the experience period. Allowed claims are provided in EHC's claim system. They reflect provider billed charges, less contractual discounts, and are not reduced for CSR subsidy payments. For incurred but not paid claims, allowed claims are estimated using a completion factor approach. Primary care encounters reimbursed under EHC's capitation arrangement with Your Health Network (YHN) were not included in claims experience for purposes of determining historical claim amounts since those services will be reimbursed under a capitation arrangement for 2017 as well.

The incurred but not paid claims value was estimated using actuarial principles and assumptions that consider historical and projected claim submission patterns, historical and projected claim processing time, medical cost trends, utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors. The claim reserves were calculated using an adjusted completion factor approach. Single large claims could cause significant variability in the patterns of completion. Therefore, completion factors were calculated adjusting for outliers. As is common with the completion factor approach, the most recent months of incurred data have high variability in completion patterns. The analysis was performed using data on the experience period claims.

Benefit categories

Below is a description of which claims were assigned to each benefit category on Worksheet 1, Section II:

- Inpatient hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.
- Other medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.
- Capitation: Includes all services provided by YHN Primary Care Offices (PCOs) under a capitated arrangement.

- Prescription drug: Includes drugs dispensed by a pharmacy.

Projection factors

CHANGES IN MORBIDITY OF THE POPULATION INSURED

The experience data provided on Worksheet 1 of the URRT is from calendar year 2015. The details regarding the changes to morbidity have been redacted to protect EHC's trade secret, financial and other information. This information has been provided to the Maryland Insurance Administration as part of EHCs product rate filing. This change is calculated holding demographics and benefit designs constant. EHC enrollment is projected to grow, and as it does, the morbidity mix is expected to change. In particular, we expect EHC's morbidity mix to move closer to the estimated state-wide average.

CHANGES IN BENEFITS

There were no changes in the scope of covered benefits between 2015, 2016 and 2017. Some cost sharing details were changed, as described more fully in EHC's form filing for 2017. These cost sharing changes have an estimated impact of 7% decrease on claim costs between 2015 and 2017 (total, not annualized).

CHANGES IN DEMOGRAPHICS

The impact of demographic changes (changes in the age, gender, and area mix of the covered population) is estimated to be 3.7% increase between 2015 and 2017 (total, not annualized).

The population covered in 2015 had an average age of 41 and was 41% male. The projected population for 2017 is expected to be slightly older (average age of 42) with greater number of females (40% males).

The population covered in 2015 was concentrated in Baltimore Metropolitan Area. A similar distribution is expected for 2017.

OTHER ADJUSTMENTS

Other adjustments included Evergreen's new pharmacy contract with Optum, the details of which have been redacted.

TREND FACTORS (COST/UTILIZATION)

This development of the 2017 rates reflects an annual trend rate varying by service category, as shown above in Table B.2.

Credibility manual rate development

The experience data were not fully credible, and a manual rate was used. This section describes the construction of the manual rates shown in Worksheet 1, Section II.

SOURCE AND APPROPRIATENESS OF EXPERIENCE DATA USED

The base experience for the proposed plans was composed of claim costs developed using the 2015 *Milliman Health Cost Guidelines™,* chosen to reflect the demographic and unit cost differences specific to Maryland, as well as EHC's plan benefit designs.

The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 65 million commercially insured lives.

ADJUSTMENTS MADE TO THE DATA

The underlying utilization and charge levels assumed in the 2015 Milliman Health Cost Guidelines baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $3,000 out of pocket maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

The adjustments we used to develop utilization rates consistent with these products are as follows:

- Adjusted for the difference in morbidity levels between the large group market and EHC's expected 2017 enrollment. We estimated EHC's expected average morbidity by reviewing data on the population enrolled to date. Open enrollment for 2017 has not happened yet, and it is not known what specific individuals will renew or lapse, and what new individuals will enroll. The morbidity estimate is therefore not certain to be accurate.
- Adjusted for differences in benefit designs (e.g., metallic levels).
- Adjusted for changes from mandated benefits (e.g., EHBs)
- Adjusted for changes in the average demographic mix of the covered population

All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Maryland-specific unit cost and utilization basis.

INCLUSION OF CAPITATION PAYMENTS

There are capitation payments assumed in the projection period, the details of which have been redacted to protect EHC's trade secret, financial and other information. This information has been provided to the Maryland Insurance Administration as part of EHCs product rate filing.

Credibility of experience

The experience has been given 63.6% weight in the development of the projected claim costs for 2017. This is based on the assumption that the experience would be fully credible with 120,000 member-months (or 10,000 life-years) of data. Experience consisted of 48,602 member-months of enrollment. The credibility formula employed was:

$$Credibility = min\left(100\%, \sqrt{\frac{48{,}602}{120{,}000}}\right) = 63.6\%$$

The manual rates were not developed with any reliance on the experience period data and are thus fully independent.

Paid to allowed ratio

The aggregate paid-to-allowed ratio is projected to be 68.5%. The following table provides this projected value by plan. Note that these are not values computed with the AV calculator. There are many differences between the AV calculator and these projections, including factors such as inclusion of out-of-network benefits, different demographic assumptions, different morbidity assumptions, different contractual discount assumptions, etc.

Table C.1 – Paid-to-allowed by plan				
Product	**Plan**	**HIOS ID**	**Metal**	**Projected paid-to-allowed**
HMO Open-Access	Evergreen Health HMO Open-Access Gold 750	72564MD0090020	Gold	[Redacted]
HMO Open-Access	Evergreen Health HMO Open-Access HSA Silver 2250	72564MD0090021	Silver	[Redacted]
HMO Open-Access	Evergreen Health HMO Open-Access Bronze HSA 6850	72564MD0090022	Bronze	[Redacted]
HMO Open-Access	Evergreen Health HMO Open-Access The Basics 7150	72564MD0090023	Catastro-phic	[Redacted]
POS	Evergreen Health POS Gold 1000	72564MD0110020	Gold	[Redacted]
POS	Evergreen Health POS Silver 5000	72564MD0110021	Silver	[Redacted]
POS	Evergreen Health POS Bronze 5000	72564MD0110022	Bronze	[Redacted]
Select	Evergreen Health Select Gold 850	72564MD0190010	Gold	[Redacted]
Select	Evergreen Health Select Silver 4400	72564MD0190011	Silver	[Redacted]

Risk adjustment and reinsurance

EXPERIENCE PERIOD RISK ADJUSTMENT AND REINSURANCE ADJUSTMENTS PMPM

In 2014, EHC received $311,876 in transitional reinsurance recoveries and paid $360,466 in risk adjustment.

The settlement amounts for 2015 are not yet final. Maryland issuers were not provided official preliminary estimates of the 2015 risk adjustment transfer in 2016. However, the Maryland Insurance Administration gathered data from all carriers in the market and reported statewide averages and payment transfer estimates. EHC's payment for 2015, based on these estimates, would be $3,192,966. It is uncertain how closely the actual transfer amount (to be announced in late June 2016) will conform to the estimate, but this value has been included for experience period risk adjustment in this rate filing.

EHC's estimated transitional reinsurance recovery for 2015 is $1,352,270.

For the experience period, on Worksheet II, these 2015 amounts have been allocated to plans as a constant percentage of premium. In reality, different plans give rise to different risk adjustment and reinsurance transfers. However, this treatment is consistent with how projected risk adjustment transfers are allocated (and the URRT instructions require that projected risk adjustment transfers be allocated proportionally based on plan premiums).

PROJECTED RISK ADJUSTMENTS PMPM

The details of the projected risk adjustment amount have been redacted to protect EHC's trade secret, financial and other information. This information has been provided to the Maryland Insurance Administration as part of EHCs product rate filing. The URRT Part I and the premium development assume a constant allocation (as a percent of premium) across all plans.

PROJECTED ACA REINSURANCE RECOVERIES NET OF REINSURANCE PREMIUM

The transitional reinsurance program will no longer be in effect in 2017. This value is therefore $0.

Non-benefit expenses and profit and risk

The following table summarizes all non-benefit amounts included in plan premiums.

Table C.3 – Admin cost detail			
Category	**Application Basis**	**PMPM**	**% Premium**
General Admin (App development)	$ PMPM	[Redacted]	[Redacted]
General admin (All other)	% Premium	[Redacted]	[Redacted]

Commission	% Premium	[Redacted]	[Redacted]
Incentive Program Expenses	$ PMPM	[Redacted]	[Redacted]
Network Access Fee	$ PMPM	[Redacted]	[Redacted]
PCORI	$ PMPM	[Redacted]	[Redacted]
Profit % Premium	% Premium	[Redacted]	[Redacted]
Quality improvement	$ PMPM	[Redacted]	[Redacted]
Reins premium	$ PMPM	[Redacted]	[Redacted]
Reins recoveries	$ PMPM	[Redacted]	[Redacted]
Total		**$73.45**	**16.8%**

The administrative expense loads were developed using EHC's 2016 budget as a starting point. This budget was based on actual experience from 2015 operations and was adjusted for items known to be different in 2017.

ADMINISTRATIVE EXPENSE LOAD

In Table C.3, the following line items are categorized as administrative expenses:

- General admin
- Incentive program expenses
- Network access fee
- Quality improvement
- Reinsurance premium, net of recoveries

PROFIT (CONTRIBUTION TO SURPLUS) AND RISK MARGIN

[Redacted]

TAXES AND FEES

The following line items are categorized as taxes and fees.

- PCORI

D. PROJECTED LOSS RATIO

The following table demonstrates the expected MLR, using the federal definition, for EHC in 2017.

Table D.1 – MLR build-up	
Numerator	
Paid claims	$310.93
Risk adjustment	$52.42
Quality improvement	$4.62
Total numerator	**$367.96**
Denominator	
Gross premium	$436.80
Taxes and fees	$0.19
Total denominator	**$436.61**
Federal MLR	**84.3%**

This calculation does not include a credibility adjustment, even though in practice one could potentially apply.

The actual calculation also is based on three years of data. Only the projected 2017 numbers are included above.

E. APPLICATION OF MARKET REFORM RATING RULES

Single risk pool

This section demonstrates that EHC complies with the single risk pool requirements of 45 CFR §156.80. The following subsections will decompose the build-up of the final premium rates to be charged.

EHC does not have any transitional policies.

Broadly speaking, EHC complies with the single risk pool requirements by developing a claim cost projection for each plan offered in 2017 and then compositing those projections into a single PMPM value for all individual market plans. For the purpose of premium development (to comply with the requirements of 45 CFR §156.80(d)(2)), plan-level projections for morbidity and demographics are not used in allocating the composite claim cost projection to each plan. Instead, a model is used assuming consistent morbidity and demographics to develop relativities for the factors listed in 45 CFR §156.80(d)(2). This ensures that premiums reflect the morbidity and demographic characteristics of the entire block, even though we expect selection to occur in reality, with premiums varying across plans only due to the permitted factors listed in 45 CFR §156.80(d)(2).

Index rate

The 2017 projected market-wide index rate is $449.10 PMPM. This value is calculated as follows:

Table E.1 – Index Rate Build-Up

Description	Value
EHB Paid claims	$307.73
Average paid-to-allowed	0.685
Market-wide index rate	**$449.10**

The projected allowed cost for non-EHBs is $4.58. The total allowed cost projection is therefore $453.68. The total PMPM allowed cost differs from the index rate because there are covered non-EHBs.

For the experience period (2015), the index rate reported in the URRT is $379.00. Please see Section C above ("ALLOWED AND INCURRED CLAIMS DURING EXPERIENCE PERIOD") for a discussion of how allowed costs are defined. The total PMPM allowed cost differs from the index rate because there are covered non-EHBs.

Market adjusted index rate[1]

The 2017 projected market-wide adjusted index rate is $525.60 PMPM. This value is calculated as follows:

Table E.2 – Market-Wide Adjusted Index Rate Build-Up

Description	Value
EHB Paid claims	$307.73
Average paid-to-allowed	0.685
Market-wide index rate	**$449.10**
Risk adjustment payment (receipt)	$76.50
Exchange fees	$0.00
Market-wide adjusted index rate	**$525.60**

The calculation begins with the market-wide index rate of $449.10, described in the previous subsection and repeated in Table E.2 for convenience. The market-wide adjustments are:

[1] The 2017 URRT instructions are inconsistent in the terminology, sometimes referring to it as the "Market Adjusted Index Rate" and sometimes as the "Market-Wide Adjusted Index Rate." Accordingly, this memorandum assumes that the two terms can be used interchangeably.

- Risk adjustment payment of $76.50. The actual expected transfer is $52.42 (net of $0.13 fee), as shown in Table C.2 above. Because both the market-wide index rate and market-wide adjusted index rate represent allowed costs, the expected risk adjustment transfer has been grossed up to an allowed basis using the paid-to-allowed ratio shown in Table E.2.
- Exchange administrative fees of $0.00.

Although the market rating rules reference the transitional reinsurance program as a market-wide adjustment, this program will no longer be in place in 2017.

Plan adjusted index rates

The market-wide adjusted index rate of $525.60 is then adjusted to each plan, taking into account the factors listed in 45 CFR §156.80(d)(2). The plan-adjusted index rate is not calibrated. In other words, it represents the average demographic and geographic mix of the entire single risk pool. Additionally, the plan-adjusted index rate is reduced by the amount of premium expected to be collected as a result of tobacco surcharges. (However, EHC does not employ a tobacco surcharge, so no adjustment was required.) The following table demonstrates the build-up of the plan-adjusted index rate for each plan.

[Redacted]

Calibration

The result of the calibration (when applied to the plan-adjusted index rate) is the calibrated plan-adjusted index rate. The following table provides the calibrated plan-adjusted index rates. There are two calibration steps (age and geography). The next two subsections will show the development of those calibration factors. As can be seen, the calibration factors are applied uniformly rather than at a plan-specific level.

Table E.4 – Calibrated plan-adjusted index rates

Plan name	HIOS ID	Metal	Plan-adjusted index rate	Age Calibration (Age 49)	Area Calibration	Calibrated plan-adjusted index rate
Evergreen Health HMO Open-Access Gold 750	72564MD0090020	Gold	$540.36	1.706	1.002	$316.06
Evergreen Health HMO Open-Access HSA Silver 2250	72564MD0090021	Silver	$424.25	1.706	1.002	$248.15
Evergreen Health HMO Open-Access Bronze HSA 6850	72564MD0090022	Bronze	$312.54	1.706	1.002	$182.81
Evergreen Health HMO Open-Access The Basics 7150	72564MD0090023	Cat.	$292.76	1.706	1.002	$171.24
Evergreen Health POS Gold 1000	72564MD0110020	Gold	$567.93	1.706	1.002	$332.18
Evergreen Health POS Silver 5000	72564MD0110021	Silver	$430.43	1.706	1.002	$251.76
Evergreen Health POS Bronze 5000	72564MD0110022	Bronze	$340.63	1.706	1.002	$199.23
Evergreen Health Select Gold 850	72564MD0190010	Gold	$511.33	1.706	1.002	$299.08
Evergreen Health Select Silver 4400	72564MD0190011	Silver	$396.54	1.706	1.002	$231.94

AGE CURVE CALIBRATION

The age curve calibration follows the process outlined in the URRT instructions. Namely, the HHS premium age factors are applied to the projected demographic mix of the population. The weighted average is then revised to the nearest value found in the HHS age curve (i.e., the calibration is to an integer age rather than the actual weighted average age that is calculated). In this process, the expected enrollment of children for whom premium cannot be collected (due to

being beyond the third child in a family) is taken into account by using a premium factor of 0.00 instead of the 0.635 that is normally applied to children. This is shown in the “Unratable child” row of the table below.

The calibration factor for age is 1.706, as shown in the following table.

Table E.5 – Age Calibration

Age	Age Factor	Population
Unratable child	0.000	0.2%
Other 0-20	0.635	10.9%
21	1.000	1.3%
22	1.000	1.2%
23	1.000	1.3%
24	1.000	1.2%
25	1.004	1.4%
26	1.024	2.5%
27	1.048	2.1%
28	1.087	2.0%
29	1.119	2.0%
30	1.135	1.8%
31	1.159	1.7%
32	1.183	1.7%
33	1.198	1.7%
34	1.214	1.8%
35	1.222	1.6%
36	1.230	1.9%
37	1.238	1.5%
38	1.246	1.5%
39	1.262	1.4%
40	1.278	1.4%
41	1.302	1.5%
42	1.325	1.6%
43	1.357	1.6%
44	1.397	1.8%
45	1.444	2.0%
46	1.500	1.7%
47	1.563	1.7%
48	1.635	1.8%
49	1.706	1.8%
50	1.786	2.2%
51	1.865	1.9%
52	1.952	2.5%
53	2.040	2.4%
54	2.135	2.6%
55	2.230	2.3%
56	2.333	2.3%
57	2.437	2.8%
58	2.548	2.5%
59	2.603	2.4%
60	2.714	2.6%

Table E.5 – Age Calibration

Age	Age Factor	Population
61	2.810	2.4%
62	2.873	2.9%
63	2.952	3.4%
64	3.000	2.7%
65 and over	3.000	2.6%
Composite	**1.680**	**100.0%**
Nearest integer age	**49**	
Chosen calibration factor	**1.706**	

GEOGRAPHY CALIBRATION

The geographic calibration factor is 1.002, as demonstrated in the following table.

Table E.6 – Area calibration

Area No.	Area Name	Rate Factor	Population
1	Baltimore Metropolitan Area	1.000	[Redacted]
2	Eastern and Southern Maryland	1.009	[Redacted]
3	Washington, D.C. Metropolitan area	0.984	[Redacted]
4	Western Maryland	1.033	[Redacted]
Composite		**1.002**	**100.0%**

The geographic cost factors are unchanged from those filed last year and approved by the Maryland Insurance Administration.

Consumer adjusted premium rate development

The consumer-adjusted premium rate for a given plan is simply the calibrated plan-adjusted index rate (shown in Table E.4) multiplied by the age, geographic, and tobacco factors applicable to a given member. The age and area factors are given in Table E.5 and E.6, respectively. The tobacco factors are as follows:

Table E.7 – Tobacco Factors

Age	Tobacco Load	Age	Tobacco Load
0-20	1.000	43	1.000
21	1.000	44	1.000
22	1.000	45	1.000
23	1.000	46	1.000
24	1.000	47	1.000
25	1.000	48	1.000
26	1.000	49	1.000
27	1.000	50	1.000
28	1.000	51	1.000
29	1.000	52	1.000
30	1.000	53	1.000
31	1.000	54	1.000
32	1.000	55	1.000
33	1.000	56	1.000
34	1.000	57	1.000
35	1.000	58	1.000
36	1.000	59	1.000
37	1.000	60	1.000
38	1.000	61	1.000
39	1.000	62	1.000
40	1.000	63	1.000
41	1.000	64	1.000
42	1.000	65 and over	1.000

The following table provides an example of the consumer-adjusted premium rate for a 40-year-old member living in Area 3 purchasing the Evergreen Health HMO Open-Access HSA Silver 2250 plan.

Table E.8 – Sample consumer adjusted premium rate	
Rating variable	**Value**
Calibrated plan-adjusted index rate: Evergreen Health HMO Open-Access HSA Silver 2250	$248.15
Age 40	1.278
Area 3 (Washington, D.C. Metropolitan area)	0.984
Tobacco: Y	1.000
Consumer-adjusted premium rate	**$312.06**

F. PLAN PRODUCT INFORMATION

AV metal values

The AV metal values in the URRT were computed using the AV calculator, with inputs adjusted to account for cost sharing features more complex than accepted by the calculator. A certification document is attached.

AV pricing values

The AV pricing values, and the decomposition thereof, are shown in the following table.

Morbidity was not taken into account in any of these factors. As described above, a model assuming consistent morbidity and demographics was used to develop these factors and to allocate the projected composite single risk pool claim costs to each plan.

[Redacted]

Membership projections

Enrollment mix by plan was based on the mix of enrollment as of January 2016. The total enrollment was projected as having a modest level of growth from 2016.

Terminated plans and products

Below is a list of terminated plans and products. It includes any plan that was in effect for either 2015 or 2016 but that will not be offered in 2016. The "year terminated" column indicates the first year the plan was *not* offered.

Table F.2 – Terminated plans and products

Product name	Plan name	HIOS ID	Year Terminated	Mapped 2017 plan
Evergreen Health POS	Evergreen Health POS Platinum 0	72564MD0110001	2016	None
Open-Access HMO	Evergreen Health HMO Bronze 5750	72564MD0090010	2016	None
Evergreen Health POS	Evergreen Health POS Bronze HSA/HRA 5350	72564MD0110009	2016	None
Open-Access HMO	HMO Open-Access Platinum 350	72564MD0090013	2017	72564MD0090020
Open-Access HMO	Select Platinum 250	72564MD0190001	2017	72564MD0190010
Evergreen Health POS	POS Gold HSA/HRA 1400	72564MD0110010	2017	72564MD0110020
Open-Access HMO	HMO Open-Access Silver 3000	72564MD0090015	2017	72564MD0090021

Plan type

There were no plans that could not be appropriately described with the options available in Worksheet 2, Section I.

Warning alerts

Rows 68 and 73 have a warning because the sum of total incurred claims by plan differs from the amount entered on Worksheet 1 by more than the template's tolerance. (Row 68 compares the total dollars and row 73 compares the PMPM.) There is no reason to expect that these amounts would match. The Worksheet 2 values, per the URRT instructions, are net of risk adjustment and reinsurance. On Worksheet 1, the URRT instructions request that risk adjustment be an adjustment to premium, not claims, and do not request that the claim value be reduced by reinsurance recoveries.

G. MISCELLANEOUS

Effective rate review information

There is no additional information to provide.

Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of EHC, including:

- Dr. Peter Beilenson, Chief Executive Officer
- Leonard Sherman, Chief Financial Officer
- Mary Porter, Legal Counsel
- Allen Katz, Actuary
- Stephanie Valarezo, Benefits Operations Manager (no longer with Evergreen)
- Elliott Hooper, Counsel

This information includes provider discounts, utilization management initiatives, market information, financial information, benefit design guidance, and compliance requirements. I have not audited or verified this data and other information. To the extent that it is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum may be materially affected.

I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

I have incorporated the facility trend rate required by the Maryland Insurance Administration in its objection dated June 22, 2016.

Actuarial certification

I, Jill Van Den Bos, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of EHC (the “Company”).

I am affiliated with Milliman, Inc. (“Milliman”), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan or health insurer.

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

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-specific premium rates. The allowable modifiers used to generate plan specific premium rates were based on the following:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the Essential Health Benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.
- Characteristics of catastrophic plans.

I certify that 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.

I certify that 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.

AV metal values in the Part I URRT were computed using blended inputs for cost sharing values. An actuarial certification is attached describing the blending methodology used to populate the AV calculator.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and multi-state plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Signed: Jill Van Den Bos

Jill Van Den Bos, ASA, MAAA, MA
Member, American Academy of Actuaries

Date: August 31, 2016

APPENDIX A: HIOS IDS

The following table lists HIOS ID numbers that are for equivalent plans to those described in the memorandum and listed in the URRT Part I template.

List of HIOS IDs

Product	Plan	HIOS ID On Exchange	HIOS ID Off Exchange
HMO Open-Access	Evergreen Health HMO Open-Access Gold 750	72564MD0090020	72564MD0100020
HMO Open-Access	Evergreen Health HMO Open-Access HSA Silver 2250	72564MD0090021	72564MD0100021
HMO Open-Access	Evergreen Health HMO Open-Access Bronze HSA 6850	72564MD0090022	72564MD0100022
HMO Open-Access	Evergreen Health HMO Open-Access The Basics 7150	72564MD0090023	72564MD0100023
POS	Evergreen Health POS Gold 1000	72564MD0110020	72564MD0120020
POS	Evergreen Health POS Silver 5000	72564MD0110021	72564MD0120021
POS	Evergreen Health POS Bronze 5000	72564MD0110022	72564MD0120022
Select	Evergreen Health Select Gold 850	72564MD0190010	72564MD0190010
Select	Evergreen Health Select Silver 4400	72564MD0190011	72564MD0190011