Health Alliance Medical Plans
Individual Comprehensive Medical Business
Rate Filing Justification
Part III – Actuarial Memorandum and Certification

Overview

This document contains the Part III Actuarial Memorandum for Health Alliance Medical Plans' (HAMP's) individual comprehensive medical block of business, effective January 1, 2019. These revised individual rates are guaranteed through December 31, 2019. These products are offered both on and off the Individual Insurance Exchange. This Actuarial Memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the Actuarial Memorandum is to provide certain information related to the submission of premium rate filings, including support for the values entered in the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This memorandum may not be appropriate for other purposes.

The information in this Actuarial Memorandum is intended for use by the Illinois Department of Insurance, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of this individual rate filing. However, we recognize that this certification may become a public document. The results included in this rate filing are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

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I. General Information

Company Identifying Information

Company Legal Name: Health Alliance Medical Plans
State: Illinois
HIOS Issuer ID: 20129
Market: Individual
Effective Date: January 1, 2019

Company Contact Information

Primary Contact Name: Brandie DeLahr
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II. Proposed Rate Increases

This filing is both an initial rate filing for ██ new plans and a requested rate change filing for ██ Individual Affordable Care Act (ACA) compliant plans for effective dates January 1, 2019 through December 31, 2019. The experience basis, benefit plans, rating factors, and other projection assumptions were updated for this filing.

Our 2019 plan designs include copay and other benefit changes from our existing 2018 plan designs to comply with changes in the most recent AV Calculator and also to improve our competitive position in the marketplace.

Premium rates for the individual plans were developed using our 2017 individual non-grandfathered experience. A number of items were considered when developing the premium rates, including but not necessarily limited to the:

- Projected morbidity level of the population anticipated to purchase the products,
- Proposed benefit plan designs,
- Anticipated medical trend, both utilization and cost of services,
- Applicable taxes and fees, including those newly applicable since 2014 under ACA,
- Anticipated risk adjustment payments (receipts),
- Anticipated 2017 Federal Transitional Reinsurance Program receipts and contributions, and
- Uncertainty with the legislative status of the 2019 ACA marketplace including changes in morbidity due to the elimination of the individual mandate and legislative proposals around short term medical plans.

The requested rate change for renewal plans is an aggregate ██ increase based on the 35,032 in-force members crosswalked to the 2019 plans. The maximum increase of ██ occurs for members crosswalking from ██ ██. Exhibit 1 shows the rate increase by the current membership's 2018 plan and product.

Reason for Rate Change

Base Experience – Our 2016 and 2017 Individual ACA experience provide the bases for our 2018 and 2019 premium rates, respectively. While the 2017 experience is showing a significant improvement over the 2016 experience used to set the 2018 rates, it is still above the target loss ratio required to cover administrative costs, taxes, fees, and profit. In developing the premium rate change for 2019 using 2017 experience, past premium rate increases were accounted for in the experience projection.

Table 1
Health Alliance Medical Plans
2016 & 2017 Illinois Individual ACA Experience

	2016	2017
Member Months	359,631	490,792
Earned Premium	154,421,659	275,831,669
Estimated Risk Adj. Transfer	1,925,800	(11,742,078)
Risk Adjusted Premium	156,347,459	264,089,591
Incurred Claims (incl. IBNR)	194,229,728	257,502,030
Estimated CSR Subsidies	15,134,396	13,510,848
Reinsurance Recoveries	10,389,732	-
Total Incurred Claims	168,705,600	243,991,182
Loss Ratio	107.9%	92.4%

- Trend – An annualized trend assumption was used to project claims costs for the period from 2017 to 2019.
- ACA Adjustment – we adjust the starting 2017 non-grandfathered experience to reflect the cost levels of the ACA single risk pool.
- Risk Adjustment – For 2017, we will which is calculated to increase our loss ratio by . This is included in our 2019 projection.
- Administrative costs, taxes and fees, profit and risk loads – The total retention decreased from PMPM in 2018 to PMPM in 2019. This decrease is primarily due to the Health Insurer Tax moratorium for 2019.
- Elimination of the Individual Mandate – Same as last year, we are building in a margin for potential additional risk due to the elimination of the individual mandate.
- Elimination of CSR Payments – We are projecting that the elimination of these payments will require an average rate increase of over the entire single risk pool. Per Illinois requirements, we are capturing this additional cost through a load on our Silver Exchange plans only.
- Short Term Health Plans – The proposed expansion of short term health plans is likely to cause selection and risk deterioration to the statewide individual single risk pool. It is not yet clear what the rules for short term plans will be or how Illinois will address this proposal. We are building in a margin for the potential risk selection of these plans entering the market and the impact they will have.
- Other Factors – Other Factors include changes in plan benefits, pricing model changes in determining pricing values and the plan design behavior factors, and changes to the provider reimbursements. These changes are applied at the benefit plan level resulting in different rate increases by plan. Exhibit 2 demonstrates the development of the 2018 to 2019 rate-specific plan factor changes.

Additional detail supporting these assumptions is provided in Section V.

III. Experience Period Premium and Claims

HAMP is a managed care organization contracting with providers and networks to provide medical and pharmacy care to its members. We contract with a few providers on a capitated basis but contract primarily on a fee-for-service basis. Our contractual arrangements for capitated services and actual claims for non-capitated services were directly incorporated in the development of the 2019 rates.

Claims Paid Through Date

The claims incurred in the experience for both non-capitated and capitated services reflect payments through March 31, 2018.

Premiums (net of MLR rebate) in Experience Period

The earned premium reported in Worksheet 1 of the URRT reflects the sum of member level premium for the experience period of calendar year 2017. Our 2017 individual loss ratio exceeded the MLR requirement. Therefore, an adjustment for MLR rebates was not included.

Allowed and Incurred Claims Incurred During the Experience Period

Our incurred claims include fee-for-service medical and prescription drug claims, and capitation payments.

The allowed claims were provided directly from internal claim records. Capitated claims are included on a PMPM basis and capitated allowed amounts are calculated on a market based fee schedule.

We review large claims but do not make a specific adjustment for large claims since our claims volume is sufficiently large such that large claims do not have a material impact on the average allowed claims per member per month (PMPM).

The claims reported are completed using lag development factors for lags across all commercial services. This method estimates the portion of claims that have been paid to date for each incurred month based on past claim lag data, which reflects historic time lags in our medical and prescription drug claim data between the month of service (i.e., the incurred month) and the month of claim processing (i.e., the processed month).

Table 2 displays a breakdown of the 2017 individual allowed and paid claims:

Table 2
Health Alliance Medical Plans
2017 Illinois Individual Non-Grandfathered Experience

	Allowed	Paid
Claims Paid through March 2018	334,527,181	272,152,659
Processed through Claims System	334,268,301	271,910,938
Processed Outside of Claims System	258,880	241,721
Incurred But Not Reported (IBNR)	4,626,764	3,764,077
Total Claims	**339,153,945**	**275,916,736**

IV. Benefit Categories in Worksheet 1, Section II of the URRT

Our fee-for-service medical claims are included by service category:

- 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.

Capitated medical claims were entered in the "Capitation" line in Worksheet 1 of the URRT. The URRT instructions indicate the benefit category for capitated services should be "Benefit Period".

Prescription drug claims are included in the "Prescription Drug" line in the URRT with a benefit category of "Prescriptions" and represent drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

V. Projection Factors Applied to Experience

Changes in Morbidity of the Population Insured

The following adjustments were applied to account for differences in morbidity between our starting experience period claims and our projection period single risk pool anticipated costs.

- Risk Adjustment Program Transfer – In setting premium rates each year, we adjust the experience with an estimate for the risk adjustment transfer to bring the morbidity to the statewide level. For 2017, we will be [redacted] risk pool [redacted] costs [redacted]

- Removing Transitional Experience – Our 2017 ACA experience has over 490,000 member months and is therefore 100% credible. Using ACA-only experience provides a better basis for the 2019 single risk pool since transitional members are not mandated to enter the single risk pool in 2019. Removing the transitional business increased the allowed claim PMPM [redacted] for just the ACA business. Table 3 shows the components of the non-grandfathered experience.

Table 3 - Redacted

- Elimination of the Individual Mandate – We anticipate an increase to the statewide morbidity due to anti-selective lapses from the elimination of this mandate. We are building in a [redacted] margin to account for this risk.

- Short Term Health Plans – The proposed expansion of short term health plans is anticipated to cause anti-selective lapses and an increase in morbidity to the statewide individual single risk pool. It is not yet clear what the rules for short term plans will be or how Illinois will address this proposal. We are building in a [redacted] margin for the potential risk selection of these plans entering the market and the impact they will have.

A summary of these "Pop'l Risk Morbidity" adjustments are shown in Table 11 in Section XIII, below.

Changes in Benefits

We are projecting that the elimination of the CSR payments will require an average rate increase of [redacted] on our ACA single risk pool. We are building factor into our 2019 claims projection however, per Illinois requirements we are capturing this additional cost through a [redacted] premium load on our Silver Exchange plans only.

EHB benefits are consistent between the 2017 experience period and the 2019 projection period. There are no other morbidity adjustments we are making to our experience period claims in regard to benefits.

Changes in Demographics

We assume our 2019 individual enrollment will have the product type, metal level, and Exchange status as shown below in Table 4. Within each product, metal, and Exchange status, we assume our 2019 individual enrollment distribution by age, gender, and tobacco status will mirror the demographics underlying our emerging 2018 enrollment.

Table 4 - Redacted

Our rate projection is based on 2017 experience and reflects the average demographics and geographic mix of the 2017 enrollees. Since this is very similar to our projected mix used to develop the 2019 Index Rate, we are not making any additional adjustments.

Other Adjustments

We are not making any other morbidity adjustments to our experience period claims.

A summary of these “Other” adjustments are shown on Table 11 in Section XIII, below.

Trend Factors

We reviewed our own experience as well as trend studies published by industry consultants including Buck, Segal, and Wells Fargo to determine appropriate cost and utilization trend assumptions for our 2019 projections. The consultant studies were consistent in showing expected medical trends to be in the [redacted] and prescription drug trends to be in the [redacted]. Table 5 below shows the cost and utilization trends we are assuming for our 2019 projections.

Table 5 - Redacted

VI. Credibility Manual Rate Development

Our 2017 non-grandfathered individual experience of 545,771 member months is fully credible based on the credibility threshold described in Section VII. Thus, no manual rate was developed. Furthermore, our 2017 individual ACA experience has 490,792 member months, which we consider fully credible as well.

Source and Appropriateness of Experience Data Used

Not applicable

Projected Enrollment

Not applicable

Adjustments Made to the Data

Not applicable

Inclusion of Capitation Payments

Not applicable

VII. Credibility of Experience

The CMS guidelines used for Medicare Advantage / Prescription Drug Plans (MA/PD) were used to determine the credibility of the experience. These guidelines specify 24,000 member months as 100% credible for medical and specify the following formula for determination of partial credibility:

(n / 24,000) ^ (1/2) for medical and
(n / 18,000) ^ (1/2) for prescription drugs

where n = member months in the experience period.

Since prescription drug and medical coverage are both covered, and medical services make up a significantly larger portion of the costs, the above medical formula was used for the determination of partial credibility. The use of the CMS MA/PD credibility is appropriate given that both MA/PD and Commercial cover similar benefit categories.

Resulting Credibility Level Assigned to the Base Period Experience

The credibility assigned to the base period experience is 100%. Table 6 summarizes the adjusted credibility of the base period experience.

Table 6
Health Alliance Medical Plans
Credibility of Base Experience

Description	Value	Annotation
Member Months – Base Experience	545,771	(a)
Full Credibility Threshold – Member Months	24,000	(b)
% Base Experience in the Manual Rate	0%	(c)
Credibility of Base Experience (no adjustment)	100%	(d) = Min {sqrt[(a)/(b)], 1}
Adjusted Credibility of Base Period	**100%**	(e) = [(d) - (c)] / [1 - (c)]

VIII. Paid to Allowed Ratio

Table 7 provides support for the average projected 2019 paid-to-allowed ratio by plan metal level.

Table 7 - Redacted

The projected paid and allowed claims reflect the member month weighted average by metal level from Worksheet 2, Section IV of the URRT. The total paid-to-allowed ratio is consistent with Worksheet 1, Section III of the URRT. The average AV Metal Value is based on AVs calculated using the federal AV calculator, weighted on projected allowable cost by metal level.

Our 2019 plans were priced with an internally developed benefit pricing model using our own Health Alliance claims data. This model uses a fixed claims data set and adjudicates claims based on the plan design entered. Since the same claims data is used to price all plans, the methodology automatically eliminates health status utilization bias from being built into the benefit relativities. It is important to note that the paid-to-allowed factors by metal tier shown above were generated when using individual non-grandfathered claims data in this model. These results are consistent with our actual paid-to-allowed experience except for Silver plans which now include the CSR load. When running the same plans through the same model backed by small group non-grandfathered claims data, my paid-to-allowed factors are much closer to what the federal AV calculator generates.

Table 8 provides the experience paid-to-allowed factors for our Individual ACA metal level plans.

Table 8 - Redacted

IX. Risk Adjustment and Reinsurance

<u>Experience Period Risk Adjustment and Reinsurance Adjustments PMPM</u>

For 2017, we will be [redacted]. This amount was added to our 2017 ACA claims to adjust to the statewide morbidity level prior to projecting forward to 2019.

The federal reinsurance program ended after the 2016 program year so there are no adjustments.

<u>Projected Risk Adjustments PMPM</u>

Our 2017 experience was adjusted to the 2017 statewide morbidity level by [redacted] for our risk adjustment payment. An assumption for the change in statewide morbidity from 2017 to 2019 is then determined and applied in our experience projection. This results in our average risk and our premium rates being set at the anticipated state average risk level with the expectation that no significant portion of this premium will be either received from or paid to the Risk Adjustment transfer program in 2019.

The estimates of relative risk and risk transfer payments are highly dependent on the population that enrolls with us, but also with other carriers in the state.

<u>Projected ACA Reinsurance Recoveries Net of Reinsurance Premium</u>

The federal transitional reinsurance program is a temporary program that ended in 2016. We did not project any federal transitional reinsurance contributions or recoveries for 2019.

X. Non-Benefit Expenses and Profit & Risk

Exhibit 3 displays the total expenses, profit and taxes and fees.

<u>Administrative Expense Load</u>

We estimate our administrative expenses to be [redacted] PMPM, as shown in Table 9. This estimate is entered as a percent of premium that does not vary by plan in Worksheet 1, Section III of the URRT. It is based on our estimate of 2019 projected expenses. We adjust the budget amount for ACA implementation expenses. Corporate overhead was allocated to our individual line of business. This amount does not include any profit, risk load, taxes, or assessments described below.

Table 9 - Redacted

<u>Target Contribution to Surplus (a/k/a Profit) and Risk Margin</u>

We build in [redacted] of premium for a target net contribution to surplus that does not vary by product or plan. We consider the uncertainty of estimated claims in the 2019 market and federal MLR requirements in the target. Exhibit 4 demonstrates the reconciliation of the pre-tax and post-tax profit margin.

<u>Taxes and Fees</u>

Table 10 displays the projected taxes and fees that may be subtracted from premiums when calculating our loss ratio for MLR purposes (with the exception of the $0.15 risk adjustment fee that is shown net of reinsurance recoveries and risk

adjustment receivables and not in this section). The composite value is displayed in Worksheet 1, Section III of the URRT. Exhibit 5 demonstrates the development of the Federal Income Tax PMPM.

Table 10 - Redacted

XI. Projected Loss Ratio

The projected loss ratio based on federally prescribed MLR methodology, excluding allowable adjustments, such as for credibility, quality improvement expenses, and high deductible is [redacted] as shown in Exhibit 6.

XII. Single Risk Pool

The experience includes all non-grandfathered individual plans, including transitional plans. We do not include transitional plans in the projection period. We adjust the single risk pool experience by removing transitional plan experience leaving only ACA experience before projecting to the 2019 single risk pool. We consider the 2017 ACA enrollment to be 100% credible.

XIII. Index Rate

Index Rate Development

The experience index rate represents the estimated total combined allowed EHB claims PMPM of our non-grandfathered individual Illinois plans. The index rate has not been adjusted for risk adjustment transfers, reinsurance fees / recoveries, or Exchange fees. The experience period index rate reflects the actual mixture of tobacco / non-tobacco population, area factors, catastrophic / non-catastrophic enrollment, and the actual mixture of risk morbidity that we received in the Single Risk Pool during the experience period.

The experience period index rate is slightly less than the experience period total allowed claims PMPM since we cover an adult vision exam benefit that is beyond the EHB benefit.

The index rate for the projection period is a measurement of the average allowed claims PMPM for EHB benefits. The projected index rate reflects the projected 2019 mixtures of tobacco / non-tobacco population, area factors, catastrophic / non-catastrophic enrollment, and the projected mixture of risk morbidity that HAMP expects to receive in the single risk pool. The projected index rate has not been adjusted for payments and charges projected under the risk adjustment and reinsurance programs, or for Exchange user fees.

The projected index rate is slightly less than the projected total allowed claims PMPM since HAMP covers an adult vision exam benefit that is beyond the EHB benefit.

We develop the 2019 projected index rate by removing transitional plans from the 2017 experience index rate and then adjusting for trend, benefit, morbidity, and demographic differences. The projected index rate is shown in Worksheet 1, Section III of the URRT.

Section II (Experience Period Premium and Claims) describes the development of the experience index rate, which includes transitional plans in the non-grandfathered experience.

The projected index rate for January 1, 2019 through December 31, 2019 is [redacted], as shown in Worksheet 1, Section III of the URRT, and in Table 11 below.

Table 11 - Redacted

XIV. Market-Adjusted Index Rate

The market-adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 CFR Part 156, §156.80(d)(1). We project exchange fees as [redacted] of premium (Section X. Non-Benefit Expenses and Profit & Risk), reinsurance recoveries net of contribution as $0.00 PMPM, and a risk adjustment transfer payment of $0.14 PMPM (Section IX. Risk Adjustment & Reinsurance). Table 12 displays the development of the market-adjusted index rate.

Table 12 - Redacted

XV. Plan-Adjusted Index Rate

The market-adjusted index rate is adjusted to compute the plan-adjusted index rates using the following allowable adjustments. The development of the plan-adjusted calibrated index rates is shown in Appendix D.

Actuarial Value and Cost Sharing Adjustment

The Actuarial Value and cost-sharing factors were developed with an internally developed benefit pricing model using our own Health Alliance claims data. This model uses a fixed claims data set and adjudicates claims based on the plan design entered. Since the same claims data is used to price all plans, expected differences in the morbidity of members assumed to select the plan are not included the resulting relativities.

Provider Network, Delivery System and Utilization Management Adjustment

For 2019, we have two different networks we are marketing. The first is our Elite network which is also branded as Elite OSF or Elite Riverside in a few regions. These are all the same provider network at the same rate. We also have an Elite Methodist network that focuses on a different provider system in a few specific regions and has a premium rate that is [redacted] [redacted]

Adjustment for Benefits in Addition to the EHBs

We offer an adult vision exam benefit in excess of the EHB benefits.

Impact of Specific Eligibility Categories for the Catastrophic Plan

The adjustment was developed to reflect the impact on the Plan Adjusted Index Rate of the projected difference in demographic characteristics of those enrolling in a catastrophic plan as compared to the entire single risk pool. Since this adjustment is not allowed to be normalized per the URRT instructions and cannot be accounted for on Worksheet 1 of the URRT, we end up with a discrepancy between the Single Risk Pool Gross Premium PMPM calculated on Worksheet 1 and the weighted average of the PAIRs entered on Worksheet 2. I have noted this in columns 7-9 of Appendix C.

Adjustment for Distribution and Administrative Costs

Distribution and administrative costs were developed and applied to each plan as a mix of “percent of premium,” “percent of claim,” and PMPM bases. The development of the plan-adjusted index rates are shown in Appendix C.

XVI. Calibration

Age Curve Calibration

We composite the CMS-approved premium age factors by the projected membership at each age based on emerging 2018 membership. Using this membership mix, the average age of the single risk pool is ███ and the average age calibration factor is ████ This calibration factor is applied uniformly to all plans. Our development of the weighted average age calibration complies with the standard age curve methodology and with applicable rating rules. Exhibit 7 displays the development of the age calibration factor.

Geographic Factor Calibration

Our geographic rating factors are shown below in Table 13. These factors were priced with internally developed model using our own Health Alliance claims data. This model uses the provider charge levels and contracted discounts of the top providers in each region and network to establish pricing relativities based on our expected average reimbursement of a region-network combination. We composite our geographic area factors by the projected membership in each area based on emerging 2018 membership. Our average geographic calibration factor is ████

For 2019 we have ████████████████████████. These changes are projected to have an overall ████████ in premium. Exhibit 8 shows the development of this geographic calibration factor as well as the projected impact of these changes on premium.

Table 13 - Redacted

Tobacco Use Rating Factor Calibration

Our tobacco use factors were developed based on our historical 2015, 2016, and 2017 Individual ACA experience by age. For 2018 we moved from a flat tobacco load across age to an age-based load as allowed by ACA guidelines. For 2019 we are staying with this age-based load ████████████████████████ ███ We composite these tobacco use factors by the projected mix of tobacco users at each age based on emerging 2018 membership. This results in a 2019 tobacco use calibration factor of ████. ████████████ ████████ The development of this calibration factor and the premium impact of the factor changes are shown in Exhibit 7.

XVII. Consumer Adjusted Premium Rate Development

The consumer-adjusted premium rate is the final premium rate for a plan charged to an individual utilizing the rating and premium adjustments as articulated in the applicable market reform rating rules. It is the product of the plan adjusted index rate, the geographic rating factor, the age rating factor and the tobacco rating factor.

XVIII. AV Metal Values

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed entirely using the CMS Actuarial Value calculator.

XIX. AV Pricing Values

Appendix F provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and a breakdown of the components attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2), to arrive at the plan level rate.

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We use our internally developed benefit pricing model using our own Health Alliance claims data to estimate the value of cost-sharing and relative utilization of services for each plan. This model uses a fixed claims data set and adjudicates claims based on the plan design entered. Since the same claims data is used to price all plans, the same demographic and risk characteristics are used across all plans thereby excluding expected differences in the morbidity of members assumed to select the plan.

XX. Membership Projections

Our projected membership (as displayed in Worksheet 2, Section IV of the URRT) is detailed in Section V and in Table 3. Within each product, metal, and Exchange status we assume our 2019 individual population distribution by age and gender will mirror the age-gender mix of the emerging 2018 enrollees' demographics. We project some growth in our total membership due to the anticipated competitiveness of our 2019 products.

For 2019, we are projecting that the mix of cost sharing reduction (CSR) members among the entire Silver plan enrollment will reflect the distribution in our emerging 2018 enrollment. Table 14 below shows the projected 2018 distribution between the CSRs and standard Silver plans.

Table 14 - Redacted

XXI. Terminated Plans and Products

The table below lists our terminated plans over the last two plan years and shows how there were mapped. The first section of the table shows plans that were available during the 2017 experience period plan year and terminated prior to January 1, 2018. The second section of the table shows plans that were effective during the 2018 plan year and terminated for the 2019 projection period plan year.

2017 HIOS ID	2017 Plan Name	2018 HIOS ID	2018 Plan Name	2019 HIOS ID	2019 Plan Name
2017 Experience Period Plans Terminated Prior to the 2018 Plan Year					
20129IL0330024	HMO 4500 Elite Silver	20129IL0330015	HMO 5000c Elite Silver	20129IL0330015	HMO 5000c Elite Silver
20129IL0330028	HMO 4000d Bronze	20129IL0330073	HMO 4000d Elite Bronze	20129IL0330066	HMO 3800 Elite Bronze
20129IL0330033	HMO 4000d Methodist Bronze	20129IL0330074	HMO 4000d Methodist Bronze	20129IL0330067	HMO 3800 Methodist Bronze
20129IL0330034	HMO 4000d OSF Bronze	20129IL0330075	HMO 4000d OSF Bronze	20129IL0330068	HMO 3800 OSF Bronze
20129IL0330051	HMO 6650 Elite Bronze	20129IL0330053	HMO 6650a Elite Bronze	20129IL0340035	POS 6000a Elite Bronze
20129IL0330052	HMO 3500 Elite Silver	20129IL0330054	HMO 3500a Elite Silver	20129IL0330054	HMO 3500a Elite Silver
20129IL0340031	POS 6000 Riverside Silver	20129IL0340057	POS 6300 Riverside Silver	20129IL0340034	POS 7250 Riverside Silver
20129IL0340032	POS 6650 Elite Bronze	20129IL0340035	POS 6650a Elite Bronze	20129IL0340035	POS 6000a Elite Bronze
20129IL0340033	POS 3500 Elite Silver	20129IL0340036	POS 3500a Elite Silver	20129IL0330054	HMO 3500a Elite Silver
20129IL0370004	PPO 4500b Silver	20129IL0340051	POS 3500a Elite Silver	20129IL0330061	HMO 3500a Elite Silver
20129IL0370013	PPO 4500 Bronze	20129IL0340019	POS 3750c Elite Bronze	20129IL0340020	POS 5000a Elite Bronze
2018 Plans Terminated Prior to the 2019 Projection Period Plan Year					
		20129IL0290014	HMO HSA 3250 Elite Silver	20129IL0330054	HMO 3500a Elite Silver
		20129IL0290015	HMO HSA 3250 Elite Silver	20129IL0330061	HMO 3500a Elite Silver
		20129IL0290016	HMO HSA 3250 Methodist Silver	20129IL0330062	HMO 3500a Methodist Silver
		20129IL0290017	HMO HSA 3250 OSF Silver	20129IL0330063	HMO 3500a OSF Silver
		20129IL0290018	HMO HSA 6000 Elite Bronze	20129IL0340061	POS HSA 6650 Elite Bronze
		20129IL0290019	HMO HSA 3250 Methodist Silver	20129IL0330059	HMO 3500a Methodist Silver
		20129IL0290020	HMO HSA 3250 OSF Silver	20129IL0330060	HMO 3500a OSF Silver
		20129IL0290021	HMO 3700 Elite Bronze	20129IL0330026	HMO 3800 Elite Bronze
		20129IL0290022	HMO 3700 Methodist Bronze	20129IL0330064	HMO 3800 Methodist Bronze
		20129IL0290023	HMO 3700 OSF Bronze	20129IL0330065	HMO 3800 OSF Bronze
		20129IL0290025	HMO HSA 6000 Methodist Bronze	20129IL0340062	POS HSA 6650 Methodist Bronze
		20129IL0290026	HMO HSA 6000 OSF Bronze	20129IL0340063	POS HSA 6650 OSF Bronze
		20129IL0290027	HMO HSA 6000 Elite Bronze	20129IL0340064	POS HSA 6650 Elite Bronze
		20129IL0290028	HMO HSA 6000 Methodist Bronze	20129IL0340065	POS HSA 6650 Methodist Bronze
		20129IL0290029	HMO HSA 6000 OSF Bronze	20129IL0340066	POS HSA 6650 OSF Bronze
		20129IL0300020	POS HSA 6550 Elite Bronze	20129IL0340064	POS HSA 6650 Elite Bronze
		20129IL0300025	POS HSA 6550 Methodist Bronze	20129IL0340065	POS HSA 6650 Methodist Bronze
		20129IL0300026	POS HSA 6550 OSF Bronze	20129IL0340066	POS HSA 6650 OSF Bronze
		20129IL0300027	POS HSA 6000 Elite Bronze	20129IL0340061	POS HSA 6650 Elite Bronze
		20129IL0300028	POS HSA 6000 Methodist Bronze	20129IL0340062	POS HSA 6650 Methodist Bronze
		20129IL0300029	POS HSA 6000 OSF Bronze	20129IL0340063	POS HSA 6650 OSF Bronze
		20129IL0300030	POS HSA 6550 Elite Bronze	20129IL0340061	POS HSA 6650 Elite Bronze
		20129IL0300031	POS HSA 6550 Methodist Bronze	20129IL0340062	POS HSA 6650 Methodist Bronze
		20129IL0300032	POS HSA 6550 OSF Bronze	20129IL0340063	POS HSA 6650 OSF Bronze
		20129IL0300033	POS HSA 6000 Elite Bronze	20129IL0340064	POS HSA 6650 Elite Bronze
		20129IL0300034	POS HSA 6000 Methodist Bronze	20129IL0340065	POS HSA 6650 Methodist Bronze
		20129IL0300035	POS HSA 6000 OSF Bronze	20129IL0340066	POS HSA 6650 OSF Bronze
		20129IL0330027	HMO 4000d Elite Bronze	20129IL0330026	HMO 3800 Elite Bronze
		20129IL0330029	HMO 3700 Elite Bronze	20129IL0330066	HMO 3800 Elite Bronze
		20129IL0330032	HMO 3700 OSF Bronze	20129IL0330068	HMO 3800 OSF Bronze
		20129IL0330049	HMO 3700 Methodist Bronze	20129IL0330067	HMO 3800 Methodist Bronze
		20129IL0330050	HMO 7350 Riverside Silver	20129IL0340034	POS 7250 Riverside Silver
		20129IL0330053	HMO 6650a Elite Bronze	20129IL0340035	POS 6000a Elite Bronze
		20129IL0330071	HMO 4000d Methodist Bronze	20129IL0330064	HMO 3800 Methodist Bronze
		20129IL0330072	HMO 4000d OSF Bronze	20129IL0330065	HMO 3800 OSF Bronze
		20129IL0330073	HMO 4000d Elite Bronze	20129IL0330066	HMO 3800 Elite Bronze
		20129IL0330074	HMO 4000d Methodist Bronze	20129IL0330067	HMO 3800 Methodist Bronze
		20129IL0330075	HMO 4000d OSF Bronze	20129IL0330068	HMO 3800 OSF Bronze
		20129IL0330078	HMO 6650a Elite Bronze	20129IL0340058	POS 6000a Elite Bronze
		20129IL0330079	HMO 6650a Methodist Bronze	20129IL0340059	POS 6000a Methodist Bronze
		20129IL0330080	HMO 6650a OSF Bronze	20129IL0340060	POS 6000a OSF Bronze
		20129IL0330081	HMO 6650a Methodist Bronze	20129IL0340049	POS 6000a Methodist Bronze
		20129IL0330082	HMO 6650a OSF Bronze	20129IL0340050	POS 6000a OSF Bronze
		20129IL0330083	HMO 7350 Riverside Silver	20129IL0340048	POS 7250 Riverside Silver
		20129IL0340012	POS 6300 Elite Silver	20129IL0340045	POS 7250 Elite Silver
		20129IL0340019	POS 3750c Elite Bronze	20129IL0340020	POS 5000a Elite Bronze
		20129IL0340022	POS 6300 Methodist Silver	20129IL0340046	POS 7250 Methodist Silver
		20129IL0340023	POS 3750c Methodist Bronze	20129IL0340025	POS 5000a Methodist Bronze
		20129IL0340024	POS 3750c OSF Bronze	20129IL0340026	POS 5000a OSF Bronze
		20129IL0340036	POS 3500a Elite Silver	20129IL0330054	HMO 3500a Elite Silver
		20129IL0340037	POS 3500a Methodist Silver	20129IL0330059	HMO 3500a Methodist Silver
		20129IL0340038	POS 3500a OSF Silver	20129IL0330060	HMO 3500a OSF Silver
		20129IL0340039	POS 3750c Elite Bronze	20129IL0340018	POS 5000a Elite Bronze
		20129IL0340040	POS 3750c Methodist Bronze	20129IL0340021	POS 5000a Methodist Bronze
		20129IL0340041	POS 3750c OSF Bronze	20129IL0340042	POS 5000a OSF Bronze
		20129IL0340043	POS 6300 OSF Silver	20129IL0340047	POS 7250 OSF Silver
		20129IL0340044	POS 6300 Riverside Silver	20129IL0340048	POS 7250 Riverside Silver
		20129IL0340051	POS 3500a Elite Silver	20129IL0330061	HMO 3500a Elite Silver
		20129IL0340052	POS 3500a Methodist Silver	20129IL0330062	HMO 3500a Methodist Silver
		20129IL0340053	POS 3500a OSF Silver	20129IL0330063	HMO 3500a OSF Silver
		20129IL0340054	POS 6300 Elite Silver	20129IL0340006	POS 7250 Elite Silver
		20129IL0340055	POS 6300 Methodist Silver	20129IL0340027	POS 7250 Methodist Silver
		20129IL0340056	POS 6300 OSF Silver	20129IL0340028	POS 7250 OSF Silver
		20129IL0340057	POS 6300 Riverside Silver	20129IL0340034	POS 7250 Riverside Silver

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XXII. Plan Type

For 2019 we will be offering only HMO and POS plan types as noted in Worksheet 2, Section I of the URRT.

XXIII. Warning Alerts

No warning alerts appear on Worksheet 2 of the URRT.

XXIV. Effective Rate Review Information

Additional information is available upon request.

XXV. Reliance

In addition to our internal trend studies, we relied on consultant industry trend studies and surveys from Buck, Segal, and Wells Fargo to help set our allowed claim trend and paid claim trend (insurance trend) assumptions.

XXVI. Actuarial Certification

I, Pasquale Reda, Jr. am an Actuary at Health Alliance Medical Plans. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries in good standing. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify to the best of my knowledge and judgment:

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 anticipated to be covered, and
    - Neither excessive nor deficient based on my best estimates of the 2019 individual market.

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 included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

4. The geographic rating factors reflect only differences in the costs of delivery (e.g., unit costs, provider practice pattern differences) and do not include differences for population morbidity by geographic area.

5. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the Part I Unified Rate Review Template for all plans.

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 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.

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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.

The results are actuarial projections. Actual experience will differ for a number of reasons including, but not necessarily limited to, population changes, claims experience, and random deviations from assumptions.

Respectfully submitted,

Pasquale Reda, Jr., FSA, MAAA
Actuary
Health Alliance Medical Plans

Attachments