Filing at a Glance

Company:	Capital Advantage Insurance Company
Product Name:	Rates - CAIC Individual Comprehensive Major Medical Preferred Provider Organization
State:	Pennsylvania
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Filing Type:	Rate - G.I. (Guaranteed Issue)
Date Submitted:	05/14/2015
SERFF Tr Num:	CABC-130079084
SERFF Status:	Assigned
State Tr Num:	CABC-130079084
State Status:	Received Review in Progress
Co Tr Num:	15-36
Implementation Date Requested:	01/01/2016
Author(s):	Pam Day, Anna Fulginiti, Mary Leberknight
Reviewer(s):	Rashmi Mathur (AH) (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:
ind ppo rri=-1%

State: Pennsylvania **Filing Company:** Capital Advantage Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Rates - CAIC Individual Comprehensive Major Medical Preferred Provider Organization
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Pam Day

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/14/2015
State Status Changed: 05/14/2015
Created By: Pam Day
Corresponding Filing Tracking Number: CABC-130072018
CABC-130073020

PPACA: Not PPACA-Related

PPACA Notes: null
Include Exchange Intentions: No
Additional Benefits: No

Filing Description:
Rates - CAIC Ind Comp MM PPO

Company and Contact

Filing Contact Information

Edmund Scheuermann, Actuary
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edmund.scheuermann@capbluecross.com
717-541-6837 [Phone]

Filing Company Information

Capital Advantage Insurance Company
2500 Elmerton Avenue
Harrisburg, PA 17110
(717) 541-7316 ext. [Phone]

CoCode: 41203
Group Code:
Group Name:
FEIN Number: 23-2195219

State of Domicile: Pennsylvania
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*CABC-130079084*	***State Tracking #:***	*CABC-130079084*	***Company Tracking #:***	*15-36*

State:	*Pennsylvania*	***Filing Company:***	*Capital Advantage Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Rates - CAIC Individual Comprehensive Major Medical Preferred Provider Organization*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Transmittal Letter (A&H)
Comments:	
Attachment(s):	IND_15-36_Initial_CAIC-CAAC_Supporting_CvrLt_V20150514.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Actuarial Memorandum
Comments:	
Attachment(s):	82795_01012016_IND_RedactedAM.pdf
Item Status:	
Status Date:	

Capital BLUE

May 14, 2015

Peter Camacci
Accident & Health Bureau
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

VIA SERFF

Re: Capital Advantage Insurance Company Individual Product Rate Filing/Rule Filing
Individual Comprehensive Major Medical Preferred Provider Organization Benefit Contract (Form No. CAIC-Ind-PPOG-C-v0116)
Capital Filing No. 15-36
TOI/Sub-TOI Code: H161 Individual Health- Major Medical/ H161.005A Individual-Preferred Provider (PPO)/ G.I.

Dear Mr. Camacci:

Capital Advantage Insurance Company (CAIC) and Capital Advantage Assurance Company (CAAC) hereby submit for the Insurance Department's review and approval a rate filing for their Individual Direct Pay Product. The effective date is January 1, 2016. Proposed forms for this product are being filed separately under Capital Filing No. 15-17.

CAIC is proposing a -1.0% rate change.

Should you or your staff have any questions regarding this filing please contact me by email at Edmund.Scheuermann@CapBlueCross.com or by phone at (717) 541-6837.

Yours Truly,

Edmund D. Scheuermann, ASA, MAAA
Actuary
Capital Blue Cross

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

C-60 (6/2013)

CAPITAL ADVANTAGE INSURANCE COMPANY CAIC – PA/ CAPITAL ADVANTAGE ASSURANCE COMPANY CAAC PA

ACTUARIAL MEMORANDUM
Individual Product Rate Filing
Effective January 1, 2016
Filing # 15-36

General Information

Company Information

- Company Legal Name: Capital Advantage Insurance Company CAIC – PA and Capital Advantage Assurance Company CAAC - PA
- State: PA
- HIOS Issuer ID: 82795
- Market: Individual
- Effective Date: 1/1/2016

Company Contact Information

- Primary Contact Name: Edmund Scheuermann
- Primary Contact Telephone Number: (717) 541 – 6837
- Primary Contact Email Address : Edmund.scheuermann@capbluecross.com

Scope and Purpose

By this filing, Capital Advantage Insurance Company (CAIC) and Capital Advantage Assurance Company (CAAC), subsidiaries of Capital BlueCross (CBC), submit rates for a POS product to be offered off the Individual Exchange, effective January 1, 2016. The product submitted by this filing will be made available to all individuals residing in Cumberland, Dauphin, and Perry Counties on and after January 1, 2016. This filing complies with the following parts of the Code of Federal Regulations (CFR):

- 45 CFR Part 147, Section 102
- 45 CFR Part 154, Sections 200, 215, 301
- 45 CFR Part 156, Sections 80, 115, 135
- 45 CFR Part 158, Sections 140, 150, 151, 161, 162, 230

The following sections simultaneously describe the data entered into the Unified Rate Review Template (URRT), and the method used to develop rates.

Proposed Rates

Plan-Level Rates: Proposed rates are contained in the rating model file titled, "IND_15-36_Initial_CAIC-CAAC_RateRule_RateDev_V20150318.xls".

Benefits: Benefits complying with the Essential Health Benefits (EHBs) and Actuarial Value (AV) Metal level provisions of the Patient Protection and Affordable Care Act (PPACA) are included in Forms Filing 15-17.

Proposed Rate Increases

CAIC is proposing a [redacted] rate change effective 1/1/2016.

Experience Period Premium and Claims

General: [redacted].

Base Experience Period: The base experience period (BEP) includes completed fee-for-service paid and incurred claims for dates of service between January 1, 2014 and December 31, 2014.

Paid Through Date: Claims in the BEP are paid through March 31, 2015.

Premiums (net of MLR Rebate) in Experience Period: Premiums are calculated on an earned basis in the BEP. No MLR rebates are applicable to the BEP, therefore no rebate adjustment was made.

Allowed and Incurred Claims during the Experience Period: Paid claims by date of service come directly from CBC's data warehouse. The method for calculating incurred claims in the BEP is as follows:

1. Historical fee-for-service claims are viewed by date of service and date of payment in a claims triangle.
2. The claims triangle payments are then accumulated by date of service to develop factors that represent the rate of accumulation or rate of "completion".
3. Historical rates of completion by duration are used to derive projected rates of completion. Some of the methods used to develop projected completion factors are averages (e.g. harmonic averages, time weighted averages, geometric averages) and regression methods. Numerous items are considered when viewing these averages or regression statistics, such as the impact of high claims on perceived completion patterns.
4. For durations that exhibit a projected completion factor greater than the Valuation Actuary's chosen threshold (e.g. 80% complete), cumulative paid and incurred claims are divided by the projected completion factor to arrive at ultimate incurred claims. For durations that are less than the chosen threshold, a projection methodology is used. Similar to completion factor development, projection methodologies are worthy of a

lengthy discussion. In general, an ultimate incurred claims PMPM is derived by projecting a recent 12-month period to the current month(s) and seasonally adjusting.

5. With all months having both a cumulative paid amount and an estimated ultimate incurred amount, the completion factors used in pricing are calculated by taking the quotient of the two. Allowed completion and incurred completion is assumed to be identical.
6. Both allowed and paid claims in the base experience period (BEP) are completed by applying completion factors by incurred month developed in Step 5.

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

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

Benefit Categories: Claims in the benefit categories displayed in Worksheet 1, Section II come directly from CBC's warehouse. See Exhibit A of file "IND_15-36_Initial_CAIC_CAAC_Supporting_Exhibits_V20150513.xls" for a description of benefits by benefit category.

Projection Factors

Changes in Morbidity of the Population Insured: [redacted].

Changes in Benefits: Effective January 1, 2016, the plan will be amended to include Pediatric Dental benefits. No other benefit changes are effective January 1, 2016. The pediatric dental benefit change has been considered in the benefit relativity factors used in pricing.

Changes in Demographics: [redacted].

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

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

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

2. Utilization. Utilization trends are established by clinicians, who combine the study of historical utilization increases and clinical knowledge of the current medical environment to determine projected utilization trends by service category. A significant factor in utilization is the impact of the Patient Protection and Affordable Care Act (PPACA). Effective October 1, 2010, CAIC removed cost share for many preventive physician and outpatient services. The impact of PPACA mandated benefits and cost sharing limits are gradually being seen in the experience. Utilization of preventive services and associated outpatient services (i.e. preventive services can lead to tests, scans, etc.) is increasing rapidly While this may have a favorable cost savings in the long term, the immediate future (the rating period) is unlikely to see any cost savings due to preventive services. CAIC expects this trend to continue as Women Preventive Services (Section 2713 (a) (4) of the Public Health Service Act effective August 1, 2012) was added to the zero cost share preventive list effective August 1, 2012. Additionally, CAIC must assume that utilization will continue to incline sharply as members become educated of these benefit changes.
3. Intensity: Intensity is defined as the amount of inputs used to provide each unit of service. This can best be seen in an example:

Year 2012

Type of Service	Units	Cost per Unit
X-Ray	1	$200
MRI	1	$5,000
Total	2	$5,200

Year 2013

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

Total Annual Trend	92%

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

CAIC has used an aggregate annualized trend factor of [redacted] in the premium development. This trend is based on past experience and represents our best estimate of future experience.

Credibility of Experience

Credibility Manual Rate Development: [redacted].

Risk Adjustment

[redacted]. The two primary activities related to attempts to quantify expected risk transfer payments are as follows:

1. Develop a thorough understanding of the Department of Health and Human Services (HHS) algorithm for calculating risk score, namely the HHS Hierarchical Condition Category Classification System (HCC) issued in the HHS Notice of Benefit and Payment Parameters.
2. Participate in multiple phases of a vendor developed and administered simulation program named "The Wakely Simulation Project".

Discussions around the two phases of the risk payment transfer simulation, as well as conclusions drawn are as follows:

1. Phase I of risk payment transfer simulation project: During phase I of the Wakely Simulation Project, which occurred prior to the HHS Notice of Benefit and Payment Parameters, the meaning and value of calculated metrics were limited by the following items:
    a. Timing of release of payment transfer formula: Phase I occurred prior to the HHS Notice of Benefit and Payment Parameters, so the official calculation noting the exact formula for payment transfer had not yet been issued
    b. Timing of release of HHS Actuarial Value (AV) Calculator: Phase I occurred prior to the release and refinement of the HHS issued AV calculator, which plays an integral role in the calculation of the concurrent risk scores assigned to each member.
    c. Participation of other carriers in the state of PA: Given that the risk adjustment payment transfer formula is completely dependent on the entire state of Pennsylvania's risk, allowable rating factors and state average premium, deriving meaningful information in the absence of these important variables was a challenge.

2. Phase II of risk payment transfer simulation project: During phase II of the Wakely Simulation Project, new information became available – information that was noted as a limitation above. The official AV calculator was released. The HHS Notice of Benefit

and Payment Parameters was released, which included all relevant variables in the payment transfer formula as well as the HHS HCC model in its entirely. Even with that, numerous limitations existed, putting the reliability of calculated metrics in question.

a. AV calculator
    i. Initial release was locked by its creator, preventing carriers from implementing it into their operations. Carriers with hundreds or thousands of products would have to run each benefit design one at a time.
    ii. Calculated AVs were not intuitive. Actuaries across the industry agreed that the answers being generated by the AV calculator made little sense. Given the importance of metal level in the calculation of a member risk score, the challenges of generated reliable metrics were exacerbated by the inclusion of an AV calculator that behaved inappropriately.
b. Market participation: The profile of the market participants changed from Phase I to Phase II of the simulation, with a noticeable absence of participation from several key players in the market. As before, given the payment transfer formula's dependency on the entire market's profile, metrics were deemed unreliable.
c. Drastic change in results: The results delivered from Phase I of the simulation and Phase II of the simulation were so drastically different that they were deemed completely unreliable.

3. Conclusions: Given the resources devoted to this project and the results delivered, the following decisions were made:

    a. Consider the time and effort to be part of the necessary learning curve. While results were not as promising as expected, the simulation project was a helpful guide in facilitating an understanding of the HHS HCC, the AV calculator, and the payment transfer formula
    b. Use an initial risk payment adjustment of [redacted].

As shown in Exhibit B of the attached "IND_15-36_Initial_CAIC-CAAC_Rate Rule_RateDev_V20150318.xls" file, we have included an adjustment factor of [redacted] for reinsurance recoveries. This factor was developed using claims continuation tables generated from our small group data.

Non-Benefit Expenses and Profit & Risk

1. Administrative Expense: Calculated using an allocation method from CBC's finance department, and trended to the rating period. Costs are allocated according to results reported through a company-wide questionnaire. On an annual basis, each cost center within the company completes a questionnaire listing the distribution of costs (in percentage terms) by product as well as by market segment. For example, the questionnaire will ask how much of one's time and/or resources is spent on PPO versus HMO versus Drug versus Medicare. And separately will ask, how much of one's time and/or resources is spent on large group, small group, individual, and government programs. Using those distributions, all costs needed to perform the business are allocated to the proper market segments and lines of business. The administrative expense applied in the rate development is the total expense expected to be allocated to CAIC individual products. Administrative expenses are included in the URRT Worksheet 1, "Administrative Expense Load".
2. Broker Expense: Calculated based on CAIC's explicit per contract broker fee. Broker Expense is included in the URRT Worksheet 1, "Administrative Expense Load".
3. Fee for Patient-Centered Outcomes Research Trust Fund (PCOR): As per the Notice of Proposed Rulemaking for Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund (REG-136008-11), 77 Fed. Reg. 22691: For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2 per member per year, translating into $0.17 per member per month. PCOR is included in the URRT Worksheet 1, "Taxes and Fees".
4. Health Insurer Tax (HIT) – Section 9010 of PPACA and Section 1406 of the Reconciliation Act (which modified PPACA) refer to HIT. The fee is a fixed-dollar amount distributed across health insurance providers: $8 billion in 2014, $11.3 billion in 2015-2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, HIF rises according to an index based on net premium growth. In 2016, CBC will pay an estimated [redacted] of insured premium as a result of HIT. [redacted] is being applied to 2016 rates. The HIT is included in the URRT Worksheet 1, "Taxes and Fees".
5. Risk Adjustment Fee (RAF) – To fund the HHS-risk adjustment program, issuers will remit to HHS a fee of $0.08 PMPM. The RAF is included in the URRT Worksheet 1, "Taxes and Fees".
6. Exchange Fee – All issuers participating in a federally-facilitated exchange will remit a fee equal to 3.5% of premium. This Exchange Fee is to be spread evenly across both on and off exchange products. CBC expects that [redacted] of all individual product premiums will be from contracts purchased on exchange. Therefore, a [redacted] premium load is being applied. The Exchange Fee is included in the URRT Worksheet 1, "Taxes and Fees".
7. Premium Tax – CAIC pays a 2% Premium Tax on all Individual Products. The Premium Tax is included in the URRT Worksheet 1, "Taxes and Fees".
8. Contingency: A [redacted] contingency load is included in the URRT Worksheet 1, "Profit and Risk".

Premium Development

As discussed, the attached file titled "IND_15-36_Initial_CAIC-CAAC_RateRule_RateDev_V20150318.xls" details CAIC's premium rate development methodology. As shown on Exhibit B, the experience period (calendar year 2014) average claim cost pmpm [redacted] ([redacted]) was benefit adjusted to the 2016 CAIC/CAAC Individual Product Silver Care Connect Plan level. The benefit adjustment factor was calculated using CBC's proprietary benefit pricing model.

[redacted]

Next, an annualized [redacted] trend factor was applied for 24 months.

A [redacted] reinsurance Adjustment factor was then applied to recognize anticipated reinsurance recoveries. [redacted]. Note that this factor is not net of the $2.25 pmpm reinsurance charge which is included in the retention load in Exhibit F1.

Finally, as described above, a Risk Adjuster factor of [redacted] was employed.

Exhibit C contains the anticipated population distribution as well as the CMS mandated age factors. Based on this data, a weighted average age factor was calculated and used to calculate the projected base claim cost for age 21 (the age with a 1.000 age factor) for the Silver Plan. Projected claim costs by age are then calculated by multiplying this projected base claim cost by the mandated age factors as shown in column D.

Exhibit D shows the benefit relativity among the plans being priced.

Exhibit E shows the costs, utilization assumption, and pricing development for the Pediatric Vision Benefits. These benefits are underwritten by CAAC.

The Hospitalization/MedSurg portion of the benefits is underwritten by CAIC. The premium for this portion of the benefits is developed in Exhibit F1. The claims costs from Exhibit C are multiplied by the appropriate Benefit Relativity Factor from Exhibit D. They are then multiplied by an Area Factor. The 21 county Capital BlueCross service area lies within pricing areas 6, 7, and 9 as established by Pennsylvania. Note, however, that the product being submitted is only available in a portion of Rating Area 9. The development of the Area Factors is included in the attached "IND_15-36_Initial_CAIC_CAAC_Supporting_AreaFactors_20150513.xls" workbook. Claim costs are then multiplied a factor representing the Hospital/MedSurg portion of the benefit. The claims costs as adjusted above are divided by (1 – Retention Load). The Retention Load is [redacted]. The components are included as a footnote in Exhibit F1.

The Pharmacy portion of the benefits is underwritten by CAAC. The premium for the Pharmacy portion of the benefits is developed in Exhibit G1 in the same manner as the Hospital/MedSurg premiums were developed in Exhibit F1. Because CAAC pays no premium tax, the Retention Load on the Pharmacy portion of the premium is [redacted]

The final Non-Smoker premium rates are developed in Exhibit H1. The Medical premium developed in Exhibit F1 is added to the Pharmacy premium developed in Exhibit G1. The Pediatric Vision Premium developed in Exhibit E is also added to the premium.

Exhibit I1 develops the Smoker rates by applying a smoker load by age to the rates calculated in Exhibit H1 for all but the 0-20 attained age group.

Paid to Allowed Ratio

Projected Paid and Incurred Claims are calculated as described above by multiplying the projected claims cost pmpm for the base (Silver) plan by the Benefit Relativity Factor as well as the Area Factor. To arrive at the Total Projected Claims PMPM, CAIC assumes a distribution of members across the benefit plans being offered in 2016. To calculate the Total Projected Claims PMPM we first sum the Projected Claims PMPM x assumed Member Months for each plan being offered. We divide this total by the total assumed member months across all plans being offered.

The Paid-To-Allowed Ratio is then:

$$Paid\ to\ Allowed\ Ratio = \frac{Total\ Projected\ Claims\ PMPM}{Projected\ Allowed\ Claims}$$

Projected Loss Ratio

See Exhibit B of file "IND_15-36_Initial_CAIC_CAAC_Supporting_Exhibits_V20150513.xls"for the projected loss ratio calculation.

Single Risk Pool

The data used to develop rates and shown in the URRT abides by 45 CFR part 156.80(d) single risk pool requirements. The single risk pool reflects all covered lives for every non-grandfathered plan for CAAC in the Individual market segment.

Index Rate

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

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

Market Adjusted Index Rate

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

$$[Market\ Adjusted\ Index\ Rate] = [Index\ Rate] - [Net\ Projected\ ACA\ Reinsurace\ Recoveries] - [Net\ Projected\ Risk\ Adjustments\ PMPM] + [Exchange\ Fees\ PMPM]$$

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

Plan Adjusted Index Rate

The Plan Adjusted Index Rate is included in Worksheet 2, Section IV of the URRT.

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

1. Actuarial Value and Cost Sharing adjustment: The Actuarial Value and Cost Sharing Adjustment is determined using CAIC's actuarial cost model. CAIC uses an actuarial cost model to measure the impact of cost-sharing designs on cost and utilization amounts by service category. The cost model shows frequency per 1,000 per year by type of service (IP, OP, Professional), and allowed cost per service for each of the same types of service, normalized to a $0 office visit copayment and a $25 ER copayment. Given a particular benefit design (for example, $20 office visit copayment), utilization is adjusted from the benchmark based on assumed utilization change factors, and cost per service is reduced by the copayment or coinsurance per service. Cost and utilization are multiplied together to derive a claim PMPM by service, summed for all services. The impact of global deductible, coinsurance, and out-of-pocket max is then measured based on CPDs, where the value of services that apply to the CPDs adjusts the level of the curve, as well as global utilization adjustments.
2. Provider Network: The Provider network is the across the projection period and experience period, and across all plans, so no adjustment is necessary.
3. Adjustment for benefits in addition to EHBs: No benefits other than EHBs are included in the plans, so no adjustment is necessary.
4. Catastrophic Plans: Does not apply to the CAIC Individual market.
5. Adjustment for distribution and administrative costs: Described in Non-Benefit Expenses and Profit & Risk section above.

Calibration

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

Age Curve Calibration: The projected average age factor is 1.430. This is calculated based on the small group population used in pricing and the age factors mandated by CMS.

Geographic Factor Calibration: The Geographic Factor Calibration is outlined in the attached "IND_15-36_Initial_CAIC_CAAC_Supporting_AreaFactors_V20150513.xls" file.

> **Geographic Factors:** CMS has approved nine geographical rating areas (GRA) in the state of Pennsylvania. CAIC operates in a 21-county area of Pennsylvania, encompassing three of the nine defined regions. CAIC performed regional analysis to quantify the cost difference between the three regions in our service area. The analysis gathered allowed claims in a 12-month period by region, normalized for demographics. We then compared the claim cost for each of the three regions, and calculated cost differentials between the regions, mostly due to differences in hospital contracting between regions.

The calibration is:

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

All consumer-level adjustments are applied uniformly to all plans in the Single Risk Pool. These adjustments do not vary by plan.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed as follows:

1. Member-Level Consumer Adjusted Premium Rate:

$$[Member-Level\ Consumer\ Adjusted\ Premium\ Rate] = [Calibrated\ Plan\ Adjusted\ Index\ Rate] \times [Age\ Factor] \times [Geographic\ Factor]$$

2. $[Family\ Consumer\ Adjusted\ Premium\ Rate] = \sum[Member-Level\ Consumer\ Adjusted\ Premium\ Rate]$

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

AV Metal Values

The AV Metal Value included in Worksheet 2 of the URRT was entirely based on the AV Calculator.

AV Pricing Values

All pricing AV values were developed using the actuarial cost model described in the Premium Development section above.

Actuarial Statement

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

I, Edmund D. Scheuermann, ASA, MAAA, do hereby certify that:

1. This filing has been prepared in accordance with the following:
    a. Actuarial Standard of Practice No. 5, "Incurred Health and Disability Claims"
    b. Actuarial Standard of Practice No. 8, "Regulatory Filings for Rates and Financial Projections for Health Plans"
    c. Actuarial Standard of Practice No. 12, "Risk Classification"
    d. Actuarial Standard of Practice No. 23, "Data Quality"
    e. Actuarial Standard of Practice No. 25, "Credibility Procedures Applicable to Health, Group Term Life, and Property/Casualty Coverages"
    f. Actuarial Standard of Practice No. 26, "Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans"
    g. Actuarial Standard of Practice No. 41, "Actuarial Communications"

2. The index rate is:
    a. Projected in compliance with all applicable state and federal statutes and regulations (45 CFR 156.80(d) (1)).
    b. Developed in compliance with the applicable Actuarial Standards of Practice.
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered
    d. Neither excessive nor deficient
    e. Adjusted by only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) to generate plan level rates.

3. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

4. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Edmund D. Scheuermann, ASA, MAAA
Actuary
Capital BlueCross

5/29/15
Date