AUGUST 3, 2017

"TRADE SECRET"

Federal Part III
Actuarial Memorandum
2018 Individual ACA Single-Risk-Pool Rate Filing

General Information

Company Legal Name	Blue Cross Blue of Shield of North Carolina
State/Market	North Carolina
HIOS Issuer ID	11512
NAIC Number	54631
Effective Date	January 1, 2018
Primary Contact Name	[redacted]
Primary Contact Number	[redacted]
Primary Contact Address	[redacted]
Primary Contact Email Address	[redacted]

Proposed Rate Increase

The overall rate increase requested for the Individual ACA single-risk pool is [redacted].

We are requesting the following rate increases by product. These increases are before policyholder aging and reflect the average increases by product based on projected 2018 enrollment (terminated plan enrollment is not included below).

Product Name	HIOS Product Code	Average Increase
Blue Advantage	11512NC006	[redacted]
Blue Select	11512NC012	[redacted]
Blue Value	11512NC010	[redacted]
Blue Local CHS	11512NC014	[redacted]
Blue Local Triangle	11512NC017	[redacted]
Total		[redacted]

The rate increase varies by product due to differences in benefit design and enrollment patterns across the products. These differences do not reflect actual experience for that product since the risk of the entire single risk pool is considered for developing rate actions. Some of our plans required benefit changes in order to remain compliant with HHS metal level requirements, due to changes in the HHS Actuarial Value Calculator for 2018 pricing.

Experience Period Premium and Claims

Dates of Claim Payments

The claims used to develop the index rate were paid through March 31, 2017.

Premiums (net of MLR Rebate) in Experience Period

In 2016, we earned [redacted] in premium from our Non-Grandfathered Individual block of business (transition and single risk pool combined). The premium total was determined by pulling subscriber-level premiums from our data warehouse and adding expected risk adjustment receivables. We do not expect to pay MLR rebates for the 2016 plan year.

Allowed and Incurred Claims Incurred During the Experience Period

The allowed charges used in the development of the index rate for the single risk pool were incurred during the period beginning January 1, 2016 and ending December 31, 2016.

The total estimated net allowed charges incurred in our baseline period are [redacted]. Approximately [redacted] of these claims were processed through our internal claims system, with the remaining [redacted] being processed by our prescription drug vendor.

These figures include an estimated [redacted] in allowed claims incurred in 2016 but not paid as of March 31, 2017. These estimates are based on completion factors developed by our Valuation department. The completion factors applied to single risk pool claims are derived using individual ACA experience, while the completion factors applied to transitional claims were developed using a combination of individual transitional and grandfathered experience. The same completion factors are used to complete both paid and allowed claims.

Benefit Categories

The inpatient category contains claims, with units measured in terms of number of admissions, which were submitted under the inpatient facility code.

The outpatient category contains claims, with units measured in terms of number of visits, which were submitted under the outpatient facility code.

The professional claims section contains all physician and professional services, including those rendered in an inpatient or outpatient setting, with units measured in terms of number of visits.

The “other” category contains ambulatory services, home infusions, and durable medical equipment claims, with units measured in terms of number of services.

The drug category contains only drug claims that resulted from utilization of the prescription drug benefit—drugs filed as part of a medical claim are not included—with units measured in terms of number of prescriptions.

Projection Factors

Changes in the Morbidity of the Population Insured

We used condition-based risk scores developed by a national consulting company to estimate the morbidity of our population.

For members with enough experience, such as those that renewed with Blue Cross NC in 2017, we used risk scores derived using a combination of medical and pharmacy data. For newer members, such as those that were new sales in 2017, we used risk scores derived using pharmacy data only. Both of these scores are predictors of overall medical plus pharmacy costs.

We have assumed that future new sales, such as 2017 SEP entrants and 2018 new sales, will have a similar risk profile to more recent new sales. We have relied on estimates from our Sales and Marketing area on the volume of future new sales.

We believe the Individual ACA market will contract in 2017 and 2018, and that this will have a deteriorating effect on the overall market risk. We believe this is the result of:

- The elimination of Federal funding of CSR payments, which will significantly increase rates for many members that do not receive APTC premium subsidies. This will drive many healthier individuals to exit the market.
- Consistent messaging from Federal policymakers stating their intent to abolish the ACA coverage mandates. We believe this will embolden many healthier individuals to drop coverage, no longer fearing enforcement of the mandate penalty.

Changes in Benefits

Individual plans will cover new Essential Health Benefits not covered in the baseline experience period as part of the standard benefits package. These services include consultations prior to preventive colonoscopies, transgender services, blood pressure monitoring devices for individuals with high blood pressure readings, new preventives, and 3D mammography. We also anticipate an increase in utilization due to more members purchasing higher benefit level plans than our 2016 single risk pool experience.

Changes in Demographics

We anticipate an older 2018 population on average than is reflected in our 2016 single risk pool experience. Projected changes due to demographics are captured in our morbidity adjustment described

in the next section; as such, we did not make an additional explicit adjustment to rates to account for changes in demographics.

Trend Factors (cost/utilization)

The trend rate used to project allowed claims from the experience period to the projection period is [redacted] overall for cost and use combined.

The trend factor is calculated using claims incurred by our Individual ACA members over the thirty-six month period ending December 31, 2016. This population was deemed appropriate for purposes of this rate filing as it is a large, fully credible block of business, with relatively stable experience.

Allowed claims were completed using completion factors prepared by our Valuation department.

To calculate the trend projection factor, completed allowed claims were adjusted for the following:

- Pharmacy rebates from manufacturers
- Seasonality (including flu-season adjustments)
- Large claims
- Changes in reimbursement for out-of-network laboratory testing that resulted in a material decrease in claims in 2016
- Savings from corporate initiatives to reduce medical and pharmacy costs
- HHS-HCC risk scores

We use this adjusted data along with a number of prospective adjustments to produce a final claims estimate for 2018. Prospective adjustments include:

- New prescription drugs
- The number of clinical workdays in the projection period, relative to the experience period

Other Adjustments

Additional adjustments not included above that impacted our rate action:

- Expansion of narrow network products
- New and eliminated benefits and benefit policy changes
- Formulary changes
- Corporate initiatives to reduce medical and pharmacy expenses

Credibility Manual Rate Development

Since our experience is fully credible, creation of a credible manual index rate was not needed for pricing.

Credibility of Experience

The Blue Cross NC Individual ACA block of business had approximately [redacted] covered lives as of December 31, 2016, and is considered fully credible for 2018 pricing.

Paid to Allowed Ratio

Our paid-to-allowed ratio for 2018 is projected to be [redacted]. This represents a significant increase from prior years due to the elimination of CSR program reimbursements, which causes more claims costs to get passed back as a plan liability. Detail on this calculation is given in section 14 of the Supporting Exhibits.

	2016 ACA	Trended to 2018
Paid PMPM	[redacted]	[redacted]
CSR Adj Paid PMPM	[redacted]	[redacted]
Allowed PMPM	[redacted]	[redacted]
Paid to Allowed:	[redacted]	[redacted]

Risk Adjustments

Experience Period Risk Adjustment PMPM

We expect a risk transfer [redacted] for the 2016 policy year. This has been added to premiums in the baseline period.

Projected Risk Adjustments PMPM

We have included a [redacted] net of risk adjustment fees. This adjustment is applied at the market level and is based on the anticipated demographic risk and prevalence of certain chronic conditions in our single risk pool population versus the North Carolina Individual single risk pool market.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

Non-benefit expenses included in premium are from the following categories:

General Administrative Expenses – these are the base operating expenses to cover company overhead, other than those attributed to sales and marketing or quality improvement. Our financial accounting area completes budget projections and allocates company expenses back to business lines based on activity based cost accounting (expected cost of staffing and resources attributable to administering the segment). This is expected to be [redacted] of overall premium.

Sales and Marketing Expenses – these are internal expenses anticipated to be paid to attract and retain members in the Individual market. Our accounting area works with our Sales and Marketing area to project costs for these activities. In 2018, we expect these expenses to be [redacted] of overall premium.

Health Care Quality Improvement – part of our base operating budget for the Individual segment is to cover expenses that are attributable to improving quality for customers or fraud detection. We anticipate these expenses to be [redacted] of premium.

Broker and Agent Commissions – brokers and agents will continue to receive commissions for placing and renewing business with us. In 2018 we anticipate these expenses will contribute [redacted] to overall premium.

Contribution to Surplus Margin

Assuming a marginal tax rate of 35% and our estimate of ACA Insurer Fees, we are projecting a net income ratio of [redacted] after Federal income tax.

Taxes and Fees

Premium Tax

State premium tax for North Carolina is expected to remain at 1.9% of premium.

State Regulatory Fees

State regulatory fees for North Carolina are expected to remain at 0.124% of premium.

Exchange User Fee

The Exchange User Fee represents [redacted] of premium. Details on the derivation of this fee are given above in section 11.

Health Insurer Tax

The Health Insurer Tax represents [redacted] of premium. Details of the derivation are given on tab 15.a.2.

Patient Centered Outcomes Research Fee

The Patient Centered Outcomes Research Fee is $0.21 PMPM for effective policy dates up to and including 10/1/2018 and $0.22 PMPM for effective policy dates through the remainder of 2018. Based on the expected distribution of policy effective dates in 2018, slightly more than $0.21 PMPM is included in premium.

Projected Loss Ratio

Below is our demonstration that our Individual Non-Grandfathered policies should meet the Federal MLR standard of 80.0%

	PMPM
Projected Incurred Claims	[redacted]

+ Risk Adjustment Program	[redacted]
+ Reinsurance Credit	[redacted]
+ Quality Improvement Expenses	[redacted]
Total Net Claims	[redacted]
Projected Premium	[redacted]
- Reinsurance Fee	[redacted]
- Risk Adjustment Fee	[redacted]
- PCORT	[redacted]
- ACA Insurer Fee	[redacted]
- Marketplace User Fee	[redacted]
- State Premium Taxes	[redacted]
- Federal Income Tax	[redacted]
Total Net Premium	[redacted]
Federal MLR	[redacted]

North Carolina has an estimated 3 year projected loss ratio requirement for any HMO licensed business. The requirement for Blue Cross NC per 11 NCAC 16.0607 (HMO Incurred Loss Ratio Standards) is that we maintain an incurred loss ratio between 65% and 80% for Individual business over the forecasted 3 year time period beginning with the effective date of our proposed rates. Our Blue Value and Blue Local POS products will be sold on our HMO license. A summary of our 3 year anticipated incurred loss ratio is shown below for this product line. Please note this is before adjustments for any Federal or State fees and taxes, which are permitted for the Federal MLR calculation.

	3 Year Total (2018-2020)
Total Revenue ($M)	[redacted]
Total Claims ($M)	[redacted]
Cumulative Loss Ratio	[redacted]

Single Risk Pool

The single risk pool in our baseline experience reflects all covered lives for the Individual Non-Grandfathered market, including transition plans, covered by Blue Cross Blue Shield of North Carolina, as established in accordance with the requirements of 45 CFR Part 156, 156.80(d).

Index Rate

Our index rate development can be found in Part I of the Federal Justification, URRT Worksheet 1. The amount is $720.01 PMPM. This is equal to 100% of the projected allowed charges for 2018.

Risk adjustment, and exchange use fees were market wide adjustments.

The catastrophic plan index rate was based on a lower assumed morbidity, relative to our non-catastrophic pool.

Market Adjusted Index Rate

The Market Adjusted Index Rate for 2018 is [redacted]. This figure includes allowable market-wide adjustments for the federal reinsurance program, risk adjustment, and marketplace user fees.

	PMPM
2018 Index Rate	$ 720.01
+ Risk Adjustment Program (net fees)	[redacted]
+ Reinsurance Credit (net contributions)	[redacted]
+ Marketplace User Fees	[redacted]
2018 Market Adjusted Index Rate	[redacted]

Details of the development of the risk adjustment and federal reinsurance program adjustments are given above under the *Risk Adjustment* heading. Since the Marketplace User Fee is applied across our on- and off-exchange business, this adjustment was derived by multiplying the expected proportion of on-exchange membership by the 3.5% baseline exchange fee.

Plan Adjusted Index Rates

Our Plan Adjusted Index Rates for the projection period are calculated by adjusting the Market Adjusted Index Rate for allowable plan-level adjustments including AV and cost sharing, provider network and delivery system, a catastrophic plan adjustment, and adjustments for distribution and administrative costs.

The AV and cost sharing adjustment is made using benefit pricing factors produced by an internally-developed benefit pricing model, as described below under the *AV Pricing Values* heading. These benefit pricing factors are adjusted to remove the portion of costs expected to be recouped through the tobacco surcharge.

The provider network and delivery system adjustment reflects differences in negotiated provider reimbursement rates and expected differences in utilization, including pharmacy management programs.

The catastrophic adjustment reflects the expected difference in demographic composition and morbidity of the catastrophic pool versus the single risk pool based on our 2016 experience of this pool.

We are not offering any benefits in addition to the required Essential Health Benefits.

Distribution and administrative costs include general administrative expenses, sales and marketing expenses, quality initiative costs, broker/agent commissions, state premium taxes, the Federal Health Insurer Tax, the Federal PCORI fee, Federal Income Tax, and our after tax profit.

Adjuster	Adjustment
Average Market Adjusted Index Rate	[redacted]
Cost Sharing Adjustment	[redacted]
Pricing Factor	[redacted]
Network Factor	[redacted]
Distribution & Administrative Costs	[redacted]
Average Plan Adjusted Index Rate	[redacted]

Calibration

The expected average age for the single risk pool in 2018 is [redacted]. The age curve calibration factor is [redacted] using the HHS-prescribed unisex age rating factors as specified in the rating rules in 45 CFR 147.102. These figures were derived on a member-weighted basis using membership projections from our Sales & Marketing department and our anticipated distribution of membership by age in the rating period, accounting for potential new entrants into the single risk pool. This calibration factor includes a factor of 0 for the expected distribution of non-billed children in 2018.

The geographic calibration factor for 2018 is [redacted]. This factor was developed using expected 2018 Individual single risk pool enrollment by geographic area alongside a set of internally-developed geographic rating factors. These rating factors are derived using risk-adjusted single risk pool experience with adjustments for expected material changes in provider contracts.

Geographic Region	Rating Factor
Region 1	[redacted]
Region 2	[redacted]
Region 3	[redacted]
Region 4	[redacted]
Region 5	[redacted]
Region 6	[redacted]
Region 7	[redacted]
Region 8	[redacted]
Region 9	[redacted]
Region 10	[redacted]
Region 11	[redacted]

Region 12	[redacted]
Region 13	[redacted]
Region 14	[redacted]
Region 15	[redacted]
Region 16	[redacted]
Overall Member Weighted Avg.	[redacted]

These calibration adjustments are uniform across all plans in the single risk pool. The weighted average calibrated plan adjustment premium rate is [redacted].

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated as the product of the Calibrated Plan Adjusted Index Rate for a given plan and the consumer-specific age, geography, and tobacco use rating factors. An example is given below:

Plan	Blue Advantage Gold $2,500
Consumer Rating Region	Region 1
Consumer Age	21
Consumer Tobacco Use	Tobacco User
Calibrated Plan-Level Premium Rate	[redacted]
x Geographic Rating Factor	[redacted]
x Age Rating Factor	[redacted]
x Tobacco Use Factor	[redacted]
Consumer Adjusted Premium Rate	[redacted]

AV Metal Values

The HHS AV Calculator was used to assign Actuarial Values to all plan designs filed.

AV Pricing Values

AV pricing values were calculated using an internally-developed benefit pricing model which estimates paid claims for a standard population of Individual and Small Group single risk pool non-transitional members. These pricing values include an adjustment for the expected change in benefit-induced utilization based on metal level. These benefit-induced utilization factors were developed using risk-adjusted claims experience, and are independent of member health status.

An additional adjustment is made for the provider network underlying each plan.

Membership Projections

We have worked with our Sales and Marketing area to help estimate the size of the Individual single risk pool in 2018 and estimated the distribution of plan choices for purposes of this rate filing. We made assumptions on how many enrolled members as of this point in time would remain enrolled with us through the duration of 2018 based on historical lapse rates, and estimated the number of new entrants into the Marketplace through 2018.

We forecasted that a large majority of Transition members will continue to keep their current plans in 2018, as they did in 2017.

Terminated Products

Terminated Plan:	11512NC0060026, Blue Advantage 7150 (broad network)
Mapped to:	11512NC0060024, Blue Advantage 6650 (broad network)
Terminated Plan:	11512NC0100030, Blue Value 7150 (limited network)
Mapped to:	11512NC0100028, Blue Value 6650 (limited network)
Terminated Plan:	11512NC0100042, Blue Value 7150 (limited network)
Mapped to:	11512NC0100040, Blue Value 6650 (limited network)
Terminated Plan:	11512NC0140006, Blue Local CHS 7150 (limited network)
Mapped to:	11512NC0140005, Blue Local CHS 6650 (limited network)
Terminated Plan:	11512NC0170005, Blue Local Triangle 7150 (limited network)
Mapped to:	11512NC0140006, Blue Local Triangle 6650 (limited network)

Plan Type

Not Applicable

Warning Alerts

There are no warning alerts.

Effective Rate Review

Additional information has been provided directly to the North Carolina Department of Insurance through the State Actuarial Memorandum and Supporting Exhibits.

Reliance

Reliance on others was required for parts of the rate development process as noted throughout this Actuarial Memorandum.

I have relied on completion factors from the valuation area of Blue Cross Blue Shield Actuarial Services. Each month our incurred claims estimates are developed by our valuation actuarial team and reviewed with the Actuarial department.

Our cost accounting area has provided the data to support administrative expense assumptions. Administrative expense assumptions are based on the best information on 2018 corporate budgets and allocated costs by segment we have at the time of this filing.

We have relied on information provided by our Corporate Pharmacy to support specific analysis around prescription drug costs; some of this information was furnished by our contacts at Prime Therapeutics, our Pharmacy Benefit Manager.

Various members of our Actuarial Services area assisted with the development of many of the factors used in the rate development buildup. If any questions are required, please contact [redacted] to facilitate discussion. [redacted] is the Staff Actuary and oversaw the rate development process for the Individual segment.

Actuarial Certification

I, [redacted], am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and an employee of Blue Cross and Blue Shield of North Carolina. I meet the Qualification Standards of the American Academy of Actuaries to sign this rate filing.

To the best of my knowledge and understanding, I certify that:

The projected index rate submitted in this filing are in compliance with all applicable State and Federal Statutes and Regulations and is reasonable in relation to the benefits provided for the population anticipated to be covered, and is neither excessive, inadequate, nor unfairly discriminatory. All plan level rates were developed using the index rate and have only been adjusted for allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2).

This rate filing, including the projected index rate calculation and the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV, has been prepared in accordance to the appropriate Actuarial Standards of Practice, notably:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*
- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41, *Actuarial Communications*

I certify that all geographic factors only reflect differences in the costs of delivery (unit cost and provider practice pattern differences) and that we do not include population morbidity as a factor in setting geographic factors.

I certify that the standard Federal AV Calculator was used to determine the Metal Actuarial Value for each plan, as shown in Worksheet 2 of the Part I URRT for all plans and all modifications to inputs as documented in this memorandum are appropriate.

I qualify the opinion rendered in this memorandum that the Part I Unified Rate Review Template does not demonstrate the process used by BCBSNC to develop rates. Rather, this template represents the information required by Federal regulation to be provided in support of the review of rates, and for certification of qualified health plans for Federally-facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

[redacted]

Actuarial Services
Blue Cross and Blue Shield of North Carolina

8/3/2017
Date