SERFF Tracking #:	*INAC-129961525*	***State Tracking #:***	*INAC-129961525*	***Company Tracking #:***	*AHPA SG HMO 1Q16*

State:	*Pennsylvania*	***Filing Company:***	*AmeriHealth HMO, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*		
Product Name:	*AHPA Small Group HMO eff 1-1-2016*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Cover letter
Comments:	Attached is the cover letter.
Attachment(s):	ahpa sg cover letter 2016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted QHP Actuarial Memorandum
Comments:	Attached is the redacted KHPE QHP Actuarial Memorandum.
Attachment(s):	33871_01012016_SG_RedactedAM.pdf
Item Status:	
Status Date:	

1901 Market Street
Philadelphia, PA 19103-1480

www.amerihealth.com

AmeriHealth

May 15, 2015

Mr. Peter Camacci, Director
Bureau of Accident and Health Insurance
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

SUBMITTED VIA SERFF

Re: AmeriHealth HMO, Inc. (AHPA)
Small Group Rate Filing effective 1/1/2016
INAC - 129961525

Dear Mr. Camacci:

Attached is the rating methodology for HMO plans of AmeriHealth HMO, Inc. (AHPA), and Direct Point-of-Service (DPOS) plans, of which a large majority of benefit expenses is attributed to AHPA and the remainder to QCC Insurance Company (QCC), and offered to small employer groups in the Commonwealth of Pennsylvania. New and renewing plans are being introduced to satisfy market reform requirements of the Affordable Care Act (ACA); however, none of the plans are available on the Federally-Facilitated Exchange. This rate filing includes rates for these plans and specifies compliance with rating requirements of the ACA. The enclosed rating methodology is for rating periods effective from January 1, 2016 through December 31, 2016.

The AHPA small employer group plans and rates are identical to the Keystone Health Plan East (KHPE) small employer plans and rates in the concurrent KHPE small group rate filing submitted under SERFF tracking number: INAC-129955625. Any references to Standard Component or Plan IDs throughout this filing and supporting documentation are not directly applicable to AHPA plans. They are used for the KHPE entity of the Independence Blue Cross Family of Companies and included here for ease of review. Furthermore, since the AHPA plans are not available on the Federally-Facilitated Exchange, but they are identical to the KHPE plans and included in the single risk pool for the individual market in the Commonwealth of

Pennsylvania, we are including the Unified Rate Review Template and federal actuarial memorandum pertaining to KHPE as supporting documentation with this rate filing submission.

This rate filing is being submitted along with concurrent form filing(s) and SERFF Plan Management binder(s):

- INBC-130052422
- INLG-130057645

Please contact David Walker at (215) 640-7846 or David.Walker@ibx.com with any questions regarding this filing.

Sincerely,

Hugh Lakshman

Hugh Lakshman, FSA, MAAA
Director and Actuary, Commercial Pricing

cc: Kathryn A. Galarneau, FSA, MAAA
Thomas Hutton
Richard F. Levins, Esquire
Mary Ellen McMillen
Daniel Rachfalski, FSA, MAAA

GENERAL OVERVIEW

PURPOSES

This Actuarial Memorandum is provided along with the Unified Rate Review Template (URRT) to provide certain information to support the gross premium for the single risk pool for small group market health care insurance underwritten by Keystone Health Plan East in the Commonwealth of Pennsylvania. It is provided as a component of an application for certification as a Qualified Health Plan and a state rate filing. This submission may not be appropriate for other purposes.

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company Legal Name: Keystone Health Plan East ("KHPE")
State: Pennsylvania
HIOS Issuer ID (5-digit): 33871
Market: Small group
Effective Date(s): 1/1/2016-3/31/2016, 4/1/2016-6/30/2016, 7/1/2016-9/30/2016, and 10/1/2016-12/31/2016

Worksheet 1 of the accompanying URRT contains experience period data and development of the projected Single Risk Pool Gross Premium Average Rate PMPM for the small group market for the Keystone Health Plan East ("KHPE"), AmeriHealth HMO, Inc. ("AHPA"), and QCC Insurance Company ("QCC") entities. Worksheet 2 contains experience period data and projections by product for the single risk pool for the same entities. This memorandum pertains only to plans denoted in Worksheet 2 by Plan IDs starting with the sequence 33871.

COMPANY CONTACT INFORMATION

Primary Contact Name: David Walker
Primary Contact Telephone Number: 215-640-7846
Primary Contact Email Address: David.Walker@ibx.com

PROPOSED RATE INCREASE

The changes to the single risk pool gross premium average rate per member per month (PMPM) from calendar year 2014 to calendar year 2016 were incorporated into the pricing and reflected in the Unified Rate Review Template. The changes are driven for by factors including: changes in market-wide population risk morbidity and covered services, increasing unit costs for medical services, increasing

utilization of medical services, increasing fees and taxes imposed by the federal government, anticipated costs to administer the plan, anticipated revenue or payments due to market-wide risk adjustment.

WORKSHEET 1: DATA COLLECTION TEMPLATE

SECTION I: EXPERIENCE PERIOD DATA

PAID THROUGH DATE

Experience period premium, claims, and member months are obtained from the company's internal data warehouse. The claims data is collected for incurred dates from January through December 2014 and paid through January 2015. Earned premiums and member months are for January through December 2014. The data are for all small group business in the Commonwealth of Pennsylvania for the following legal entities: Keystone Health Plan East ("KHPE"), AmeriHealth HMO, Inc. ("AHPA"), and QCC Insurance Company ("QCC").

PREMIUMS (NET OF MLR REBATE) IN EXPERIENCE PERIOD

Earned Premiums (net of MLR Rebate) in Experience Period are developed by summing the earned premium reported in the company's internal data warehouse and adjusting for MLR rebates, if any, for the period. Although 2014 federal MLR rebate calculations are not final as of the writing of this memorandum, no federal MLR rebates are expected for calendar year 2014, so no adjustment to earned premium for MLR rebates is needed.

The calculation for federal minimum loss ratio rebates is based on 2012, 2013, and 2014 experience of earned premium, incurred claims, quality improvement expenses, and taxes. The three years of experience is blended for all segments.

ALLOWED AND INCURRED CLAIMS INCURRED DURING THE EXPERIENCE PERIOD

Paid-to-Date and Incurred Claims, and Member Months

Insurer fee-for-service claims expenses and member liabilities for dates of service in January 2014 through December 2014 and paid through January 2015 are sourced from the IBCFOC's internal data warehouse. The claims and member liabilities are completed with incurred but not reported (IBNR) adjustments to develop ultimate incurred insurer fee-for-service claims expenses and member liabilities for the January through December 2014 period. Capitation amounts are also sourced from the internal data warehouse for the January through December 2014 period but they are not adjusted for IBNR.

IBNR Development

Medical fee for service incurred but not reported (IBNR) claims are modeled through the use of standard claim lag methodologies. A range of results is developed, and a provision for adverse deviation is

applied. The provision for adverse deviation is dependent on many factors such as stability, size, product mix, etc.

The completion factors are developed annually in the 2Q – 3Q period. We do not believe our IBNR is unusually high or unusually low for incurred 2014 paid through January 2015.

Allowed Claims

Allowed claims are determined by separately obtaining paid-to-date fee-for-service claims and member cost-sharing amounts, applying claim lag factors to those amounts to estimate ultimate incurred fee-for-service claims and member-sharing amounts and adding them together with capitation amounts.

Allowed claims do not include ineligible claims, payments for services other than medical care provided, recovery payments related to internal large claim pooling mechanisms, or active live reserves.

Experience Period Index Rate

The Index Rate of Experience Period is estimated by removing cost and utilization trend from the first quarter Index Rate for Projection Period.

SECTION II: ALLOWED CLAIMS, PMPM BASIS

BENEFIT CATEGORIES

Utilization and Unit Cost data for allowed claims in the experience period are provided in Section II. The data is provided by benefit category using a standardized indicator from the internal data warehouse that assigns each claim line to a category based on the type of provider and the location of the service. The utilization and unit cost data are provided for the following categories: Inpatient Hospital admits, Outpatient Hospital visits, Professional visits, Other Medical visits, Capitation per member per month (PMPM), and Prescription Drug scripts.

Experience Period capitation is reported as a per member per month (PMPM) value. In order to complete the URRT, the Utilization per 1,000 statistics for capitated services only is reported as 1,000 so that the appropriate capitation PMPM is reported.

PROJECTION FACTORS

The estimated incurred claims experience on an allowed basis for January 2014 through December 2014 is projected to the future rating period by several factors.

Changes in Population Risk Morbidity

Experience period allowed claims are adjusted to account for differences in the average morbidity of the single risk pool population underlying the experience and the anticipated population in the

projection period. This adjustment reflects changes in either the individual or small group market-wide morbidity due to one or more of the following: guarantee issue, the individual mandate, Medicaid and CHIP migration, take-up of insurance by the previously uninsured, health status of the newly insured, enrollment from prior high risk pools, subsidy effects, dumping of enrollment from group markets to the individual market, and market-wide impact of transitional products/plans.

Changes in Other Factors

Experience period allowed claims are adjusted to account for differences in the single risk pool population underlying the experience and the anticipated population in the projection period pertaining to several factors not due to changes in morbidity or the costs and utilization of medical care. This adjustment reflects: additional benefits required to be covered as essential health benefits; recently mandated benefits required by state law that are not reflected in the experience period data; benefits in the experience that are removed for the projection period; anticipated changes in the average utilization of services due to differences in average cost sharing requirements during the experience period and average cost sharing requirements in the projection period; changes in demographic characteristics of the single risk pool experience period population and the projection period population (including age, gender, region, and tobacco use); changes in the provider network (adding or removing a provider system or introducing a limited network option); and anticipated changes in pharmacy rebates.

Annualized Cost Trend

Annual cost trend reflects changes in costs of medical treatment due to medical inflation and changes in the distribution of services across network providers. The trend value is developed by reviewing historical medical costs for the single risk pool and adjusting them for anticipated future provider contracting reimbursement levels. The data is normalized for changes in age, benefit changes during the experience period, changes to provider contracts, and prescription drug formulary, and new drugs brought to market.

Annualized Utilization Trend

Annual utilization trend reflects the change in the number of units per 1,000 members for a fixed level of illness burden and includes changes due to the mix and intensity of services provided and changes related to shifts in product mix. It also includes effects of selection, if any, since this cannot be reflected in the relative cost of the various products and plans offered.

CREDIBILITY MANUAL RATE DEVELOPMENT

The experience period claims for the single risk pool are determined to be fully credible, therefore no credibility adjustment is required.

SECTION III: PROJECTED EXPERIENCE

PAID TO ALLOWED RATIO

The Projected Allowed Experience Claims PMPM shown in Worksheet 1 represents projected allowed claims experience PMPM for the projected portfolio of plans. The Paid to Allowed Average Factor in Projection Period adjusts the allowed down to Projected Incurred Claims before ACA reinsurance and risk adjustment for the population anticipated to be covered in the projection period. The Projected Incurred Claims before ACA reinsurance and risk adjustment represents the net amount of incurred insurer claim liability expected in the projection period, net of member cost sharing and cost sharing paid by HHS on behalf of low-income members. It reflects the average benefit level anticipated during the projection period.

RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustment PMPM

Projected Risk Adjustment is accounted for in Projected Incurred Claims before ACA Reinsurance and Risk Adjustment to reflect anticipated risk adjustment transfer amounts for the projection period. The amount reflects the projected morbidity for the single risk pool for IBCFOC in the projection period.

The estimated risk adjustment revenue for all of the plans in the risk pool is developed using the following methodology. We recognize that the HHS payment transfer formula implies that the projected incurred claims based solely on the experience period single risk pool claims need to be adjusted by the ratio of the current statewide market's risk relative to allowable rating factor (ARF) for age compared to the single risk pool's risk relative to ARF presented during the experience period. This adjustment, together with the assumed future changes in population risk morbidity, results in the issuer's pricing being consistent with the anticipated morbidity level of the future statewide market.

Estimating the current statewide market's risk and ARF is difficult, because we do not have access to the relevant data from other carriers operating in this market. In order to gain insight, we participated in the Wakely Consulting Group's risk adjustment reporting project for this market. Our assumptions are the result of a combination of measurements based on Wakely's reports and our own actuarial judgment.

The anticipated risk adjustment transfer revenue is allocated proportionally based on plan premium. The Projected Risk Adjustment is subtracted from Projected Incurred Claims before ACA Reinsurance and Risk Adjustment to reflect anticipated receipt of risk adjustment transfer amounts for the projection period.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market Only)
A Projected ACA Reinsurance Recoveries Net of Reinsurance Premium adjustment is not applicable in the small group market. However, the Reinsurance Program Funding fee is included and applied equally across all plans in the single risk pool.

NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load
An Administrative Expense Load is applied to Projected Incurred Claims to reflect expenses related to quality improvement and fraud detection/recovery and other expenses of operating a business, broker commissions, and premium payment processing fees.

Profit & Risk Load/Contribution to Surplus
A Profit & Risk Load/Contribution to Surplus for the single risk pool is applied to Projected Incurred Claims for the projection period, if applicable.

Taxes and Fees
A Taxes & Fees load is applied to Projected Incurred Claims to pass through the following fees and taxes levied by the federal and state governments:

- *Risk Adjustment Fee & PCORT (Comparative Clinical Effectiveness Research Tax)*: applied equally across all plans in the single risk pool.
- *Exchange User Fee*: applied to all plans as an adjustment to the index rate at the market level, as per regulation.
- *State Premium Tax*: not applicable to plans under the KHPE and AHPA Entities; applied to plans under the QCC entity.
- *Health Insurer Fee*: applied equally across all plans in the single risk pool

PROJECTED LOSS RATIO

The projected loss ratio for the single risk pool is estimated to exceed 80%, [redacted] reflecting premium adjustments permitted by the federal MLR calculation.

INDEX RATE

The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. The Index Rate is the same value for all non-grandfathered plans for an issuer in a state and market.

We reserve the right to make subsequent filings to replace rates listed above with effective dates 4/1/2016 and beyond to reflect any changes which would affect the adequacy of the rates presented with this memorandum.

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: federal reinsurance program adjustment, risk adjustment and exchange user fees. The Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool.

Note that the on-exchange premiums presented in the Unified Rate Review Template do not include coverage of pediatric dental that is expected to be available elsewhere on the exchange. Premiums for the same QHP plans offered off-exchange may differ to reflect costs due to the possible inclusion or exclusion of pediatric dental coverage.

PLAN ADJUSTED INDEX RATE

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rule. These include actuarial value and cost sharing adjustment, provider network, delivery system and utilization management adjustment, adjustment for benefits in addition to the EHBs, impact of specific eligibility categories for the catastrophic plan and administrative costs.

CALIBRATION

The plan adjusted index rate is projected for all products using the same anticipated age distribution and the mandated age curve. Therefore the consumer adjusted premium rate is the plan adjusted index rate divided by the average age and geographic factor for the expected distribution. [redacted]

Note that the on-exchange premiums presented in the Unified Rate Review Template do not include coverage of pediatric dental that is expected to be available elsewhere on the exchange. Premiums for the same QHP plans offered off-exchange may differ to reflect costs due to the possible inclusion or exclusion of pediatric dental coverage.

There is only one geographic rating area for this filing. The geographic rating area factor for this filing is 1.0.

WORKSHEET 2: PRODUCT-PLAN DATA COLLECTION

AV METAL VALUES

The AV Metal Values included in Worksheet 2 of the URRT were valued using the AV Calculator, where possible, otherwise the AV Metal Values were developed under an alternate methodology. Actuarial certifications required by 45 CFR Part 156, §156.135 are provided in a separate document.

AV PRICING VALUES

The AV Pricing Value represents the cumulative effect of adjustments made by plan to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate.

MEMBERSHIP PROJECTIONS

Enrollment is projected based on current and anticipated enrollment by plan. Items impacting these projections include changes in the size of the market due to introduction of guarantee issue requirements, the individual mandate, and the introduction of a Basic Health Program.

TERMINATED PLANS

The following plans are being terminated as policy years end throughout calendar year 2015:

STATE	SEGMENT	COMPANY	COMPANY LEGAL NAME	ISSUER ID	PLAN	PLAN ID	HIOS PLAN NAME
PA	Small Group	KHPE	Keystone Health Plan East	33871	HMO	33871PA002	33871PA0100017-Keystone HMO-Bronze Basic

WARNING ALERTS

There are no warning alerts in URRT part 1.

ACTUARIAL CERTIFICATION

I, Hugh Lakshman, am Director & Actuary of Commercial Markets for the Independence Blue Cross Family of Companies. I am a member of the Society of Actuaries and the American Academy of Actuaries with the education and experience necessary to perform the work necessary and meet the Qualification Standards of the American Academy of Actuaries to render the qualified actuarial opinion contained herein. The developed rates and memorandum have been prepared in conformity with appropriate Actuarial Standards of Practice and the Academy's Code of Professional Conduct.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the premium rates and allowable rating factors. Rather, it represents information required by Federal regulation to be provided in support of the review of gross premium 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.

I hereby certify that, to the best of my knowledge and judgment, the following:

- The projected index rate is:
  - —In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.08(d)(1));
  - —Developed in compliance with applicable Actuarial Standards of Practice;
  - —Reasonable in relation to the benefits provided and the population anticipated to be covered; and
  - —Neither excessive nor deficient.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
- 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.
- 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, unless an alternate methodology was required. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR Part 156, §156.135 will be included.

Hugh Lakshman, FSA, MAAA
May 15, 2015

SERFF Tracking #:	*INAC-129961525*	***State Tracking #:***	*INAC-129961525*	***Company Tracking #:***	*AHPA SG HMO 1Q16*

State:	*Pennsylvania*	***Filing Company:***	*AmeriHealth HMO, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*		
Product Name:	*AHPA Small Group HMO eff 1-1-2016*		
Project Name/Number:	*/*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Cherri Sanders-Jones	06/24/2015	06/24/2015

Response Letters

Responded By	Created On	Date Submitted

State: Pennsylvania **Filing Company:** AmeriHealth HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: AHPA Small Group HMO eff 1-1-2016
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/24/2015
Submitted Date	06/24/2015
Respond By Date	07/08/2015

Dear Hugh Lakshman,

Introduction:

June 24, 2015

Hugh Lakshman
Director and Actuary - Commercial Markets
AmeriHealth HMO, Inc.
1901 Market Street
Philadelphia, PA 19103

RE: AmeriHealth HMO, Inc. – Small Group - HMO
Received: May 11, 2015 SERFF ID# INAC-129961525

Dear Mr. Lakshman:

The Pennsylvania Insurance Department has received and conducted a review of the above captioned filing. In order to complete the review, we are requesting the following information. To facilitate a timely review, we request this information be provided within 14 days of the date of this letter. If you have any questions or difficulties in providing the information within this time frame, please call me.
Please note, many of the items identified below should have been identified and detailed narrative provided in the actuarial memorandum.
1.It is my understanding that Section I of worksheet I of the URRT is to contain the single risk pool data for a given issuer, state and market. Your actuarial memorandum indicates that the experience period data provided represents KHPE, AmeriHealth and QCC. Please revise to reflect data solely for the named issuer for stated experience period. If you believe there are special circumstances that allow for the aggregation of the 3 companies please provide a detailed discussion. Please note, to the extent that AmeriHealth supports KHPE POS, it is only those claims data that should be included in the KHPE HMO URRT. Only the pure AmeriHealth HMO (non KHPE supporting) data should be reported in this filing.
2.Does AmeriHealth offer any products directly in the Pennsylvania market or does this entity solely support KHPE? Please provide a detailed discussion of the relationship and how it works. If products are offered directly, please identify the Plan ID#s in the Base Rate Schedule and the SERFF Tracking Number for the corresponding form filing.
3.Is the geographic rating area the same for AmeriHealth HMO as it is for KHPE?
4.The Department Rate Exhibit shows rates for plans offered on and off SHOP, while the rate filing cover letter and the corresponding contract forms (INBC-130052422, INLG-130057645) indicate only off SHOP plans/products. Please review and revise all impacted documents.
5.Please review the contract form numbers indicated on the Department Rate Exhibit to ensure consistency with the corresponding filed contract forms.
6.The filing indicates the weighted average increase across products/plans is 6.7%. Worksheet 2 of the URRT (row 28) shows a rate increase of 6.49% for a PPO Product and a 6.88% increase for the HMO product. Since HMOs are only allowed to do HMO/POS business, should the threshold product rate increase for the HMO be 6.88% and not 6.7%? Please review the URRT, company rate information contained in the Rate/Rule Schedule tab and any other items that may be impacted and revise as necessary.
7.The company rate information contained in the Rate/Rule Schedule Tab indicates that an overall rate change of 11.4% is proposed, with a maximum of 14.5% and a minimum of -6.5% with an overall % impact of 6.7%. Please explain these adjustments and show how they were developed.

State: Pennsylvania **Filing Company:** AmeriHealth HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: AHPA Small Group HMO eff 1-1-2016
Project Name/Number: /

8.The filing indicates the weighted average increase across plans based on current ACA-compliant membership is 6.7% (or the revised average per question #2 above). Please show how this average breaks down by the following and discuss the basis for the proposed changes:
• Impact of medical claim trend;
• Revisions to assumptions about population morbidity and the projected population distribution;
• Changes to the reinsurance program;
• Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;
• Changes in pricing models used to determine the impact of cost sharing design;
• Changes in benefits and plan design;
• Changes in fees, taxes and administrative expenses.

9.Please provide the Federal Rate Template in the Rate/Rule Schedule tab.
10.The actuarial memorandum does not meet the standard as prescribed by CMS in the 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I (v2.0.4, II, and III) version 2/21/15. Please provide an actuarial memorandum that reflects company specific data and assumptions, not simply a generic template.
11.The actuarial memorandum indicates that member cost sharing is included in calculating allowed claims, but does not speak to the cost sharing payments by HHS from the federal government. Please discuss why.
12.Please provide further discussion of the rates in the Base Rate Schedule and show their development. Also, show the rate change for each plan identified in the Base Rate Schedule.
13.Please provide an Excel exhibit that shows the development of the Index Rate for the 2016 Projection Period, starting from the 2014 experience data. Also, provide narrative that explains the development and all adjustments.
14.Please provide an Excel exhibit that shows the development of the Plan adjusted Index Rate for each plan design offered in 2016, starting from the Index Rate.
15.Please identify the specific taxes and fees and the corresponding percent of premium or the pmpm amounts. Additionally, show the components of the administrative expense load of 9.9% and their corresponding costs.
16.Please provide Excel exhibits that show the development of all calibration adjustments.
17.What is the basis for the trend selection of approximately 7.4%? Please provide support and a narrative that explains the trend development.
18.For the January 1, 2016, through October 1, 2016 will QCC allow current enrolled groups of size 51-100 transitional relief? That is, will you allow a particular enrolled group to continue under the large group rating process? What is your current (2015) definition of small group? Please be advised that the experience period data should only include groups that meet the 2-50 group size. However, in the projection period, expected claims experience should reflect group policies for employers with 100 or fewer employees that the issuer expects to be enrolled in single risk pool compliant plans during the projection period. This may be done through the projection factors, use of a manual rate, or combination of the two. Please acknowledge your company's understanding and compliance.
19.The Department notes that the Dental field in the Department Rate Exhibit is not populated. Please review and ensure that every field is appropriately populated.
20.The actuarial memorandum indicates that Plan ID 33871PA002 has been terminated. Does this plan have membership? What will AmeriHealth HMO do with these enrollees? If AmeriHealth HMO is mapping the 2015 enrollees to 2016 products and plans, please provide a mapping illustration that shows the development of the rate impact to these consumers.
21.Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must be, concurrently, updated. Please acknowledge your understanding and certify that you are in compliance.
22.Does your company offer transitional policies in Pennsylvania? If so, what markets (individual and/or small group). Please provide the SERFF # for the approved transitional rate filing(s) and the number of transitional members enrolled in each market as of April 1, 2015.
23.Under what pricing assumptions regarding the King v. Burwell Supreme Court Case has your filing been made? Please provide an actuarial narrative and justification regarding the rate impact for the alternate decision.
24.The Department notes that several of the screenshots of the AV Output for CSR plans reflect errors indicating that the desired metal level was unsuccessful. Please provide a discussion of the methodology used to achieve the desired metal level for these plans as well as the appropriate actuarial certification.

State: Pennsylvania **Filing Company:** AmeriHealth HMO, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: AHPA Small Group HMO eff 1-1-2016
Project Name/Number: /

Response to this request should be provided via SERFF in Microsoft Excel spreadsheets (version 2010 or less). Please retain all formulas.

Please be advised that there may be additional questions based on the responses to the above.

Should you have any questions regarding this correspondence, please contact me at csandersjo@pa.gov or by telephone at (717) 787-5172.

Sincerely,

Cherri Sanders-Jones
Actuarial Review Division
Bureau of Accident & Health Insurance

Conclusion:

Sincerely,
Cherri Sanders-Jones

SERFF Tracking #:	*INAC-129961525*	***State Tracking #:***	*INAC-129961525*	***Company Tracking #:***	*AHPA SG HMO 1Q16*

State:	*Pennsylvania*	***Filing Company:***	*AmeriHealth HMO, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*		
Product Name:	*AHPA Small Group HMO eff 1-1-2016*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	REDACTED Response to Objection Letter Dated June 24, 2015
Comments:	Attached are redacted versions of the exhibits sent in response to the June 24, 2015 objection letter.
Attachment(s):	R-Comparison To URRT Instructions.pdf R-Mapping Impact.pdf R-Exhibit C - 2016 Plan Adjusted Index Rate Calculation.pdf R-Exhibit D - 2016 Taxes, Fees, & Admin.pdf R-Trend Basis.pdf R-ahpa sg 2016 response to obj letter dated 6-24-15.pdf R-Exhibit A - 2016 Projected Index Rate Calculation.pdf R-Exhibit B - 2016 Market Index Rate Calculation.pdf R-Breakdown of 2016 Small Group Increase.pdf R-Calibration.pdf
Item Status:	
Status Date:	

	LOCATION: Page	Paragraph	Heading
4.2 General Information			
Company Legal Name			Company Identifying Information
State			Company Identifying Information
HIOS Issuer ID			Company Identifying Information
Market			Company Identifying Information
Effective Date			Company Identifying Information
Company Contact Information			Company Contact Information
4.3 Proposed Rate Increase			
Reason for Rate Increase (List factors)			Proposed Rate Increase
4.4 Market Experience			
4.4.1 Experience Period Premium and Claims			
Paid through date			Paid Through Date
Premiums net of rebate in Experience Period			Premiums (Net of MLR Rebate) in Experience Period
Amount of (expected) rebates			Premiums (Net of MLR Rebate) in Experience Period
Allowed and Incurred Claims During the Experience Period (separately)			
Amount processed through issuer's claim system			Paid-to-Date and Incurred Claims
Amount processed outside issuer's claim system			Paid-to-Date and Incurred Claims
IBNR			IBNR Development
Method for determining Allowed Claims			Allowed Claims
Support for IBNR			IBNR Development
4.4.2 Benefit Categories			
Describe methodology to determine into which category claims fall			Benefit Categories
4.4.3 Projection Factors			
Description of each factor used and supporting information			Projection Factors
Changes in Morbidity			
Describe adjustment factors used			Changes in Population Risk Morbidity
Changes in Benefits			
Describe adjustment factors used during the projection period			Changes in Other Factors
Changes in Demographics			
Describe adjustment factors used between average mix in experience and projection period			Changes in Other Factors
Other Adjustments			
Describe adjustment factors used			Changes in Other Factors
Trend factors			
Describe adjustment factors used and claim sources used			Annualized Cost Trend
4.4.4 Credibility Manual Development			Credibility Manual Trend Developmrnt
4.4.5 Credibility of Experience			Credibility Manual Trend Developmrnt
4.4.6 Paid to Allowed Ratio			
Provide support for factor shown in Worksheet 1, Section III			Paid to Allowed Ratio
4.4.7 Risk Adjustment and Reinsurance			
Explain methodology used to estimate the amounts during experience period			Projected Risk Adjustment PMPM
Explain development of risk adjustment revenue for the risk pool			Projected Risk Adjustment PMPM
Explain how risk adjustment revenue was applied the Index Rate			Projected Risk Adjustment PMPM
Report Reinsurance payments net of contributions			Projected ACA Reinsurance Recoveries
Explain underlying experience data and assumptions			Projected ACA Reinsurance Recoveries
Explain how liability for claims liability between attachment point and cap			Projected ACA Reinsurance Recoveries
State assumed amount of assessment as PMPM			Projected ACA Reinsurance Recoveries
4.4.8 Non-Benefit Expenses and Profit & Risk			
Provide support for Administrative Expense Load			Administrative Expense Load

Describe methodology for estimating projection period amounts	Administrative Expense Load
Describe target underwriting gain/loss margin and change from last filing	
Describe each tax and fee and indicate the amount for each that may be deducted in MLR formula	Administrative Expense Load
Do not include contributions to federal reinsurance or risk adjustment	
Taxes and fees are considered Administrative Expenses per 45 CFR 156.80(d)	
4.5 Projected Loss Ratio	
Indicate the projected MLR	Projected Loss Ratio
4.6 Application of Market Reform Rating Rules	
4.6.1 Single Risk Pool	
Provide support that it meets requirements	Index Rate
4.6.2 Index Rate	
Support for the development in both the experience and projection periods	Index Rate
Explain difference between total allowed claims PMPM and the Index Rate	Index Rate
Individual Market - should match 12 month projection in Worksheet 1	Index Rate
SG - should reflect weighted average of projected index rates for all four quarters	
SG Quarterly trend factors should be filed	
4.6.3 Market Adjusted Index Rate	
Explain how the allowed variables are applied (market-wide)	
Federal reinsurance	Market Adjusted Index Rate
Risk adjustment	Market Adjusted Index Rate
Marketplace user fee adjustment	Market Adjusted Index Rate
Should not be calibrated	
4.6.4 Plan Adjusted Index Rates	
Explain how allowed modifiers were applied	
AV and cost-sharing	Plan Adjusted Index Rate
Provider network, delivery system, and utilization management adjustment	Plan Adjusted Index Rate
Benefits in addition to EHBs	Plan Adjusted Index Rate
Specific eligibility for catastrophic plans	Plan Adjusted Index Rate
Distribution and admin costs	Plan Adjusted Index Rate
Tobacco surcharge	
4.6.5 Calibration	
Age Curve	
Provide average age rounded to a whole number associated with the projected single risk pool	Calibration
Explain factors used to determine the average age	Calibration
Actuarial justification and description of the calculation	Calibration
Demonstration of how the Plan Adjusted Index Rate and age curve are used to produce rate schedule	Calibration
Geographic Factor	
List all geographic factors	Calibration
Provide the geographic calibration if one is necessary	Calibration
4.6.6 Consumer Adjusted Premium Rate Development	
Describe how allowable consumer level adjustments are applied to Plan Adjusted Index Rate	
SG - Consumer Adjusted should reflect appropriate quarter, trend	
4.7 AV Pricing Values	
4.7.1 AV Metal Values	
Describe the methodology used to determine AV Metal Values	AV Metal Values
4.7.2 AV Pricing Values	
Indicate the portion of the AV Pricing Value that is attributable to each of the allowable modifiers	AV Pricing Values
4.7.3 Membership Projections	
Describe how membership projections from Worksheet 2 were developed	Membership Projections
Explain differences relative to current membership	
For Silver Consumer, describe distribution by CSR level	

4.7.5 Terminated Plans and Products
List terminated plans, products not in experience period but available later
Provide cross-walks for terminated plans mapped to new plans
4.7.6 Warning Alerts
Explain
4.8 Miscellaneous Instructions
4.8.1 Effective Rate Review Information
Optional
4.8.2 Reliance
Disclose reliance on other individuals (names)
4.8.3 Actuarial Certification
List of Elements

Rate Comparison for Plan Mapping
Rate for 21 Year Old Non-Tobacco User

	1Q2015 Keystone HMO Bronze Basic	1Q2016 Keystone HMO Bronze Essential	% Change
On-Exchange	[redacted]	[redacted]	[redacted]
Off-Exchange			

PA Small Group

Confidential Actuarial Memorandum - Addendum
Exhibit C

2016 PA Small Group Pricing
Single Risk Pool

Calculation of the Plan Adjusted Index rate, beginning from the Market Adjusted Index Rate

Market Adjusted Index Rate (Exhibit B) 1Q2016	[redacted]

Plan Name	Plan ID	Pricing AV	1Q2016 Plan Adjusted Index Rate
Keystone HMO Platinum Preferred $10/$20/$100	33871PA0100020		
Keystone HMO Platinum Preferred $20/$40/$150	33871PA0100021		
Keystone HMO Gold Preferred $30/$60/$600	33871PA0100022		
Keystone HMO Gold Classic $1,000 $25/$50/90%	33871PA0100023		
Keystone HMO Silver Classic $2,000 $25/$50/70%	33871PA0100024		
Keystone HMO Silver Classic $2,500 $30/$60/50%	33871PA0100025		
Keystone HMO Bronze Essential $6,000 $50/$100/$700	33871PA0100026		
Keystone DPOS Platinum Preferred $10/$20/$100	33871PA0100027		
Keystone DPOS Platinum Preferred $20/$40/$150	33871PA0100028		
Keystone DPOS Gold Preferred $30/$60/$600	33871PA0100029		
Keystone DPOS Gold Classic $1,000 $25/$50/90%	33871PA0100030		
Keystone DPOS Silver Classic $2,000 $25/$50/70%	33871PA0100031		
Keystone DPOS Silver Classic $2,500 $30/$60/50%	33871PA0100032		
Keystone DPOS Bronze Essential $6,000 $50/$100/$700	33871PA0100033		
Keystone DPOS Gold Classic $2,000 $40/$80/100%	33871PA0100041		
Keystone DPOS Silver Classic $4,250 $40/$80/100%	33871PA0100042		
Keystone DPOS Silver Secure $3,500 $40/$80/$600	33871PA0100043		
Keystone HMO Gold Proactive	33871PA0100044		
Keystone HMO Silver Proactive	33871PA0100045		
Keystone HMO Gold Classic $2,000 $40/$80/100%	33871PA0100047		
Keystone HMO Silver Classic $4,250 $40/$80/100%	33871PA0100048		
Keystone HMO Silver Secure $3,500 $40/$80/$600	33871PA0100049		

PASML
Confidential Actuarial Memorandum - Addendum
Exhibit D
2016 PASML Pricing

Taxes & Fees	PMPM	% of Premium
PCORT ($2 per year)	[redacted]	
Exchange User Fees		
Health Insurer Fee (HIF)		
Premium Tax		
Total		

Administrative Expenses	PMPM	% of Premium
Broker Commission	[redacted]	
Administrative Fees PMPM		
Claims Administration		
General Administration		
Total		

[redacted]

Unit Cost

- Facility - Inpatient (non-capitated)
- Admits
- Days
- Facility - Outpatient (non-capitated)
- Facility - Capitated Services
- Professional - Non-Capitated
- Professional - Capitated
  - PCP
  - Mental health
  - Physical Therapy
  - Podiatry
  - Lab
- Other Medical (non-capitated)
- Other Medical (capitated)
  - Vision (Embedded)
  - Dental (Embedded)
- Total Medical Claims

Projected Utilization

Projected Trend

1901 Market Street
Philadelphia, PA 19103-1480

www.amerihealth.com

AmeriHealth

July 8, 2015

Mr. Peter Camacci, Director
Bureau of Accident and Health Insurance
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

SUBMITTED VIA SERFF

Re: AmeriHealth HMO, Inc. (AHPA)
Small Group Rate Filing effective 1/1/2016
INAC - 129961525

Dear Mr. Camacci:

The following is our response to the Objection letter received (via SERFF) June 24, 2015 regarding the above referenced filing. For ease of review, we have included the original questions along with our replies. Attachments in Supporting Documentation can be found under "Response to Objection Letter Dated June 24, 2015".

1. *It is my understanding that Section I of worksheet I of the URRT is to contain the single risk pool data for a given issuer, state and market. Your actuarial memorandum indicates that the experience period data provided represents KHPE, AmeriHealth and QCC. Please revise to reflect data solely for the named issuer for stated experience period. If you believe there are special circumstances that allow for the aggregation of the 3 companies please provide a detailed discussion. Please note, to the extent that AmeriHealth supports KHPE POS, it is only those claims data that should be included in the KHPE HMO URRT. Only the pure AmeriHealth HMO (non KHPE supporting) data should be reported in this filing.*

   The URRT we submit for AHPA matches the URRT submitted for KHPE. As noted below, there are no AHPA Small Group plans that do not support KHPE.

2. *Does AmeriHealth offer any products directly in the Pennsylvania market or does this entity solely support KHPE? Please provide a detailed discussion of the relationship and how it works. If products are offered directly, please identify the Plan ID#s in the Base Rate Schedule and the SERFF Tracking Number for the corresponding form filing.*

AmeriHealth

[redacted]

3. *Is the geographic rating area the same for AmeriHealth HMO as it is for KHPE?*

[redacted]

4. *The Department Rate Exhibit shows rates for plans offered on and off SHOP, while the rate filing cover letter and the corresponding contract forms (INBC-130052422, INLG-130057645) indicate only off SHOP plans/products. Please review and revise all impacted documents.*

[redacted]

5. *Please review the contract form numbers indicated on the Department Rate Exhibit to ensure consistency with the corresponding filed contract forms.*

   We have compared the form numbers in the Rate Exhibit to the corresponding filed contract forms and did not find differences.

6. *The filing indicates the weighted average increase across products/plans is 6.7%. Worksheet 2 of the URRT (row 28) shows a rate increase of 6.49% for a PPO Product and a 6.88% increase for the HMO product. Since HMOs are only allowed to do HMO/POS business, should the threshold product rate increase for the HMO be 6.88% and not 6.7%? Please review the URRT, company rate information contained in the Rate/Rule Schedule tab and any other items that may be impacted and revise as necessary.*

[redacted]

7. *The company rate information contained in the Rate/Rule Schedule Tab indicates that an overall rate change of 11.4% is proposed, with a maximum of 14.5% and a minimum of -6.5% with an overall % impact of 6.7%. Please explain these adjustments and show how*

they were developed.

[redacted]

8. *The filing indicates the weighted average increase across plans based on current ACA-compliant membership is 6.7% (or the revised average per question #2 above). Please show how this average breaks down by the following and discuss the basis for the proposed changes:*
   - *Impact of medical claim trend;*
   - *Revisions to assumptions about population morbidity and the projected population distribution;*
   - *Changes to the reinsurance program;*
   - *Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;*
   - *Changes in pricing models used to determine the impact of cost sharing design;*
   - *Changes in benefits and plan design;*
   - *Changes in fees, taxes and administrative expenses.*

[redacted]

9. *Please provide the Federal Rate Template in the Rate/Rule Schedule tab.*

[redacted]

10. *The actuarial memorandum does not meet the standard as prescribed by CMS in the 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I (v2.0.4, II, and III) version 2/21/15. Please provide an actuarial memorandum that reflects company specific data and assumptions, not simply a generic template.*

[redacted]

AmeriHealth

11. *The actuarial memorandum indicates that member cost sharing is included in calculating allowed claims, but does not speak to the cost sharing payments by HHS from the federal government. Please discuss why.*

    Cost sharing payments by HHS from the federal government apply to the Individual market and are not available in the small group market.

12. *Please provide further discussion of the rates in the Base Rate Schedule and show their development. Also, show the rate change for each plan identified in the Base Rate Schedule.*

[redacted]

13. *Please provide an Excel exhibit that shows the development of the Index Rate for the 2016 Projection Period, starting from the 2014 experience data. Also, provide narrative that explains the development and all adjustments.*

    This information is provided on [redacted]

14. *Please provide an Excel exhibit that shows the development of the Plan adjusted Index Rate for each plan design offered in 2016, starting from the Index Rate.*

[redacted]

15. *Please identify the specific taxes and fees and the corresponding percent of premium or the pmpm amounts. Additionally, show the components of the administrative expense load of 9.9% and their corresponding costs.*

    This information is provided in [redacted] response.

16. *Please provide Excel exhibits that show the development of all calibration adjustments.*

AmeriHealth

[redacted]

What is the basis for the trend selection of approximately 7.4%? Please provide support and a narrative that explains the trend development.

[redacted]

17. *For the January 1, 2016, through October 1, 2016 will QCC allow current enrolled groups of size 51-100 transitional relief? That is, will you allow a particular enrolled group to continue under the large group rating process? What is your current (2015) definition of small group? Please be advised that the experience period data should only include groups that meet the 2-50 group size. However, in the projection period, expected claims experience should reflect group policies for employers with 100 or fewer employees that the issuer expects to be enrolled in single risk pool compliant plans during the projection period. This may be done through the projection factors, use of a manual rate, or combination of the two. Please acknowledge your company's understanding and compliance.*

[redacted]

18. *The Department notes that the Dental field in the Department Rate Exhibit is not populated. Please review and ensure that every field is appropriately populated.*

    Thank you for your explanation of this item. We have reviewed the exhibit and completed the Dental field for all plans.

19. *The actuarial memorandum indicates that Plan ID 33871PA002 has been terminated. Does this plan have membership? What will AmeriHealth HMO do with these enrollees? If AmeriHealth HMO is mapping the 2015 enrollees to 2016 products and plans, please provide a mapping illustration that shows the development of the rate impact to these consumers.*

AmeriHealth

[redacted]

20. *Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must be, concurrently, updated. Please acknowledge your understanding and certify that you are in compliance.*

    We do not file a separate URRT in HIOS for AHPA, since it matches KHPE and since AHPA does not directly market to Small Groups in Pennsylvania.

21. *Does your company offer transitional policies in Pennsylvania? If so, what markets (individual and/or small group). Please provide the SERFF # for the approved transitional rate filing(s) and the number of transitional members enrolled in each market as of April 1, 2015.*

[redacted]

22. *Under what pricing assumptions regarding the King v. Burwell Supreme Court Case has your filing been made? Please provide an actuarial narrative and justification regarding the rate impact for the alternate decision.*

    The pricing assumptions in this filing assumed that premium subsidies would continue.

23. *The Department notes that several of the screenshots of the AV Output for CSR plans reflect errors indicating that the desired metal level was unsuccessful. Please provide a discussion of the methodology used to achieve the desired metal level for these plans as well as the appropriate actuarial certification.*

[redacted]

AmeriHealth

With the department's decision to post objection and response letters, we request that the information in this letter and attachments be considered the unredacted version. We will submit redacted versions once guidelines have been released.

Please contact [redacted] with any questions regarding this filing.

Sincerely,

[redacted]

Director and Actuary, Commercial Pricing

PASML
Confidential Actuarial Memorandum - Addendum
Exhibit A
2016 PASML Pricing

		PMPM
Experience Period Allowed Claims		
KHPE	[redacted]	[redacted]
QCC		
Total		
Trend	[redacted]	
Population Distribution & Morbidity Changes		
Other		[redacted]
Projected to 2016		[redacted]
Value of Non-EHB Benefits		[redacted]
2016 Projected Index Rate		[redacted]

PA Small Group

Confidential Actuarial Memorandum - Addendum
Exhibit B

2016 PA Small Group Pricing
Single Risk Pool

Experience Period: 01/01/2014 thru 12/31/2014 paid thru 01/01/2015 with IBNR
Projection Period: 01/01/2016 thru 12/31/2016 incurred

Calculation of the Market Adjusted Index rate, beginning from the Index Rate

Index Rate 1Q2016	[redacted]
Non-EHB	
Non-EHB	
Total EHB and Non-EHB	
Projected Allowed PMPM Total	[redacted]
EHB	[redacted]
Non-EHB	[redacted]
Projected Allowed PMPM (EHB)	[redacted]
Reinsurance Assessment	[redacted]
Risk Adj Prog User Fee	
Exchange User Fees	
Market Adjusted Index Rate 1Q2016	[redacted]

Breakdown of 2016 Small Group Base Premium Increase

Medical Claim Trend	
Population Distribution & Morbidity Changes	
Reinsurance Fee Change	
Benefit Changes	
Actual vs. Expected Experience	
Retention Changes	
Total	

2016 Small Group Gross Premium

2015 Premium	
Rate Increase	
2016 Gross Premium	

KHPE		
Age	% of Members	Factor
<21	[redacted]	0.656
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
35		1.222
36		1.230
37		1.238
38		1.246
39		1.262
40		1.278
41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000
	[redacted]	

QCC		
Age	% of Members	Factor
<21	[redacted]	0.657
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
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36		1.230
37		1.238
38		1.246
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41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000
	[redacted]	

Total		
Age	% of Members	Factor
<21	[redacted]	0.656
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
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41		1.302
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48		1.635
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50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000
	[redacted]	

Projected Average Factor for Tobacco Users Projected Tobacco Use Prevalence	[redacted]
Tobacco Use Calibration Factor	[redacted]