

State:	Pennsylvania	Filing Company:	Keystone Health Plan Central
TOI/Sub-TOI:	H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense		
Product Name:	Rates - KHPC Individual HMO		
Project Name/Number:	/		

Supporting Document Schedules

Satisfied - Item:	Public Rate Filing revised 08/15/18
Comments:	
Attachment(s):	Ind_18-11_Revised_KHP_HMO_PublicFiling01_201808015.pdf Ind_18-11_Revised_KHP_HMO_PublicFiling02_201808015.pdf Ind_18-11_Revised_KHP_HMO_PublicFiling03_201808015.pdf Ind_18-11_Revised_KHP_HMO_PublicFiling04_201808015.pdf Ind_18-11_Revised_KHP_HMO_PublicFiling05_201808015.pdf
Item Status:	
Status Date:	



May 18, 2018

██████████, Director
Bureau of Life, Accident and Health Insurance
Office of Insurance Product Regulation and Administration
Commonwealth of Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

**Re: Keystone Health Plan Central
Individual Rates
Filing No 18-11
TOI Code: H15I Individual Health – Hospital/Surgical/Medical Expense
Sub-TOI Code: H15I.001 - Hospital/Surgical/Medical Expense
Filing Type: Rate**

Dear ██████████:

By this filing Capital BlueCross, on behalf of its wholly owned subsidiary Keystone Health Plan Central, submits to the Department its Individual Rates effective January 1, 2019.

The following is a summary of the rate filing:

- Company Name: Keystone Health Plan Central (KHPC)
- NAIC: 95199
- Market: Individual
- On/Off Exchange: Off Exchange
- Effective Date: 1/1/2019
- Average Rate Change Requested: -5.7%
- Range of Requested Rate Change: -8.3% to 6.7%
- Total additional annual revenue generated from the proposed rate change: \$(788,441)
- Product: HMO
- Rating Areas: 6,7,9
- Metal Levels: Bronze, Catastrophic
- Current Covered Lives and Policyholders: 2,043/1,452
- 2019 Number of Plans: 2
- 2018 Number of Plans and Percent Change: 2/0%
- Contract Form #: KHPC-Ind-HMO-21cnty-AGRMT-v0119
- Form Filing SERFF #: CABC-131453908
- Binder SERFF #: CABC-PA19-125079437
- HIOS Issuer ID: 53789
- HIOS Submission Tracking Number: 53789-1217515730619118596

Harrisburg, PA 17177 | capbluecross.com

Please note that per instructions from the Insurance Department, 0.06 was added to the morbidity factor to account for the possible repeal of the individual mandate.

In support of this filing, I have included an Actuarial Memorandum with supporting exhibits, URRT, Consumer Friendly Justification, Rates Table Template, Rate Change Request Summary, and PA Plan Design Summary and Rate Tables.

If you have any questions regarding this filing, please call me at [REDACTED] (or via email at [REDACTED]) or [REDACTED] at [REDACTED] ([REDACTED]). Thank you for your assistance in this matter.

Sincerely,

[REDACTED]

[REDACTED], ASA, MAAA
Manager, Actuarial Services
Capital BlueCross

Enclosures

cc: [REDACTED], FSA, MAAA, Senior Director, Actuarial Services
[REDACTED], ASA, MAAA, Vice President and Chief Actuary, Actuarial Services
[REDACTED], Corporate Counsel

Attachment I

Rate Change Summary

Keystone Health Plan Central (KHPC) – Individual Plans

Rate request filing ID # CABC-131454728 - This document is prepared by the insurance company submitting the rate filing as a consumer tool to help explain the rate filing. It is not intended to describe or include all factors or information considered in the review process. For more information, see the filing at

<http://www.insurance.pa.gov/Consumers/ACARelatedFilings/>

Overview

Initial requested average rate change:	-6.2% ¹
Revised requested average rate change:	-7.3%
Range of requested rate change:	-9.9% to 5.4%
Effective date:	1/1/2019
People impacted:	2,043
Available in:	Rating Area 6, Rating Area 7 and Rating Area 9

Key information

Jan. 2017-Dec. 2017 financial experience

Premiums	\$	9,690,526
Claims	\$	6,618,197
Administrative expenses	\$	1,323,452
Taxes & fees	\$	(8,149,809)
Company made (after taxes)		\$9,898,686

How it plans to spend your premium

This is how the insurance company plans to spend the premium it collects in 2019:

Claims:	86.95%
Administrative:	10.63%
Taxes & fees:	0.42%
Profit:	2.0%

The company expects its annual medical costs to increase **9.15%**.

Explanation of requested rate change

Stabilization of the Individual market in recent years
Suspension of the Health Insurer Fee in 2019
Anticipated increase in facility and physician unit costs
Anticipated changes in prescription drug unit costs
Continuing change in utilization

¹ Note that insurers will have the opportunity to revise their rate change request in July, after they are scheduled to receive updated information about the impact of a federal program called risk adjustment. This document will be updated accordingly at that time.



July 23, 2018

██████████, Director
Bureau of Life, Accident and Health Insurance
Office of Insurance Product Regulation and Administration
Commonwealth of Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

**Re: Keystone Health Plan Central
Individual Rates
Filing No 18-11
TOI Code: H15I Individual Health – Hospital/Surgical/Medical Expense
Sub-TOI Code: H15I.001 - Hospital/Surgical/Medical Expense
Filing Type: Rate**

Dear ██████████:

By this filing Capital BlueCross, on behalf of its wholly owned subsidiary Keystone Health Plan Central, submits to the Department its Individual Rates effective January 1, 2019.

The following is a summary of the rate filing:

- Company Name: Keystone Health Plan Central (KHPC)
- NAIC: 95199
- Market: Individual
- On/Off Exchange: Off Exchange
- Effective Date: 1/1/2019
- Average Rate Change Requested: -7.3%
- Range of Requested Rate Change: -9.9% to 5.4%
- Total additional annual revenue generated from the proposed rate change: \$(845,473)
- Product: HMO
- Rating Areas: 6,7,9
- Metal Levels: Bronze, Catastrophic
- Current Covered Lives and Policyholders: 2,043/1,452
- 2019 Number of Plans: 2
- 2018 Number of Plans and Percent Change: 2/0%
- Contract Form #: KHPC-Ind-HMO-21cnty-AGRMT-v0119
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Sincerely,

[REDACTED]

[REDACTED], ASA, MAAA
Manager, Actuarial Services
Capital BlueCross

Enclosures

cc: [REDACTED], FSA, MAAA, Senior Director, Actuarial Services
[REDACTED], ASA, MAAA, Vice President and Chief Actuary, Actuarial Services
[REDACTED], Corporate Counsel

KEYSTONE HEALTH PLAN CENTRAL, INC.

ACTUARIAL MEMORANDUM

Individual Rates

Effective January 1, 2019

General Information

Company Information

- Company Legal Name: Keystone Health Plan Central
- State: PA
- HIOS Issuer ID: 53789
- Market: Individual
- Effective Date: 1/1/2019

PID Company Information

- Company Name: Keystone Health Plan Central (KHPC)
- NAIC: 95199
- Market: Individual
- On/Off Exchange: Off Exchange
- Effective Date: 1/1/2019
- Average Rate Change Requested: -7.3%
- Range of Requested Rate Change: -9.9% to 5.4%
- Total additional annual revenue generated from the proposed rate change: \$(1,004,854)
- Product: HMO
- Rating Areas: 6,7,9
- Metal Levels: Bronze, Catastrophic
- Current Covered Lives and Policyholders: 2,043/1,452
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- HIOS Issuer ID: 53789
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Company Contact Information

- Primary Contact Name: [REDACTED]
- Primary Contact Telephone Number: [REDACTED]
- Primary Contact Email Address: [REDACTED]

Scope and Purpose

By this filing, Keystone Health Plan Central (KHPC), a subsidiary of Capital BlueCross (CBC), submits rates for products to be made available to individuals on and after January 1, 2019. KHPC will offer individual products off the federally-facilitated exchange.

Rate History and Proposed Variations in Rate Changes

Market	Company	Effective Date	SERFF #	Annual Increase
Individual	KHPC	1/1/2015	CABC-129635491	-8.00%
Individual	KHPC	1/1/2016	CABC-130076965	1.40%
Individual	KHPC	1/1/2017	CABC-130539563	55.10%
Individual	KHPC	1/1/2018	CABC-13102203	9.20%

Average Rate Change

KHPC is proposing an aggregate annual 7.3% rate decrease. The rate change does vary by plan. The rate change is calculated in PA Rate Template Part III, Table 10, cell AC15.

Regulatory Considerations

Rates submitted by this filing assume changes to the current regulatory framework. As directed by the Insurance Department, the following factors have been applied to the rates for regulatory changes:

- Individual Mandate: 0.06 added to the morbidity factor.

Membership

Membership is shown in PA Rate Template Part I, Table 1. The average age is 34.

Benefit Changes 2018-2019

A summary of proposed 2019 benefits is included in Exhibit A.

There are several benefit changes being implemented in 2018. All benefit changes comply with the uniform modification of coverage standards described in 45 CFR 147.106(e). Any plan with a benefit change that did not meet the uniform modification of coverage standard was terminated, and

a new plan was created in its place. Benefit changes by plan are listed in Exhibit B, highlighted in yellow.

Experience Period Premium and Claims

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 product/plan combination for KHPC in the individual market. The single risk pool includes transitional products/plans for purposes of base rate experience.

Base Experience Period: The base experience period (BEP) includes completed fee-for-service paid and incurred claims for dates of service between January 1, 2017 and December 31, 2017.

Paid Through Date: Claims in the BEP are paid through March 31, 2018

Premiums (net of MLR Rebate) in BEP: Premiums are calculated on an earned basis in the BEP. MLR rebate adjustments are equal to zero as KHPC does not expect to refund any MLR rebates in the BEP.

Allowed and Incurred Claims in BEP:

- Allowed claims are developed by combining paid claims with member cost-sharing. Allowed claims meet the definition in the URR instructions. They do not include provider quality incentive payments.
- Incurred claims are net of HHS CSR payments.
- CBC only covers Essential Health benefits (EHBs).
- KHPC does not include capitated services.
- Allowed and Incurred claims are net of pharmacy rebates. BEP rebates are completed based on actual utilization of rebate-eligible drugs and rebate amounts.

Estimated Incurred but Not Paid Claims: 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 are assumed to be identical.
6. Both allowed and paid claims in the BEP are completed by applying completion factors by incurred month developed in Step 6.

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

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

Risk Adjustment in BEP: Risk adjustment amounts in the BEP are equal to those reported by the Department on 5/9/2018.

Loss Ratio in BEP: Loss ratio is 145.03%

Credibility of Data

No Credibility Manual was used.

Trend Identification

Trend: 11.3%

Trend levels reflect CBC's 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. CBC uses the following to project future costs:
 - a. Vendor Physician Cost Model and Internal Hospital Contracting Model
 - i. The medical cost models use best estimates of Capital BlueCross (CBC)'s future contracting increases with physicians and hospitals. The models use cost estimates based on varying contract effective dates by physician and hospital. All facilities and providers are considered in this modeling effort (i.e. acute and non-acute, network and non-network, inpatient and outpatient, in- area and out-of-area). From there, a monthly anticipated

cost (assuming static utilization) summary is produced which can be used in projecting future claims costs. Cost trends are determined at the CBC book of business level for all commercial business.

- b. Internal Prescription Drug Trend Model
 - i. Price Inflation
 - ii. Contract Pricing
 - iii. Member Cost-Sharing
 - iv. Units per Script
 - v. Brand/Generic Mix
 - vi. Therapeutic Mix
 - vii. Cost per Script
- 2. Utilization Considerations:
 - a. Intensity of medical services rendered
 - b. Changes in place of service (e.g. continued migration of inpatient stays to outpatient setting)
 - c. Further migration from brand prescription drugs to generic prescription drugs
 - d. Favorable impacts of value based benefits designs
 - e. Induced Utilization: Induced utilization is CBC's best estimate for increased utilization in the individual market due to unknown future regulatory changes. CBC predicts that consumers will use more services in 2019 due to unknown coverage status in 2020.
 - f. Medical utilization estimates reviewed by CBC's Chief Medical Officer
- 3. Leveraging: The trend model is based on allowed cost increases. Paid claims trend at a higher rate than allowed due to leveraging. Leveraging is the impact of static cost-share, such as deductibles, to the paid trend. Estimated leveraging is calculated in Exhibit E1.
 - o Estimated costs are based on average plan benefit value in the month, calculated using CBC's internal benefit model.
 - o CBC expects the average benefit level in 2019 to be similar to current month, 201803.
 - o As of 201803, on average, Individual members pay 44.8% of costs, while CBC pays 55.2%. So for example,
 - \$2,000 in annual allowed claims results in member pay = \$896, and CBC pay = \$1,104.
 - \$2,000 trends at 5.5% = \$2,110
 - Member pay is fixed at \$896
 - CBC pay = $2,110 - 896 = \$1,214$
 - Total CBC trend = $1,214 / 1,104 - 1 = 10\%$
 - o With an allowed trend of 5.5%, and static cost-share, leveraging will add an additional 4.5% to trend.
- 4. 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 2018

<u>Type of Service</u>	<u>Units</u>	<u>Cost per Unit</u>
X-Ray	1	\$200
MRI	1	\$5,000
Total	2	\$5,200

Year 2019

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

Total Annual Trend	92%
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5. **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. KHPC strives to mitigate the underwriting cycle by keeping trends consistent through times of increasing and decreasing claim cost and utilization.

Historical Experience: Historical experience was not used to the develop trend.

Benefit Categories: Claims in the benefit categories displayed in the URRT come directly from CBC's data warehouse. These same categories are used to develop category-level trend. See Exhibit C for a description of benefits by benefit category.

See Exhibit E for KHPC's pricing trend, as well as cost and utilization components of the pricing trend.

Rate Development & Change

Projection Factors

Changes in Morbidity: Found in URRT Worksheet 1, "Pop'l risk Morbidity", and PA Rate Template Table 5.

The changes to morbidity incorporate both the Department's Individual Mandate factor discussed above, and changes to the population going from Bronze and Catastrophic experience to Catastrophic in the projection period. The additional morbidity change factor calculated in Exhibit F.

Changes in Benefits: Benefit changes are not applied to allowed claims as allowed should stay consistent from 2017 to 2019. Benefit changes are applied in the development of future incurred claims, due to changes in member cost-share. This calculation is shown in Exhibit D, and applied in Exhibit G. The manual cost PMPMs are developed from CBC's internal benefit relativity model, discussed in the Plan Adjusted Index Rate section below. The benefit change is equal to member-month weighted average projected manual PMPM divided by member-month weighted average manual PMPM in the BEP. This process is further discussed in the Paid-to-Allowed section below.

Changes in Demographics: KHPC does not expect changes in demographics in its individual population.

Changes in Network: No network adjustment is applied.

Other Adjustments: No other adjustment is applied.

Benefits, Demographics, Network and Other adjustments are found in URRT, Worksheet 1, "Other", and PA Rate Template Table 5.

Index Rate

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

Projected Allowed Claims: The KHPC 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)").

To calculate the projected index rate:

1. Start with *Projected Allowed Claims at Current Benefits*
2. The *Projected Allowed Claims at Current Benefits* reflect EHBs 100 percent, so no adjustment needs to be made to add EHBs and remove non-EHB claim cost. This is the index rate for individuals renewing January – December.

See Exhibit J for the Index Rate.

Paid to Allowed Ratio

KHPC used the prescribed URRT allowed claim rate development methodology in conjunction with a paid and incurred rate development methodology to determine final premium rates. The URRT projects allowed claims, and uses a paid-to-allowed ratio in order to adjust allowed claims to paid levels. This value is then used to develop premiums. In order to determine the paid-to-

allowed ratio, KHPC projected paid and incurred claims, adjusted for benefits, to the experience period.

Projected Paid and Incurred Claims are calculated as follows:

1. Gather claims experience as described in the Data section above.
 - a. Base Experience Period (BEP) Paid Claims, Capitation, and Rx Rebates
 - b. BEP Member Months
2. Develop BEP *Paid and Incurred Claims*:

$$\text{BEP Paid and Incurred Claims} = \frac{\text{BEP Paid Claims}}{\text{Completion Factor}}$$

The development of completion factors is described in Experience Period Premium and Claims above.

3. Develop the *BEP Paid and Incurred Claim PMPM*:

$$\text{BEP Paid and Incurred Claim PMPM} = \frac{\text{BEP Paid and Incurred Claims}}{\text{BEP Member Months}}$$

4. Develop *Trended Claim PMPM*: Using the aggregate trend described in the Projection Factors section above, trend the BEP Paid and Incurred Claim PMPM from the midpoint of the experience period to the midpoint of the rating period.

Trended Claim PMPM

$$= [\text{BEP Paid and Incurred Claim PMPM}] \times (1 + [\text{Trend}\%])^{\text{Trend Months}/12}$$

5. Develop *Projected Paid and Incurred Claim PMPM*:

$$\begin{aligned} \text{Projected Paid and Incurred Claims PMPM} \\ = [\text{Trended Claim PMPM}] \times [\text{Benefit Adjustment}] \\ \times [\text{Morbidity Adjustment}] \times [\text{Other Adjustment}] \end{aligned}$$

The *Benefit Adjustment*, *Morbidity Adjustment*, and *Other Adjustment* are discussed in the Projections Factors section above.

6. Develop *Projected Claims PMPM by Benefit* as follows:

- a. KHPC 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 PMPM by service, summed for all services. The impact of global deductible, coinsurance, and out-of-pocket max is then measured based on cumulative probability distributions (CPDs), where the value of services that apply to the CPDs adjusts the level of the curve, as well as global utilization adjustments.

- b. This actuarial cost model derives a Manual Cost for each benefit design in the experience period, as well as plans being offered in the projection period. The average Manual Cost of the experience is compared to the Manual Cost of the base plan. The projected experience period data is then adjusted to the base plan:

$$\text{Benefit Level Adjustment} = \frac{\text{Average Manual Cost in Projection Period}}{\text{Manual Cost of Base Plan}}$$

- c. The *Projected Paid and Incurred Claim PMPM* (Step 5) is then adjusted to the Base Plan as follows:

$$\begin{aligned} &\text{Base Plan Paid and Incurred Claims PMPM} \\ &= \frac{\text{Benefit Adjusted Paid and Incurred Claims PMPM}}{\text{Benefit Level Adjustment}} \end{aligned}$$

- d. Each additional benefit design has its own unique Manual Cost, which can then be compared to the Base Plan to develop a Benefit Relativity:

$$\text{Benefit Relativity A} = \frac{\text{Manual Cost of Benefit A}}{\text{Manual Cost of Base Plan}}$$

- e. The Benefit Relativity developed in d. above is then used as a gauge to develop a final *Pricing Relativity*. This pricing relativity is developed using actuarial judgment including the following considerations:
 - i. Final premium relativities must make sense based on benefits. For example, the annual cost difference between a PPO 2000 and PPO 1000 must be less than \$1000.
 - ii. Adjustments for plan designs that fall outside of the actuarial cost model.
- a. So the *Projected Claims PMPM by Benefit* is:

$$\begin{aligned} &\text{Projected Claims PMPM Benefit A} \\ &= \text{Projected Claims PMPM Base Plan} \\ &\times \text{Pricing Relativity A} \end{aligned}$$

- b. And to arrive at the *Total Projected Claims PMPM*, KHPC assumes a distribution of members across the benefit plans being offered in 2019. The *Total Projected Claims PMPM* :

$$= \text{Projected Claims PMPM Benefit A} \times \text{Expected Member Dist of Benefit A} \\ + \text{Projected Claims PMPM Benefit B} \\ \times \text{Expected Member Dis of Benefit B} + \dots$$

7. The Paid-To-Allowed Ratio is then:

$$\text{Paid to Allowed Ratio} = \frac{\text{Total Projected Claims PMPM}}{\text{Projected Allowed Claims at Current Benefits}}$$

See Exhibit G for the development of the *Paid-to-Allowed Ratio*. And see Exhibit L for the plan-level projected incurred amount development.

Risk Adjustment

Projected Risk Adjustments PMPM:

Relevant to 2019 pricing is the impact of Commercial Risk Adjustment (CRA) payment transfers that are expected to be earned in 2019. The pricing impact is:

$$[\text{Net Projected Risk Adjustments PMPM}] \\ = [\text{Projected CRA Transfer PMPM}] - [\text{Risk Adjustment Fee PMPM}]$$

The following items are those that we deem important in generating a CRA payment transfer adjustment:

1. Risk profile of the those enrolled in CRA eligible plans for the market or state (i.e. competitors) relative to risk profile of CRA eligible membership enrolled in our plans
2. Statewide average premiums
3. Current market penetration of this company and competitors in the market and in the state
4. 2016-2017 risk adjustment results
5. Market improvement in coding risk: CBC's ACA book of business has had a churn rate that makes a multi-year perspective of member diagnosis and risk very challenging. Because closing gaps in care and coding, and a myriad of other risk adjustment functions require more than a single year of data to facilitate an accurate depiction of risk, it is believed that CBC is disadvantaged in the market. This will drive CBC's relative risk to the market down over time.

To fund the HHS-risk adjustment program, issuers will remit to HHS a fee of \$0.13 PMPM. The Risk Adjustment Fee PMPM is included in the URRT Worksheet 1, "Projected Risk Adjustments PMPM", and is found on Exhibit K.

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,

$$\begin{aligned} & [\textit{Market Adjusted Index Rate}] \\ &= ([\textit{Index Rate}] \times [\textit{Paid to Allowed Ratio}] \\ &\quad - [\textit{Net Projected ACA Reinsurance Recoveries}] \\ &\quad - [\textit{Net Projected Risk Adjustments PMPM}] + [\textit{Exchange Fees PMPM}]) \\ &\quad \div [\textit{Paid to Allowed Ratio}] \end{aligned}$$

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

Retention Items

Administrative Expense Load:

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 what percentage of time is spent on PPO versus HMO versus Drug versus Medicare. And separately will ask what percentage of time 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 allocated to KHPC Individual products. Administrative expenses are included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6. Expense as a percentage of premium vary by plan because a fixed dollar admin PMPM is applied to each plan.
2. Broker Expense: Calculated based on KHPC's explicit per contract broker fee. Broker Expense is included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6. KHPC pays commissions for new business and renewal enrollment received during open enrollment, both on and off exchange, and in all geographic areas. Commission is less on catastrophic plans due to the lower premium. KHPC does not pay commission during Special Enrollment Periods (SEP). The 2019 broker commission schedule is yet to be finalized. Attached please find the 1/1/2018 copy of the broker agreement – redacted version. Files are as follows:
 - a. Redacted Agent Agreement: "Ind_18-11_Initial_KHPC_PPO_WBEBrokerIndRedacted_Supporting_20180518.pdf"
 - b. Redacted Preferred Producer Master Agreement: "Ind_18-11_Initial_KHPC_PPO_PPMABrokerIndRedacted_Supporting_20180518.pdf"
3. Member Out-Of-Pocket (OOP) and Ways to Save:
 - a. Description: These products offer enhanced transparency to cost savings potential both prospectively and retrospectively. These are new services included in each

of KHPC's plans that work to decrease costs by engaging members in their health care decisions. The Member OOP program will show a member, prospectively, the value of a service and the impact of member cost-sharing when that service is incurred. It allows a member to shop for the best price while introducing transparency related to the member's expected cost share at the time of service. The "Ways to Save" program allows members to receive alerts, retrospectively, informing them of cost savings that could have been incurred had they have known about competing medical providers in the area. The alerts are retrospective and offer transparency around member's healthcare options.

- b. Costs: Costs are aggregated into CBC's total administrative expense above. No additional fee is charged. The cost is approximately \$0.25 PMPM. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
4. Value-Based Benefits (VBB): Standard with each plan, Capital BlueCross includes wellness incentives to maximize the likelihood that consumers make positive behavioral changes, which lead to better health, and curbed health care costs for employers and employees alike. The incentive is as follows:
 - a. Complete Health Risk Assessment questionnaire and receive a gift card.
 - b. Participate in an online coaching program and receive a gift card reward.
 - c. The wellness program is administered through a vendor and costs are based on vendor fees, anticipated participation, and reward card amounts.
 - d. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
5. Identity Theft Coverage: Identity protection offering will include the following components:
 - a. Credit monitoring – Monitors activity that may affect credit
 - b. Fraud detection – Identifies potentially fraudulent use of identity or credit
 - c. Fraud resolution support – Assists members in addressing issues that arise in relation to credit monitoring and fraud detection
 - d. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
6. Additional Quality Improvement: The Final Notice of Benefit and Payment Parameters (NBPP) for 2019 finalized the rule to allow issuers to apply a standard 0.8% of premium for quality improvement (QI) measures in the MLR calculation. Total QI amounts applied in rating equal 0.8%.

Profit (or Contribution to Surplus) & Risk Margin:

7. Contingency: Contingency is included in the URRT Worksheet 1, "Profit and Risk", and PA Rate Template Table 6.

Taxes and Fees:

1. Health Insurer Fee (HIF) – Section 9010 of PPACA and Section 1406 of the Reconciliation Act (which modified PPACA) refers to HIF. The fee is a fixed-dollar amount distributed across health insurance providers. This fee has been suspended for 2019.

2. Exchange Fee – All issuers participating in a federally-facilitated exchange will remit 3.5% of premium to HHS. The exchange user fee is applied as an adjustment to the Index Rate at the market level. The calculation and amount is found in Exhibit K. The amount is also found in PA Rate Template, Table 5.
3. Federal Income Tax: Federal Income Tax will be collected on the 2% contingency built into the premium. The projected Federal Income Tax is included in the URRT Worksheet 1, “Taxes and Fees”, and PA Rate Template, Table 6.

See Exhibit H for all retention values.

Plan Rate Development

The Plan Adjusted Index Rates are 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 KHPC’s actuarial cost model. KHPC 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. Induced Demand: Please see Table 8
3. Provider Network: The Provider network is the same across all PPO plans. A network factor is applied to the EPO plan.
 - a. The Capital Advantage EPO plan is a plan built around Pinnacle Health’s delivery system and is available in Cumberland, Dauphin, and Perry counties.
 - b. See Exhibit O1 for the development of the network factor.
4. Adjustment for benefits in addition to EHBs: No benefits other than EHBs are included in the plans, so no adjustment is necessary.
5. Catastrophic Plans: Applied to catastrophic plans to reflect lower morbidity.
6. Adjustment for distribution and administrative costs: Described in Non-Benefit Expenses and Profit & Risk section above.
7. Tobacco Adjustment: Calculated as the average tobacco factor applied across the risk pool.

The development of the Plan Adjusted Index rate is found in Exhibit L, and summarized in Exhibit M.

Plan Premium Development for 21-Year-Old Non-Tobacco User

Age Curve Calibration: The average age factor is calculated by taking the member-weighted average of current individual enrollment by age in KHPC. Age factors are applied in accordance with CMS's Standard Age Curve. The age calibration factor is adjusted for contracts with greater than three children under the age of 21. Please see file Ind_18-12_Initial_KHPC_PPO_List-Billed_Supporting_20180518 for the calculation.

Geographic Factor Calibration: The average geographic rating factor is calculated by taking the KHPC member-weighted average by region.

Geographic Factors: KHPC 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 found cost differentials between the regions, mostly due to differences in hospital contracting between regions. The data from the analysis is found in Exhibit Q.

Tobacco Factor Calibration: Average tobacco factor is calculated using 2017 member and smoking status data.

The calibration is:

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

Calibrated Plan Adjusted Index Rates are found on PA Rate Template Table 10.
The calibration factors and development are found on Exhibit N.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed as follows:

1. Member-Level Consumer Adjusted Premium Rate:

$$\begin{aligned} [\textit{Member - Level Consumer Adjusted Premium Rate}] \\ &= [\textit{Calibrated Plan Adjusted Index Rate}] \times [\textit{Age Factor}] \\ &\times [\textit{Geographic Factor}] \times [\textit{Tobacco Factor}] \end{aligned}$$

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

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

All consumer-level adjustments are applied uniformly to all plans in the Single Risk Pool. These adjustments do not vary by plan. Age and Geographic factors are displayed in Exhibits O.

Base Rates, i.e. Calibrated Plan Adjusted Index Rates, are found on Exhibit P.

AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based on the federally issued AV Calculator.

AV Pricing Values

All AV Pricing values were developed using KHPC's actuarial cost model and actuarial judgment as described in section Paid to Allowed above. Differences in health status are not included.

Projected Loss Ratio

See Exhibit I for the projected loss ratio calculation. The projected loss ratio is calculated using the federally prescribed MLR methodology.

Membership Projection

The membership projections found in Worksheet 2 of the URRT were developed by assuming that moderate growth and similar distribution to current.

Attachments and Examples

The following is a list of Exhibits and Data to support this filing:

PA Rate Template Part I through Part V

Table 8

Exhibit A – Benefit Summary
Exhibit B – Benefit Change Summary
Exhibit C – Benefit Categories
Exhibit D – Benefit Mix
Exhibit E – Trend
Exhibit F – URRT
Exhibit F1 - Leveraging
Exhibit G – Paid-to-Allowed Development
Exhibit G1 – Transitional Data
Exhibit H – Retention
Exhibit I – Projected Loss Ratio
Exhibit J – Index Rate
Exhibit K – Market Adjusted Index Rate
Exhibit L – Rate Development by Plan
Exhibit M – Plan Adjusted Index Rates

Exhibit N – Calibration
Exhibit O – Rating Factors
Exhibit P – Quarterly Base Rates
Exhibit Q – Regional Analysis

Broker Contracts
List-Billed Data

Actuarial Statement

I, [REDACTED], 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, [REDACTED], ASA, MAAA, do hereby certify that:

1. This filing has been prepared in accordance with the following:
 - a. Actuarial Standard of Practice No. 5, “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 Accident and Health, Group Term Life, and Property/Casualty Coverage”
 - 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, and in accordance with CFR 156.135(b)(2) as necessary. For any plan requiring an alternative method, the

development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for benefits that deviate substantially from the parameters of the AVC and have a material impact on the actuarial value.

- a. The analysis was
 - i. conducted by a member of the American Academy of Actuaries, and
 - ii. performed in accordance with generally accepted actuarial principles and methods.
5. All factor, benefit and other changes from the prior approved filing have been disclosed in the actuarial memorandum.
6. New plans cannot be considered modifications of existing plans under the uniform modification standards in 45 CFR 147.106.
7. The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2019 Rate Filing Justification.



██████████, ASA, MAAA
Actuarial Associate
Capital BlueCross

PA Rate Template Part I
Data Relevant to the Rate Filing

Table 0. Identifying Information

Carrier Name:	Keystone Health Plan Central
Product(s):	HMO
Market Segment:	Individual
Rate Effective Date:	1/1/2019
Base Period Start Date	1/1/2017
Date of Most Recent Membership	2/1/2018

to 12/31/2019
to 12/31/2017

Table 1. Number of Members

	Member-months Experience Period	Members Current Period (as of 02-01-2018)	Member months Projected Rating Period
Average Age	34.1	34.5	34.5
Total	32,931	2,043	26,652
17 <18	6,554	287	3,744
18-24	3,449	208	2,713
25-29	5,091	239	4,162
30-34	2,576	97	1,265
35-39	1,754	118	1,539
40-44	1,615	100	1,269
45-49	2,523	165	2,153
50-54	2,861	183	2,187
55-59	3,170	225	2,935
60-64	3,317	231	3,066
65+	1,781	106	1,383

*Tables 1, 2 and 4 must include data for all non-grandfathered business (ACA compliant and Transitional)

Table 2. Experience Period Claims and Premiums

Earned Premium	Paid Claims	Ultimate Incurred Claims	Member Months	Estimated Cost Sharing (Member + HHS)	Allowed Claims (Non-Capitated)	Non-EHB portion of Allowed Claims	Total Prescription Drug Rebates*	Total EHB Capitation	Total Non-EHB Capitation	Estimated Risk Adjustment
\$ 25,424,640.86	\$ 6,302,797.05	\$ 6,481,932.00	32,931	\$ 2,739,033.63	\$ 9,220,965.63	\$ -	\$ (211,852.14)	\$ 347,616.96	\$ -	\$ (5,734,135.00)
Experience Period Total Allowed EHB Claims + EHB Capitation PMPM (net of prescription drug rebates)										286.13
Less Rate										68.30

*Express Prescription Drug Rebates as a negative number

Table 3. Trend Components

Service Category	Cost*	Utilization*	Induced Demand*	Composite URR Trend **	Weight*
Inpatient Hospital	7.28%	0.00%	1.00%	8.36%	19.58%
Outpatient Hospital	7.05%	0.00%	1.00%	8.11%	14.81%
Professional	5.45%	1.00%	1.00%	7.57%	55.87%
Other Medical	7.04%	0.00%	1.00%	8.11%	4.60%
Capitation				3.00%	3.71%
Prescription Drugs	11.18%	0.82%	1.00%	14.23%	20.20%
Total Annual Trend				8.15%	100.00%
Months of Trend				24	
Total Applied Trend Projection Factor				1.191	

* Express Cost, Utilization, Induced Utilization and Weight as percentages

** Should = URR Trend

Table 4. Historical Experience

Month-Year	Total Annual Premium	Incurred Claims	Completion Factors*	Ultimate Incurred Claims	Members	Ultimate Incurred PMPM	Estimated Annual Cost Sharing (Member + HHS)	Prescription Drug Rebates**	Allowed Claims (Net of Prescription Drug Rebates)	Allowed PMPM
201401		\$ 114,270.88	1.0000	\$ 114,270.88	402	\$ 334.00		\$ (1,301)	\$ 165,879	\$ 412.61
201402		\$ 498,545.84	1.0000	\$ 498,545.00	511	\$ 976.05		\$ (2,443)	\$ 541,110	\$ 1,060.74
201403		\$ 495,149.05	1.0000	\$ 495,149.00	647	\$ 765.30		\$ (3,220)	\$ 555,878	\$ 859.16
201404		\$ 299,915.17	1.0000	\$ 299,916.00	1,006	\$ 298.13		\$ (516)	\$ 374,634	\$ 372.40
201405		\$ 415,728.89	1.0000	\$ 415,728.00	1,439	\$ 288.90		\$ (409)	\$ 487,637	\$ 338.89
201406		\$ 247,444.17	1.0000	\$ 247,444.00	1,418	\$ 174.29		\$ (209)	\$ 312,404	\$ 228.07
201407		\$ 385,727.54	1.0000	\$ 385,728.00	1,406	\$ 274.34		\$ (526)	\$ 462,529	\$ 328.97
201408		\$ 297,347.72	1.0000	\$ 297,348.00	1,368	\$ 234.50		\$ (732)	\$ 364,592	\$ 267.53
201409		\$ 496,344.73	1.0000	\$ 496,344.00	1,247	\$ 398.03		\$ (4,501)	\$ 547,650	\$ 439.17
201410		\$ 532,214.07	1.0000	\$ 532,222.00	1,214	\$ 438.40		\$ (941)	\$ 609,496	\$ 502.86
201411		\$ 256,265.17	1.0000	\$ 256,270.00	1,171	\$ 218.85		\$ (848)	\$ 295,209	\$ 252.19
201412	\$ 3,952,282.00	\$ 568,697.05	1.0000	\$ 568,704.00	1,132	\$ 502.39	\$ 1,079,482.80	\$ (14,571)	\$ 616,686	\$ 544.78
201501		\$ 729,311.26	1.0000	\$ 729,320.17	1,783	\$ 409.04		\$ (1,448)	\$ 1,165,471	\$ 653.66
201502		\$ 773,878.25	1.0000	\$ 773,887.71	2,150	\$ 359.95		\$ (2,298)	\$ 1,491,676	\$ 693.80
201503		\$ 718,848.96	1.0000	\$ 718,957.75	2,822	\$ 254.77		\$ (60,635)	\$ 1,587,965	\$ 562.71
201504		\$ 780,027.13	1.0000	\$ 780,088.79	2,761	\$ 284.16		\$ (6,383)	\$ 1,892,420	\$ 685.41
201505		\$ 805,070.04	1.0000	\$ 805,079.88	2,717	\$ 296.31		\$ (14,866)	\$ 2,002,011	\$ 736.85
201506		\$ 773,728.75	1.0000	\$ 773,738.21	2,702	\$ 286.36		\$ (134,954)	\$ 1,490,857	\$ 551.76
201507		\$ 992,610.19	1.0000	\$ 992,622.21	2,650	\$ 374.57		\$ (2,165)	\$ 1,871,481	\$ 706.22
201508		\$ 776,246.82	1.0000	\$ 776,254.31	2,625	\$ 295.72		\$ (10,868)	\$ 1,743,961	\$ 660.18
201509		\$ 845,440.81	1.0000	\$ 845,451.14	2,627	\$ 321.83		\$ (136,744)	\$ 875,901	\$ 333.42
201510		\$ 758,189.96	1.0000	\$ 758,199.23	2,562	\$ 295.94		\$ (5,618)	\$ 868,090	\$ 338.83
201511		\$ 986,676.20	1.0000	\$ 986,688.38	2,565	\$ 388.57		\$ (4,128)	\$ 1,103,170	\$ 430.09
201512	\$ 8,532,932.38	\$ 986,123.35	1.0000	\$ 986,335.40	2,522	\$ 391.09	\$ 2,733,666.68	\$ (156,847)	\$ 947,983	\$ 375.80
201601		\$ 6,120,965.25	0.9193	\$ 6,658,151.17	31,433	\$ 211.82		\$ (174,314)	\$ 9,131,855	\$ 290.52
201602		\$ 7,284,406.47	0.9100	\$ 8,361,358.88	28,349	\$ 244.82		\$ (211,148)	\$ 11,207,725	\$ 396.29
201603		\$ 10,963,363.32	0.9488	\$ 11,579,764.26	36,771	\$ 314.92		\$ (127,982)	\$ 14,982,095	\$ 407.44
201604		\$ 8,993,138.11	0.9413	\$ 10,510,067.94	36,815	\$ 285.48		\$ (335,719)	\$ 13,694,625	\$ 371.98
201605		\$ 10,330,524.97	0.9486	\$ 10,936,626.80	36,131	\$ 302.69		\$ (134,828)	\$ 13,975,540	\$ 386.80
201606		\$ 11,311,274.78	0.9527	\$ 13,874,464.09	35,495	\$ 394.51		\$ (346,541)	\$ 14,715,296	\$ 415.08
201607		\$ 10,168,747.44	0.9492	\$ 10,758,411.28	34,420	\$ 308.09		\$ (316,315)	\$ 13,654,585	\$ 391.02
201608		\$ 9,177,123.09	0.9449	\$ 9,719,646.27	34,373	\$ 282.77		\$ (366,880)	\$ 12,530,431	\$ 364.54
201609		\$ 8,962,242.24	0.9418	\$ 9,487,498.54	33,916	\$ 279.74		\$ (338,516)	\$ 12,138,338	\$ 357.89
201610		\$ 8,868,462.16	0.9500	\$ 10,387,314.47	32,975	\$ 315.01		\$ (385,881)	\$ 12,892,131	\$ 390.97
201611		\$ 10,724,976.55	0.9544	\$ 11,236,915.95	32,179	\$ 349.20		\$ (450,198)	\$ 13,692,148	\$ 425.50
201612	\$ 143,617,456.00	\$ 10,440,861.65	0.9503	\$ 10,921,582.42	30,466	\$ 356.15	\$ 37,744,626.00	\$ (444,739)	\$ 14,401,474	\$ 437.03
201701		\$ 411,135.14	0.8861	\$ 473,141.68	9,141	\$ 51.94		\$ (13,097)	\$ 601,270	\$ 205.81
201702		\$ 303,707.01	0.9050	\$ 335,590.45	3,020	\$ 111.12		\$ (14,463)	\$ 604,144	\$ 200.05
201703		\$ 318,448.57	0.9522	\$ 350,578.39	3,010	\$ 282.58		\$ (15,494)	\$ 1,104,645	\$ 366.99
201704		\$ 113,842.24	0.9098	\$ 145,053.12	1,929	\$ 112.81		\$ (15,064)	\$ 616,951	\$ 216.10
201705		\$ 684,527.84	0.9568	\$ 715,468.64	2,835	\$ 252.28		\$ (27,090)	\$ 994,110	\$ 350.53
201706		\$ 696,517.78	0.9584	\$ 726,747.49	2,762	\$ 263.12		\$ (27,811)	\$ 1,034,142	\$ 374.42
201707		\$ 318,246.03	0.9164	\$ 347,460.03	1,212	\$ 279.56		\$ (29,038)	\$ 592,210	\$ 202.54
201708		\$ 463,857.47	0.9407	\$ 493,059.84	2,660	\$ 185.35		\$ (22,765)	\$ 702,025	\$ 263.92
201709		\$ 455,551.81	0.9389	\$ 485,177.86	2,621	\$ 185.11		\$ (13,521)	\$ 641,559	\$ 245.54
201710		\$ 486,520.07	0.9377	\$ 486,547.50	2,508	\$ 192.14		\$ (14,099)	\$ 652,183	\$ 255.16
201711		\$ 522,902.18	0.9467	\$ 564,683.37	2,505	\$ 223.43		\$ (14,255)	\$ 738,871	\$ 294.58
201712	\$ 15,424,040.86	\$ 847,411.93	0.9520	\$ 890,184.66	2,393	\$ 379.00	\$ 3,086,620.50	\$ (15,475)	\$ 1,058,935	\$ 459.23

* Express Completion Factor as a percentage

**Express Prescription Drug Rebates as a negative number

Carrier Name: Keystone Health Plan Central
 Product(s): HMO
 Market Segment: Individual
 Rate Effective Date: 1/1/2019

Table 2b. Manual Experience Period Claims and Premiums

Earned Premium	Paid Claims	Ultimate Incurred Claims	Member Months	Estimated Cost Sharing (Member & HHS)	Allowed Claims (Non-Capitated)	Non-EHB portion of Allowed Claims	Total Prescription Drug Rebates*	Total EHB Capitation	Total Non-EHB Capitation	Estimated Risk Adjustment
\$ 437,201,880.95	\$ 329,768,070.91	\$ 331,849,890.87	640,741	\$ 102,812,968.99	\$ 434,315,242.90		\$ (11,016,416.46)	\$ 347,616.96	\$ -	\$ 534,132,194.00
Experience Period Total Allowed EHB Claims + EHB Capitation PMPM (net of prescription drug rebates)										\$ 661.18
Loss Ratio										68.14%

*Express Prescription Drug Rebates as a negative number

Table 3b. Manual Trend Components

Service Category	Cost*	Utilization*	Induced Utilization*	Composite URRT Trend**	Weight*
Inpatient Hospital	7.28%	0.00%	1.00%	8.36%	19.58%
Outpatient Hospital	7.04%	0.00%	1.00%	8.11%	34.83%
Professional	5.45%	1.00%	1.00%	7.57%	16.96%
Other Medical	7.04%	0.00%	1.00%	8.11%	4.66%
Capitation				3.00%	3.71%
Prescription Drugs	12.18%	0.82%	1.00%	14.23%	20.26%
Total Annual Trend				9.15%	100.00%
Months of Trend				24	
Total Applied Trend Projection Factor				1.191	

* Express Cost, Utilization, Induced Utilization and Weight as percentages

** Should = URRT Trend

Table 4b. Historical Manual Experience

Month-Year	Total Annual Premium	Incurred Claims	Completion Factors*	Ultimate Incurred Claims	Members	Ultimate Incurred PMPM	Estimated Annual Cost Sharing (Member + HHS)	Prescription Drug Rebates**	Allowed Claims (Net of Prescription Drug Rebates)	Allowed PMPM
201401		\$ 1,851,612.28	1.0000	\$ 1,851,612.28	12,051	\$ 153.65		\$ (611,410.55)	\$ 2,190,724.58	\$ 181.79
201402		\$ 1,933,861.85	1.0000	\$ 1,933,861.85	11,871	\$ 162.91		\$ (198,253.09)	\$ 2,487,599.42	\$ 209.55
201403		\$ 2,557,886.55	1.0000	\$ 2,557,886.55	11,716	\$ 218.32		\$ (217,679.18)	\$ 3,163,218.32	\$ 269.99
201404		\$ 3,151,901.77	1.0000	\$ 3,151,901.77	11,857	\$ 265.83		\$ (352,901.21)	\$ 3,630,827.18	\$ 306.22
201405		\$ 3,339,330.38	1.0000	\$ 3,339,330.38	12,111	\$ 275.73		\$ (367,831.75)	\$ 3,789,080.27	\$ 312.86
201406		\$ 2,749,483.09	1.0000	\$ 2,749,483.09	11,893	\$ 233.18		\$ (338,516.75)	\$ 3,194,705.10	\$ 268.62
201407		\$ 2,958,902.48	1.0000	\$ 2,958,902.48	11,710	\$ 252.68		\$ (388,471.12)	\$ 3,333,423.49	\$ 284.66
201408		\$ 3,261,038.71	1.0000	\$ 3,261,038.71	11,420	\$ 285.56		\$ (418,529.23)	\$ 3,575,047.90	\$ 313.03
201409		\$ 3,157,998.41	1.0000	\$ 3,157,998.41	11,259	\$ 280.41		\$ (393,499.49)	\$ 3,524,354.61	\$ 313.03
201410		\$ 3,470,252.87	1.0000	\$ 3,470,252.87	11,105	\$ 312.49		\$ (421,737.68)	\$ 3,820,855.07	\$ 344.07
201411		\$ 2,874,872.56	1.0000	\$ 2,874,872.56	10,922	\$ 263.22		\$ (376,990.49)	\$ 3,167,928.71	\$ 290.05
201412	\$ 37,297,368.20	\$ 4,188,224.08	1.0000	\$ 4,188,224.08	10,788	\$ 388.23	\$ 9,435,186.84	\$ (388,553.80)	\$ 4,577,517.27	\$ 424.32
201501		\$ 3,866,956.25	0.9939	\$ 3,890,723.09	11,635	\$ 334.40		\$ (409,966.16)	\$ 4,505,555.25	\$ 387.24
201502		\$ 4,195,636.33	0.9933	\$ 4,223,958.29	12,101	\$ 349.06		\$ (376,295.32)	\$ 4,817,755.09	\$ 398.13
201503		\$ 4,325,269.20	0.9917	\$ 4,361,259.62	12,723	\$ 342.79		\$ (379,739.98)	\$ 5,040,497.25	\$ 396.17
201504		\$ 4,618,161.29	0.9924	\$ 4,653,344.85	12,580	\$ 369.90		\$ (439,185.67)	\$ 5,181,929.24	\$ 411.92
201505		\$ 4,208,953.73	0.9918	\$ 4,243,753.64	12,472	\$ 340.26		\$ (420,938.82)	\$ 4,783,823.74	\$ 383.57
201506		\$ 4,863,246.22	0.9928	\$ 4,898,299.49	12,389	\$ 395.37		\$ (421,261.71)	\$ 5,391,412.42	\$ 435.18
201507		\$ 4,494,507.00	0.9924	\$ 4,529,125.52	12,264	\$ 369.30		\$ (550,635.44)	\$ 4,857,934.65	\$ 396.11
201508		\$ 4,477,489.10	0.9924	\$ 4,511,812.13	12,194	\$ 370.00		\$ (481,463.61)	\$ 4,856,082.39	\$ 398.24
201509		\$ 4,889,079.73	0.9930	\$ 4,923,678.35	12,155	\$ 405.07		\$ (465,593.62)	\$ 5,300,130.37	\$ 436.05
201510		\$ 5,521,177.60	0.9939	\$ 5,555,244.91	12,101	\$ 459.07		\$ (513,974.68)	\$ 5,868,688.71	\$ 484.98
201511		\$ 5,416,794.80	0.9936	\$ 5,451,455.83	12,053	\$ 452.29		\$ (517,781.07)	\$ 5,691,462.54	\$ 472.20
201512	\$ 43,966,933.85	\$ 5,406,585.80	0.9937	\$ 5,440,687.08	11,955	\$ 455.10	\$ 10,865,011.07	\$ (601,767.26)	\$ 5,674,478.88	\$ 474.65
201601		\$ 19,209,949.32	0.9728	\$ 19,747,671.38	66,784	\$ 295.69		\$ (446,737.83)	\$ 26,643,869.08	\$ 398.96
201602		\$ 24,183,014.10	0.9767	\$ 24,761,739.93	71,327	\$ 347.16		\$ (721,081.75)	\$ 32,131,319.31	\$ 450.48
201603		\$ 30,234,877.17	0.9800	\$ 30,852,060.04	74,561	\$ 413.78		\$ (802,604.79)	\$ 38,914,298.68	\$ 521.91
201604		\$ 26,641,207.04	0.9773	\$ 27,259,758.32	74,572	\$ 365.55		\$ (831,140.04)	\$ 34,473,442.60	\$ 462.28
201605		\$ 27,875,680.39	0.9787	\$ 28,483,745.99	73,692	\$ 386.52		\$ (852,710.03)	\$ 35,291,229.25	\$ 478.90
201606		\$ 30,137,726.58	0.9812	\$ 30,716,350.31	72,853	\$ 421.62		\$ (850,801.74)	\$ 37,294,608.66	\$ 511.92
201607		\$ 27,411,235.80	0.9768	\$ 28,062,822.48	72,134	\$ 389.04		\$ (880,717.08)	\$ 34,337,437.58	\$ 476.02
201608		\$ 29,210,182.92	0.9816	\$ 29,757,228.48	71,340	\$ 417.12		\$ (925,784.18)	\$ 36,195,337.29	\$ 507.36
201609		\$ 27,433,341.13	0.9808	\$ 27,971,400.54	70,546	\$ 396.50		\$ (913,903.22)	\$ 33,853,295.20	\$ 479.88
201610		\$ 29,988,526.21	0.9829	\$ 30,511,070.69	69,225	\$ 440.75		\$ (921,225.57)	\$ 36,154,067.98	\$ 522.27
201611		\$ 31,771,682.07	0.9839	\$ 32,291,141.49	67,941	\$ 475.28		\$ (1,063,036.89)	\$ 37,913,172.20	\$ 558.03
201612	\$ 333,214,835.19	\$ 32,814,675.37	0.9850	\$ 33,314,221.83	64,951	\$ 512.91	\$ 88,672,804.45	\$ (1,127,064.07)	\$ 38,883,132.91	\$ 598.65
201701		\$ 23,527,707.49	0.9982	\$ 23,700,640.69	54,218	\$ 434.74		\$ (568,286.11)	\$ 32,043,696.30	\$ 591.02
201702		\$ 22,981,471.03	0.9980	\$ 23,027,613.64	56,130	\$ 410.26		\$ (675,476.31)	\$ 33,976,662.97	\$ 605.32
201703		\$ 29,819,587.37	0.9983	\$ 29,870,507.45	56,677	\$ 527.03		\$ (869,367.84)	\$ 39,102,398.00	\$ 689.92
201704		\$ 26,740,626.08	0.9980	\$ 26,793,937.82	55,977	\$ 478.66		\$ (908,052.91)	\$ 34,952,443.56	\$ 624.41
201705		\$ 29,313,512.28	0.9973	\$ 29,395,175.33	55,033	\$ 524.14		\$ (949,196.73)	\$ 38,085,548.29	\$ 692.05
201706		\$ 28,774,744.64	0.9968	\$ 28,865,843.61	54,187	\$ 532.71		\$ (978,627.23)	\$ 36,578,548.18	\$ 675.04
201707		\$ 25,777,667.91	0.9962	\$ 25,876,026.21	53,410	\$ 484.48		\$ (917,123.73)	\$ 32,742,510.57	\$ 613.04
201708		\$ 27,714,413.40	0.9959	\$ 27,828,895.28	52,776	\$ 527.30		\$ (993,911.81)	\$ 34,794,223.57	\$ 659.28
201709		\$ 26,228,913.93	0.9946	\$ 26,372,521.41	52,086	\$ 506.33		\$ (1,007,304.59)	\$ 32,791,352.86	\$ 629.56
201710		\$ 29,619,255.50	0.9927	\$ 29,838,205.89	51,269	\$ 581.99		\$ (1,052,211.37)	\$ 36,262,836.99	\$ 707.31
201711		\$ 29,280,915.39	0.9866	\$ 29,678,082.87	50,391	\$ 588.96		\$ (983,181.51)	\$ 35,725,418.04	\$ 708.96
201712	\$ 437,201,880.95	\$ 29,989,255.89	0.9758	\$ 30,732,440.67	48,587	\$ 632.52	\$ 102,812,968.99	\$ (1,113,676.32)	\$ 36,590,804.07	\$ 753.10

* Express Completion Factor as a percentage

**Express Prescription Drug Rebates as a negative number

PA Rate Template Part II
Rate Development and Change

Carrier Name:	Keystone Health Plan Central
Product(s):	HMO
Market Segment:	Individual
Rate Effective Date:	1/1/2019

Table 5. Development of the Projected Index Rate, Market-Adjusted Index Rate, and Total Allowed Claims

Development of the Projected Index Rate	Actual Experience Data	Manual Data		
Total Allowed EHB Claims + EHB Capitation PMPM (net of prescription drug rebates) PMPM	\$ 284.15	\$ 661.18	< Actual Experience	\$284.15
Two year trend projection factor	1.191	1.191		
Unadjusted Projected Allowed EHB Claims PMPM	\$ 338.53	\$ 787.73		
Single Risk Pool Adjustment Factors				
Change in Morbidity	1.000	1.060	< See URRT Instructions	
Change in Other	1.000	1.000		
Change in Demographics	1.000	1.000	< See URRT Instructions	
Change in Network	1.000	1.000	< See URRT Instructions	
Change in Benefits	1.000	1.000	< See URRT Instructions	
Change in Other	1.000	1.000	< See URRT Instructions	
Total Adjusted Projected Allowed EHB Claims PMPM	\$ 358.84	\$ 834.99		
Credibility Factors	100%	0%	< See Instructions	
Blended Projected EHB Claims PMPM	\$ 358.84	\$ 358.84	< Projected Index	\$358.84
Development of the Market-Adjusted Index Rate and Total Allowed Claims				
Adjusted Projected Allowed EHB Claims PMPM	\$ 358.84		< Index Rate for Projection Period on URRT - Individual or First Quarter Small Group	
Adjusted Projected Allowed EHB Claims PMPM [will only populate for small group filings]	\$ 0.681		< Paid to Allowed Average Factor in Projection Period on URRT	
Projected Paid to Allowed Ratio				
Projected Paid EHB Claims PMPM	\$ 244.20			
Market-wide Adjustments				
Projected Risk Adjustment PMPM	\$ (191.67)			
Projected Paid Exchange User Fees PMPM	\$			
Market-Adjusted Projected Paid EHB Claims PMPM	\$ 435.87			
Market-Adjusted Projected Allowed EHB Claims PMPM	\$ 640.49		< Market-Adjusted Index	640.49
Projected Allowed Non-EHB Claims PMPM	\$ -			
Market-Adjusted Projected Paid Total Claims PMPM	\$ 435.87			
Market-Adjusted Projected Allowed Total Claims PMPM	\$ 640.49			

Table 6. Retention

Retention Items - Express in percentages	Percentages	PMPM Amounts	
Administrative Expenses	10.63%	\$53.29	
General and Claims	8.18%	\$41.03	
Agent/Broker Fees and Commissions	0.98%	\$4.90	
Quality Improvement Initiatives	1.47%	\$7.36	
Taxes and Fees	0.42%	\$2.11	
PCORI Fees	0.00%	\$0.00	
PA Premium Tax (if applicable)	0.00%	\$0.00	
Federal Income Tax	0.42%	\$2.11	
Health Insurance Provider's Fee (Prorated for Small Groups only)	0.00%	\$0.00	
Profit/Contingency (after tax)	2.00%	\$10.03	
Total Retention	13.05%	\$65.42	
Projected Required Revenue PMPM	\$ 501.29		< Single Pool Gross Premium Avg. Rate, PMPM on URRT

Table 8. Components of Rate Change

Rate Components	2018	2019	Difference	Percent Change
A. Calibrated Plan Adjusted Index Rate (PMPM)	\$ 323.12	\$ 299.47	-\$23.65	-7.3%
B. Base period allowed claims before normalization	\$ 384.94	\$ 284.15	-\$100.79	-31.2%
C. Normalization factor component of change	\$ (139.07)	\$ (90.34)	\$48.73	15.1%
D. Change in Normalized Allowed Claims Adjustment Components				
D1. Base period allowed claims after normalization	\$ 245.87	\$ 193.80	\$(52.07)	-16.1%
D2. URRT Trend	\$ 71.89	\$ 37.09	\$(34.79)	-10.8%
D3. URRT Morbidity	\$ 57.84	\$ 13.85	\$(43.99)	-13.6%
D4. URRT Other	\$ 5.24	\$ (0.00)	\$(5.24)	-1.6%
D5. Normalized URRT RA/R1 on an allowed basis	\$ 43.29	\$ 192.10	\$ 148.81	46.1%
D6. Normalized Exchange User Fee on an allowed basis	\$ -	\$ -	\$ -	0.0%
D7. Subtotal - Sum(D1:D6)	\$ 424.12	\$ 436.85	\$ 12.72	3.9%
E. Change in Allowable Plan Adjusted Level Components				
E1. Network	\$ -	\$ -	\$ -	0.0%
E2. Pricing AV	\$ (113.88)	\$ (199.33)	\$(85.45)	-26.4%
E3. Benefit Richness	\$ (12.41)	\$ 72.42	\$ 84.83	26.3%
E4. Catastrophic Eligibility	\$ (32.24)	\$ (18.23)	\$(5.99)	-1.9%
E5. Subtotal - Sum(E1:E4)	\$ (158.53)	\$ (165.14)	\$(6.61)	-2.0%
F. Change in Retention Components				
F1. Administrative Expenses	\$ 36.59	\$ 31.84	\$(4.75)	-1.5%
F2. Taxes and Fees	\$ 14.62	\$ 1.26	\$(13.36)	-4.1%
F3. Profit and/or Contingency	\$ 6.46	\$ 5.99	\$(0.47)	-0.1%
F4. Subtotal - Sum(F1:F3)	\$ 57.67	\$ 39.08	\$(18.58)	-5.8%
G. Change in Miscellaneous Items			\$ -	0.0%
H. Sum of Components of Rate Change (should approximate the change shown in line A)	\$ 323.26	\$ 310.79	\$(12.47)	-3.9%

For Informational Purposes only - No input required.

Blended Base Period Unadjusted Claims before Normalization	\$ 284.15	< Index Rate of Experience Period on URRT
Blended Earned Premium	\$ 15,424,640.86	
Blended Loss Ratio	68.30%	

Table 5A. Small Group Projected Index Rate with Quarterly Trend

Effective Date	1/1/2019	4/1/2019	7/1/2019	10/1/2019	Total Single Risk Pool
# of Member Months Renewing in Quarter	-	-	-	-	-
Adjusted Projected Allowed EHB Claims PMPM Q1	\$ 358.84	\$ 358.84	\$ 358.84	\$ 358.84	\$ 358.84
Months of Trend	-	3	6	9	9
Annual Trend	9.15%	9.15%	9.15%	9.15%	9.15%
Single Risk Pool Projected Allowed Claims	\$ 358.84	\$ 366.78	\$ 374.90	\$ 383.20	\$ -
Quarterly Trend Factor	100.0%	102.2%	104.5%	106.8%	0.0%
2019 Trend Factors by Quarter	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Table 7. Normalized Market-Adjusted Projected Allowed Total Claims

Normalization Factors	2018	2019	
Average Age Factor	1.507	1.618	Exhibit N
Average Geographic Factor	1.032	1.027	Exhibit N
Average Tobacco Factor	1.006	1.006	
Average Benefit Richness (induced demand)	1.008	0.877	
Average Network Factor	1.000	1.000	
Market-Adjusted Projected Allowed Total Claims PMPM	\$ 664.02	\$ 640.49	
Normalized Market-Adjusted Projected Allowed Total Claims PMPM	\$ 424.12	\$ 436.85	

Table 9. Year-over-Year Data to Support Table 8

	2018	2019	
Paid-to-Allowed	0.628	0.681	
URRT Trend (Total Applied Trend Factor)	1.292	1.191	< URRT W1, S2
URRT Morbidity	1.182	1.060	< URRT W1, S2
URRT "Other"	1.016	1.000	< URRT W1, S2
Risk Adjustment	\$ 42.55	\$ 191.67	< URRT W1, S3
Exchange User Fee	\$ -	\$ -	< URRT W1, S3
Capitation	\$ -	\$ 0.30	< URRT W1, S2
Network	1.000	1.000	
Pricing AV	0.731	0.544	
Benefit Richness	0.960	1.305	
Catastrophic Eligibility	0.892	0.877	
Administrative Expenses	11.32%	10.63%	
Taxes and Fees	4.52%	0.42%	
Profit and/or Contingency	2.00%	2.00%	

PA Rate Template Part III
Table 10. Plan Rates

Carrier Name: Keystone Health Plan Central
Product/ID: H&O
Market Segment: Individual
Rate Effective Date: 1/1/2018
Base Period Start Date: 1/1/2017
Date of Most Recent Membership: 2/1/2018
Market Adjusted Index Rate: \$ 640.49

Calibration	
Age Calibration Factor	1.00
Geographic Calibration Factor	1.00
Health Status Calibration Factor	1.00
Age/Health Calibration Factor	0.97

Total Covered Lives @ 12-01-2018

Date of Most Recent Membership Renewal: 1/1/2018 Market Adjusted Index Rate: \$ 640.00										45 CBE Part 156.8 (b) (2) Allowable Factors											
Plan Number	HDS Plan ID (Standard Component)	Plan Type (HDS, PHS, PPO, EPO, Indemnity, Other)	1/1/2018 Plan Marketing Name	Existing, Modified, New, Discontinued & Merged (HDS for 2018)	1/1/2018 Plan HDS Plan ID (if 1/1/2018 Plan Discontinued & Merged)	Medical Type	Medical Use Actual Value	Standard AV Approach (A)	Exchange (B) (C) or Off	Pricing AV (Jumpstart discount) (D)	Benefit Enhance (discount) (E)	Benefits in addition to CBE	Provider Network	Catastrophic Eligibility	Non-Funding of CBE Adjustment	Pure Premium	Admin Costs	Taxes & Fees (not including Exchange Fee)	Profit or Contingency		
Totals										0.630	0.546	1,489	1,000	1,000	0.877	1,000	\$	436.46	10.6%	0.4%	2.0%
Transitional Plan	TRANSITIONAL	N/A	TRANSITIONAL	OMP	TRANSITIONAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Plan 1	11100000000000000000	HDS	Keystone HDS 11100000000000000000	M	Keystone	0.000-0000	Standard AV	OMP	0.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
Plan 2	11100000000000000000	HDS	Keystone HDS 11100000000000000000	M	Keystone	0.000-0000	Standard AV	OMP	0.500	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
Plan 3																					
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Total Covered Lives Merged into 2018 Plan @ 01-01-2018	Total Policyholders @ 01-01-2018
2,043	1,402

2018 Calibrated Plan Adjusted Index Rate PMPM	2019 Calibrated Plan Adjusted Index Rate PMPM
\$ 323.12	\$ 299.47

Proposed Rate Change Compared to prior 12 months
-7.3%

% of Total Covered Lives
N/A

01-01-2018 Number of Covered Lives by Rating Area										2019 Continued/ Discontinued Plan Indicator		
1	2	3	4	5	6	7	8	9	Total			
									000	1,000	2,000	3,000
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PA Rate Template Part IV A - Individual

Table 11. Plan Premium Development for 21-Year-Old Non-Tobacco User

Carrier Name:	Keystone Health Plan Central
Product(s):	HMO
Market Segment:	Individual
Rate Effective Date:	1/1/2019

[illegible]

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Table B

<u>Plan ID</u>	<u>Plan Name</u>	<u>Metal Level</u>	<u>Projected</u>	<u>Projected Allowed</u>	<u>Projected Paid</u>	<u>Paid to Allowed</u>	<u>Average Tobacco</u>	<u>AV and Cost</u>	<u>(8)/(6*7) Induced</u>	<u>Induced Demand</u>
(1)		(2)	<u>Membership</u>	<u>Claims</u>	<u>Claims</u>	<u>Factor</u>	<u>Factor</u>	<u>Sharing Factor</u>	<u>Utilization</u>	<u>Table 10</u>
(3)			(4)	(5)	(6)	(7)	(8)	(9)		
53789PA0100008	Bronze HMO 7350/0/60	Bronze	20,077	12,859,110	9,472,672	0.74	1.000	0.55	0.74	1.35
53789PA0100004	Catastrophic HMO 7900/0/75	Catastrophic	6,575	4,211,219	2,159,900	0.51	1.000	0.53	0.52	1.92
Total			26,652	17,070,329	11,632,572	0.68	1.00	0.54	0.69	1.49
PMPM				640.49	436.46					
Rate Dev II				640.49	435.87					

Company Name:	Keystone Health Plan Central							
Market:	Individual							
Product:	HMO							
Effective Date of Rates:	January 1, 2019				Ending date of Rates:		December 31, 2019	
HIOS Plan ID (On Exchange)=>								
HIOS Plan ID (Off Exchange)=>	53789PA0100004				53789PA0100004		53789PA0100004	
Plan Marketing Name =>	Catastrophic HMO 7900/0/75				Catastrophic HMO 7900/0/75		Catastrophic HMO 7900/0/75	
Form # =>	PC-Ind-HMO-21cnty-AGRMT-v0				PC-Ind-HMO-21cnty-AGRMT-v0		PC-Ind-HMO-21cnty-AGRMT-v0	
Rating Area =>	6				7		9	
Network =>	HMO				HMO		HMO	
Metal =>	Catastrophic				Catastrophic		Catastrophic	
Deductible =>	\$7900 Med/Rx Combined				\$7900 Med/Rx Combined		\$7900 Med/Rx Combined	
Coinsurance =>	0%				0%		0%	
Copays =>	\$75/\$0/\$0 PCP/SPC/ER				\$75/\$0/\$0 PCP/SPC/ER		\$75/\$0/\$0 PCP/SPC/ER	
OOP Maximum =>	\$7900 Med/Rx Combined				\$7900 Med/Rx Combined		\$7900 Med/Rx Combined	
Pediatric Dental (Yes/No) =>	Yes				Yes		Yes	
Age Band	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 14	\$178.28	\$178.28	\$183.63	\$183.63	\$192.55	\$192.55	\$245.73	\$245.73
15	\$194.13	\$194.13	\$199.95	\$199.95	\$209.66	\$209.66	\$267.58	\$267.58
16	\$200.19	\$200.19	\$206.20	\$206.20	\$216.21	\$216.21	\$275.93	\$275.93
17	\$206.25	\$206.25	\$212.44	\$212.44	\$222.75	\$222.75	\$284.28	\$284.28
18	\$212.77	\$212.77	\$219.16	\$219.16	\$229.80	\$229.80	\$293.27	\$293.27
19	\$219.30	\$219.30	\$225.88	\$225.88	\$236.84	\$236.84	\$302.27	\$302.27
20	\$226.06	\$226.06	\$232.84	\$232.84	\$244.14	\$244.14	\$311.58	\$311.58
21	\$233.05	\$233.05	\$240.04	\$240.04	\$251.69	\$251.69	\$321.22	\$321.22
22	\$233.05	\$233.05	\$240.04	\$240.04	\$251.69	\$251.69	\$321.22	\$321.22
23	\$233.05	\$233.05	\$240.04	\$240.04	\$251.69	\$251.69	\$321.22	\$321.22
24	\$233.05	\$233.05	\$240.04	\$240.04	\$251.69	\$251.69	\$321.22	\$321.22
25	\$233.98	\$233.98	\$241.00	\$241.00	\$252.70	\$252.70	\$322.50	\$322.50
26	\$238.64	\$238.64	\$244.61	\$244.61	\$257.73	\$257.73	\$328.93	\$328.93
27	\$244.24	\$244.24	\$250.34	\$250.34	\$263.78	\$263.78	\$336.64	\$336.64
28	\$253.33	\$253.33	\$259.66	\$259.66	\$273.59	\$273.59	\$349.17	\$349.17
29	\$260.78	\$260.78	\$268.61	\$268.61	\$281.65	\$281.65	\$359.45	\$359.45
30	\$264.51	\$264.51	\$271.12	\$271.12	\$285.67	\$285.67	\$364.58	\$364.58
31	\$270.10	\$270.10	\$276.86	\$276.86	\$291.71	\$291.71	\$372.29	\$372.29
32	\$275.70	\$275.70	\$282.59	\$282.59	\$297.75	\$297.75	\$380.00	\$380.00
33	\$279.19	\$279.19	\$286.17	\$286.17	\$301.53	\$301.53	\$384.82	\$384.82
34	\$282.92	\$282.92	\$291.41	\$291.41	\$305.56	\$305.56	\$389.96	\$389.96
35	\$284.79	\$284.79	\$293.33	\$293.33	\$307.57	\$307.57	\$392.53	\$392.53
36	\$286.65	\$286.65	\$295.25	\$295.25	\$309.58	\$309.58	\$395.10	\$395.10
37	\$288.52	\$288.52	\$297.17	\$297.17	\$311.60	\$311.60	\$397.67	\$397.67
38	\$290.38	\$290.38	\$299.09	\$299.09	\$313.61	\$313.61	\$400.24	\$400.24
39	\$294.11	\$294.11	\$302.93	\$302.93	\$317.64	\$317.64	\$405.38	\$405.38
40	\$297.84	\$297.84	\$306.77	\$306.77	\$321.66	\$321.66	\$410.52	\$410.52
41	\$303.43	\$303.43	\$312.53	\$312.53	\$327.71	\$327.71	\$418.23	\$418.23
42	\$308.79	\$308.79	\$318.05	\$318.05	\$333.49	\$333.49	\$425.62	\$425.62
43	\$316.25	\$316.25	\$325.74	\$325.74	\$341.55	\$341.55	\$435.90	\$435.90
44	\$325.57	\$325.57	\$335.34	\$335.34	\$351.62	\$351.62	\$448.74	\$448.74
45	\$336.52	\$336.52	\$346.62	\$346.62	\$363.45	\$363.45	\$463.84	\$463.84
46	\$349.58	\$349.58	\$360.06	\$360.06	\$377.54	\$377.54	\$481.83	\$481.83
47	\$364.26	\$364.26	\$375.18	\$375.18	\$393.40	\$393.40	\$502.07	\$502.07
48	\$381.04	\$381.04	\$392.47	\$392.47	\$411.52	\$411.52	\$525.19	\$525.19
49	\$397.58	\$397.58	\$409.51	\$409.51	\$429.39	\$429.39	\$548.00	\$548.00
50	\$416.23	\$416.23	\$428.71	\$428.71	\$449.53	\$449.53	\$573.70	\$573.70
51	\$434.64	\$434.64	\$447.68	\$447.68	\$469.41	\$469.41	\$599.08	\$599.08
52	\$454.91	\$454.91	\$468.56	\$468.56	\$491.31	\$491.31	\$627.02	\$627.02
53	\$475.42	\$475.42	\$489.68	\$489.68	\$513.46	\$513.46	\$655.29	\$655.29
54	\$497.56	\$497.56	\$512.49	\$512.49	\$537.37	\$537.37	\$685.80	\$685.80
55	\$519.70	\$519.70	\$535.29	\$535.29	\$561.28	\$561.28	\$716.32	\$716.32
56	\$543.71	\$543.71	\$560.02	\$560.02	\$587.20	\$587.20	\$749.41	\$749.41
57	\$567.94	\$567.94	\$584.98	\$584.98	\$613.38	\$613.38	\$782.81	\$782.81
58	\$593.81	\$593.81	\$611.63	\$611.63	\$641.32	\$641.32	\$818.47	\$818.47
59	\$606.63	\$606.63	\$624.83	\$624.83	\$655.16	\$655.16	\$836.14	\$836.14
60	\$632.50	\$632.50	\$651.47	\$651.47	\$683.10	\$683.10	\$871.79	\$871.79
61	\$654.87	\$654.87	\$674.52	\$674.52	\$707.26	\$707.26	\$902.63	\$902.63
62	\$669.55	\$669.55	\$689.64	\$689.64	\$723.12	\$723.12	\$922.87	\$922.87
63	\$687.96	\$687.96	\$708.60	\$708.60	\$743.00	\$743.00	\$948.24	\$948.24
64+	\$699.14	\$699.14	\$720.11	\$720.11	\$755.07	\$755.07	\$963.65	\$963.65

Company Name: Keystone Health Plan Central
 Market: Individual
 Product: HMO
 Effective Date of Rates: January 1, 2019

Ending date of Rates:

December 31, 2019

HIOS Plan ID (On Exchange)=>				
HIOS Plan ID (Off Exchange)=>	53789PA0100008		53789PA0100008	
Plan Marketing Name =>	Bronze HMO 7350/0/60		Bronze HMO 7350/0/60	
Form # =>	PC-Ind-HMO-21cnty-AGRMT-v0		PC-Ind-HMO-21cnty-AGRMT-v0	
Rating Area =>	7		9	
Network =>	HMO		HMO	
Metal =>	Bronze		Bronze	
Deductible =>	\$7350 Med/Rx Combined		\$7350 Med/Rx Combined	
Coinsurance =>	0%		0%	
Copays =>	\$60/\$85/\$0 PCP/SPC/ER		\$60/\$85/\$0 PCP/SPC/ER	
OOP Maximum =>	\$7350 Med/Rx Combined		\$7350 Med/Rx Combined	
Pediatric Dental (Yes/No) =>	Yes		Yes	
Age Band	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
0 - 14	\$253.11	\$253.11	\$265.39	\$265.39
15	\$275.60	\$275.60	\$288.98	\$288.98
16	\$284.21	\$284.21	\$298.00	\$298.00
17	\$292.81	\$292.81	\$307.02	\$307.02
18	\$302.07	\$302.07	\$316.74	\$316.74
19	\$311.34	\$311.34	\$326.45	\$326.45
20	\$320.93	\$320.93	\$336.51	\$336.51
21	\$330.86	\$339.13	\$346.92	\$355.59
22	\$330.86	\$339.13	\$346.92	\$355.59
23	\$330.86	\$339.13	\$346.92	\$355.59
24	\$330.86	\$339.13	\$346.92	\$355.59
25	\$332.18	\$340.48	\$348.31	\$357.01
26	\$338.80	\$347.27	\$355.24	\$364.12
27	\$346.74	\$355.41	\$363.57	\$372.66
28	\$359.64	\$368.63	\$377.10	\$386.53
29	\$370.23	\$379.48	\$388.20	\$397.91
30	\$375.52	\$384.91	\$393.75	\$403.60
31	\$383.46	\$393.05	\$402.08	\$412.13
32	\$391.40	\$401.19	\$410.40	\$420.66
33	\$396.37	\$406.28	\$415.61	\$426.00
34	\$401.66	\$411.70	\$421.16	\$431.69
35	\$404.31	\$414.41	\$423.93	\$434.53
36	\$406.95	\$417.13	\$426.71	\$437.38
37	\$409.60	\$419.84	\$429.48	\$440.22
38	\$412.25	\$422.55	\$432.26	\$443.07
39	\$417.54	\$427.98	\$437.81	\$448.76
40	\$422.83	\$454.55	\$443.36	\$476.61
41	\$430.78	\$463.08	\$451.69	\$485.56
42	\$438.38	\$471.26	\$459.67	\$494.14
43	\$448.97	\$482.65	\$470.77	\$506.07
44	\$462.21	\$496.87	\$484.64	\$520.99
45	\$477.76	\$525.53	\$500.95	\$551.04
46	\$496.28	\$545.91	\$520.38	\$572.41
47	\$517.13	\$568.84	\$542.23	\$596.46
48	\$540.95	\$595.05	\$567.21	\$623.93
49	\$564.44	\$620.89	\$591.84	\$651.03
50	\$590.91	\$679.55	\$619.59	\$712.53
51	\$617.05	\$709.60	\$647.00	\$744.05
52	\$645.83	\$742.71	\$677.18	\$778.76
53	\$674.95	\$776.19	\$707.71	\$813.87
54	\$706.38	\$812.34	\$740.67	\$851.77
55	\$737.81	\$885.37	\$773.63	\$928.35
56	\$771.89	\$926.27	\$809.36	\$971.23
57	\$806.30	\$967.56	\$845.44	\$1,014.53
58	\$843.02	\$1,011.63	\$883.95	\$1,060.74
59	\$861.22	\$1,033.46	\$903.03	\$1,083.63
60	\$897.94	\$1,122.43	\$941.53	\$1,176.92
61	\$929.71	\$1,162.13	\$974.84	\$1,218.55
62	\$950.55	\$1,188.19	\$996.69	\$1,245.87
63	\$976.69	\$1,220.86	\$1,024.10	\$1,280.13
64+	\$992.57	\$1,240.71	\$1,040.75	\$1,300.94

Keystone Health Plan Central Individual Plan Design Summary

HIOS Plan ID	Plan Marketing Name	Product	Metal	On/Off Exchange	Network	Rating Area	Counties Covered
53789PA0100004	Catastrophic HMO 7900/0/75	HMO	Catastrophic	Off	HMO	6,7,9	All
53789PA0100008	Bronze HMO 7350/0/60	HMO	Bronze	Off	HMO	6,7,9	All

Company Name Keystone Health Plan Central
Market Individual
RATES FOR AGE 21, NON-TOBACCO USER, BY RATING AREA AND COUNTY

02-01-2018 Number of Covered Lives by Rating County				
HIOS Plan ID	Plan Marketing Name	Product	Metal	On/Off Exchange
53789PA0100004	Catastrophic HMO 7900/0/75	HMO	Catastrophic	Off
53789PA0100008	Bronze HMO 7350/0/60	HMO	Bronze	Off

RATING AREA 6										RATING AREA 7				RATING AREA 9							
19	15	286	16	0	279	28	35	9	18	64	335	368	258	117	120	45	1	6	2	22	
Centre	Columbia	Lehigh	Mifflin	Montour	Northampton	Northumberland	Schuylkill	Snyder	Union	Adams	Berks	Lancaster	York	Cumberland	Dauphin	Franklin	Fulton	Juniata	Lebanon	Perry	
\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$233.05	\$240.04	\$240.04	\$240.04	\$240.04	\$251.69	\$251.69	\$251.69	\$251.69	\$251.69	\$251.69	\$251.69	
\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$321.22	\$330.86	\$330.86	\$330.86	\$330.86	\$346.92	\$346.92	\$346.92	\$346.92	\$346.92	\$346.92	\$346.92	

Product-Plan Data Collection

Company Legal Name: **Keystone Health Plan Central**
 HIOS Issuer ID: **53789**
 Effective Date of Rate Change(s): **1/1/2019**

State: **PA**
 Market: **Individual**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	HMO	
Product ID:	53789PA010	
Metal:	Catastrophic	Bronze
AV Metal Value	0.600	0.626
AV Pricing Value	0.534	0.547
Plan Category	Renewing	Renewing
Plan Type:	HMO	HMO
Plan Name	Catastrophic HMO	Bronze HMO
Plan ID (Standard Component ID):	7900/0/75	7350/0/60
Exchange Plan?	53789PA0100004	53789PA0100008
Historical Rate Increase - Calendar Year - 2	No	No
Historical Rate Increase - Calendar Year - 1		1.40%
Historical Rate Increase - Calendar Year - 0		55.10%
Effective Date of Proposed Rates	1/1/2019	1/1/2019
Rate Change % (over prior filing)		5.43%
Cum/Tive Rate Change % (over 12 mos prior)		-9.91%
Proj'd Per Rate Change % (over Exper. Period)		104.55%
Product Rate Increase %		-7.32%

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	53789PA0100004	53789PA0100008
Inpatient	\$0.00	\$0.00	\$0.00
Outpatient	\$0.00	\$0.00	\$0.00
Professional	\$0.00	\$0.00	\$0.00
Prescription Drug	\$0.00	\$0.00	\$0.00
Other	\$0.00	\$0.00	\$0.00
Capitation	\$0.00	\$0.00	\$0.00
Administration	\$0.00	\$0.00	\$0.00
Taxes & Fees	\$0.00	\$0.00	\$0.00
Risk & Profit Charge	\$0.00	\$0.00	\$0.00
Total Rate Increase	\$0.00	\$0.00	\$0.00
Member Cost Share Increase	\$0.00	\$0.00	\$0.00

Average Current Rate PMPM	\$505.89	\$346.08	\$558.22
Projected Member Months	26,652	6,575	20,077

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	53789PA0100004	53789PA0100008
Plan Adjusted Index Rate	\$464.32	\$193.04	\$560.60
Member Months	32,891	8,616	24,275
Total Premium (TP)	\$15,271,751	\$1,663,212	\$13,608,538
EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$9,407,171	\$1,145,960	\$8,261,212
EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	\$3,352,627	\$577,669	\$2,774,958
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0		
Portion of above payable by HHS on behalf of insured person, as %	0.00%		
Total incurred claims, payable with issuer funds	\$6,054,545	\$568,291	\$5,486,254
Net Amt of Rein	\$0.00	\$0.00	\$0.00
Risk Adjustment Transfer Amount	-\$5,734,115.00	\$767,623.77	-\$6,501,738.77
Incurred Claims PMPM	\$184.08	\$65.96	\$236.00
Allowed Claims PMPM	\$286.01	\$133.00	\$340.32
EHB portion of Allowed Claims, PMPM	\$286.01	\$133.00	\$340.32

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	53789PA0100004	53789PA0100008
Plan Adjusted Index Rate	\$509.98	\$394.86	\$547.67
Member Months	26,652	6,575	20,077
Total Premium (TP)	\$13,591,856	\$2,596,213	\$10,995,643
EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$21,799,339	\$4,104,318	\$17,695,021
EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%

Allowed Claims which are not the issuer's obligation	\$15,055,288	\$2,858,515	\$12,196,774
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0		
Portion of above payable by HHS on behalf of insured person, as %	0.00%		
Total incurred claims, payable with issuer funds	\$6,744,051	\$1,245,803	\$5,498,248
Net Amt of Reins	\$0	\$0	\$0
Risk Adjustment Transfer Amount	-\$5,108,326	-\$1,260,215	-\$3,848,111

KEYSTONE HEALTH PLAN CENTRAL, INC.

ACTUARIAL MEMORANDUM

Individual Rates

Effective January 1, 2019

General Information

Company Information

- Company Legal Name: Keystone Health Plan Central
- State: PA
- HIOS Issuer ID: 53789
- Market: Individual
- Effective Date: 1/1/2019

PID Company Information

- Company Name: Keystone Health Plan Central (KHPC)
- NAIC: 95199
- Market: Individual
- On/Off Exchange: Off Exchange
- Effective Date: 1/1/2019
- Average Rate Change Requested: -7.3%
- Range of Requested Rate Change: -9.9% to 5.4%
- Total additional annual revenue generated from the proposed rate change: \$(1,004,854)
- Product: HMO
- Rating Areas: 6,7,9
- Metal Levels: Bronze, Catastrophic
- Current Covered Lives and Policyholders: 2,043/1,452
- 2019 Number of Plans: 2
- 2018 Number of Plans and Percent Change: 2/0%
- Contract Form #: KHPC-Ind-HMO-21cnty-AGRMT-v0119
- Form Filing SERFF #: CABC-131453908
- Binder SERFF #: CABC-PA19-125079437
- HIOS Issuer ID: 53789
- HIOS Submission Tracking Number: 53789-1217515730619118596

Company Contact Information

- Primary Contact Name: [REDACTED]
- Primary Contact Telephone Number: [REDACTED]
- Primary Contact Email Address: [REDACTED]

Scope and Purpose

By this filing, Keystone Health Plan Central (KHPC), a subsidiary of Capital BlueCross (CBC), submits rates for products to be made available to individuals on and after January 1, 2019. KHPC will offer individual products off the federally-facilitated exchange.

Rate History and Proposed Variations in Rate Changes

Market	Company	Effective Date	SERFF #	Annual Increase
Individual	KHPC	1/1/2015	CABC-129635491	-8.00%
Individual	KHPC	1/1/2016	CABC-130076965	1.40%
Individual	KHPC	1/1/2017	CABC-130539563	55.10%
Individual	KHPC	1/1/2018	CABC-13102203	9.20%

Average Rate Change

KHPC is proposing an aggregate annual 7.3% rate decrease. The rate change does vary by plan. The rate change is calculated in PA Rate Template Part III, Table 10, cell AC15.

Regulatory Considerations

Rates submitted by this filing assume changes to the current regulatory framework. As directed by the Insurance Department, the following factors have been applied to the rates for regulatory changes:

- Individual Mandate: 0.06 added to the morbidity factor.

Membership

Membership is shown in PA Rate Template Part I, Table 1. The average age is 34.

Benefit Changes 2018-2019

A summary of proposed 2019 benefits is included in Exhibit A.

There are several benefit changes being implemented in 2018. All benefit changes comply with the uniform modification of coverage standards described in 45 CFR 147.106(e). Any plan with a benefit change that did not meet the uniform modification of coverage standard was terminated, and

a new plan was created in its place. Benefit changes by plan are listed in Exhibit B, highlighted in yellow.

Experience Period Premium and Claims

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 product/plan combination for KHPC in the individual market. The single risk pool includes transitional products/plans for purposes of base rate experience.

Base Experience Period: The base experience period (BEP) includes completed fee-for-service paid and incurred claims for dates of service between January 1, 2017 and December 31, 2017.

Paid Through Date: Claims in the BEP are paid through March 31, 2018

Premiums (net of MLR Rebate) in BEP: Premiums are calculated on an earned basis in the BEP. MLR rebate adjustments are equal to zero as KHPC does not expect to refund any MLR rebates in the BEP.

Allowed and Incurred Claims in BEP:

- Allowed claims are developed by combining paid claims with member cost-sharing. Allowed claims meet the definition in the URR instructions. They do not include provider quality incentive payments.
- Incurred claims are net of HHS CSR payments.
- CBC only covers Essential Health benefits (EHBs).
- KHPC does not include capitated services.
- Allowed and Incurred claims are net of pharmacy rebates. BEP rebates are completed based on actual utilization of rebate-eligible drugs and rebate amounts.

Estimated Incurred but Not Paid Claims: 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 are assumed to be identical.
6. Both allowed and paid claims in the BEP are completed by applying completion factors by incurred month developed in Step 6.

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

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

Risk Adjustment in BEP: Risk adjustment amounts in the BEP are equal to those reported by the Department on 5/9/2018.

Loss Ratio in BEP: Loss ratio is 145.03%

Credibility of Data

No Credibility Manual was used.

Trend Identification

Trend: 11.3%

Trend levels reflect CBC's 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. CBC uses the following to project future costs:
 - a. Vendor Physician Cost Model and Internal Hospital Contracting Model
 - i. The medical cost models use best estimates of Capital BlueCross (CBC)'s future contracting increases with physicians and hospitals. The models use cost estimates based on varying contract effective dates by physician and hospital. All facilities and providers are considered in this modeling effort (i.e. acute and non-acute, network and non-network, inpatient and outpatient, in- area and out-of-area). From there, a monthly anticipated

cost (assuming static utilization) summary is produced which can be used in projecting future claims costs. Cost trends are determined at the CBC book of business level for all commercial business.

- b. Internal Prescription Drug Trend Model
 - i. Price Inflation
 - ii. Contract Pricing
 - iii. Member Cost-Sharing
 - iv. Units per Script
 - v. Brand/Generic Mix
 - vi. Therapeutic Mix
 - vii. Cost per Script
- 2. Utilization Considerations:
 - a. Intensity of medical services rendered
 - b. Changes in place of service (e.g. continued migration of inpatient stays to outpatient setting)
 - c. Further migration from brand prescription drugs to generic prescription drugs
 - d. Favorable impacts of value based benefits designs
 - e. Induced Utilization: Induced utilization is CBC's best estimate for increased utilization in the individual market due to unknown future regulatory changes. CBC predicts that consumers will use more services in 2019 due to unknown coverage status in 2020.
 - f. Medical utilization estimates reviewed by CBC's Chief Medical Officer
- 3. Leveraging: The trend model is based on allowed cost increases. Paid claims trend at a higher rate than allowed due to leveraging. Leveraging is the impact of static cost-share, such as deductibles, to the paid trend. Estimated leveraging is calculated in Exhibit E1.
 - o Estimated costs are based on average plan benefit value in the month, calculated using CBC's internal benefit model.
 - o CBC expects the average benefit level in 2019 to be similar to current month, 201803.
 - o As of 201803, on average, Individual members pay 44.8% of costs, while CBC pays 55.2%. So for example,
 - \$2,000 in annual allowed claims results in member pay = \$896, and CBC pay = \$1,104.
 - \$2,000 trends at 5.5% = \$2,110
 - Member pay is fixed at \$896
 - CBC pay = $2,110 - 896 = \$1,214$
 - Total CBC trend = $1,214 / 1,104 - 1 = 10\%$
 - o With an allowed trend of 5.5%, and static cost-share, leveraging will add an additional 4.5% to trend.
- 4. 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 2018

<u>Type of Service</u>	<u>Units</u>	<u>Cost per Unit</u>
X-Ray	1	\$200
MRI	1	\$5,000
Total	2	\$5,200

Year 2019

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

Total Annual Trend	92%
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5. **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. KHPC strives to mitigate the underwriting cycle by keeping trends consistent through times of increasing and decreasing claim cost and utilization.

Historical Experience: Historical experience was not used to the develop trend.

Benefit Categories: Claims in the benefit categories displayed in the URRT come directly from CBC's data warehouse. These same categories are used to develop category-level trend. See Exhibit C for a description of benefits by benefit category.

See Exhibit E for KHPC's pricing trend, as well as cost and utilization components of the pricing trend.

Rate Development & Change

Projection Factors

Changes in Morbidity: Found in URRT Worksheet 1, "Pop'l risk Morbidity", and PA Rate Template Table 5.

The changes to morbidity incorporate both the Department's Individual Mandate factor discussed above, and changes to the population going from Bronze and Catastrophic experience to Catastrophic in the projection period. The additional morbidity change factor calculated in Exhibit F.

Changes in Benefits: Benefit changes are not applied to allowed claims as allowed should stay consistent from 2017 to 2019. Benefit changes are applied in the development of future incurred claims, due to changes in member cost-share. This calculation is shown in Exhibit D, and applied in Exhibit G. The manual cost PMPMs are developed from CBC's internal benefit relativity model, discussed in the Plan Adjusted Index Rate section below. The benefit change is equal to member-month weighted average projected manual PMPM divided by member-month weighted average manual PMPM in the BEP. This process is further discussed in the Paid-to-Allowed section below.

Changes in Demographics: KHPC does not expect changes in demographics in its individual population.

Changes in Network: No network adjustment is applied.

Other Adjustments: No other adjustment is applied.

Benefits, Demographics, Network and Other adjustments are found in URRT, Worksheet 1, "Other", and PA Rate Template Table 5.

Index Rate

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

Projected Allowed Claims: The KHPC 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)").

To calculate the projected index rate:

1. Start with *Projected Allowed Claims at Current Benefits*
2. The *Projected Allowed Claims at Current Benefits* reflect EHBs 100 percent, so no adjustment needs to be made to add EHBs and remove non-EHB claim cost. This is the index rate for individuals renewing January – December.

See Exhibit J for the Index Rate.

Paid to Allowed Ratio

KHPC used the prescribed URRT allowed claim rate development methodology in conjunction with a paid and incurred rate development methodology to determine final premium rates. The URRT projects allowed claims, and uses a paid-to-allowed ratio in order to adjust allowed claims to paid levels. This value is then used to develop premiums. In order to determine the paid-to-

allowed ratio, KHPC projected paid and incurred claims, adjusted for benefits, to the experience period.

Projected Paid and Incurred Claims are calculated as follows:

1. Gather claims experience as described in the Data section above.
 - a. Base Experience Period (BEP) Paid Claims, Capitation, and Rx Rebates
 - b. BEP Member Months
2. Develop BEP *Paid and Incurred Claims*:

$$\text{BEP Paid and Incurred Claims} = \frac{\text{BEP Paid Claims}}{\text{Completion Factor}}$$

The development of completion factors is described in Experience Period Premium and Claims above.

3. Develop the *BEP Paid and Incurred Claim PMPM*:

$$\text{BEP Paid and Incurred Claim PMPM} = \frac{\text{BEP Paid and Incurred Claims}}{\text{BEP Member Months}}$$

4. Develop *Trended Claim PMPM*: Using the aggregate trend described in the Projection Factors section above, trend the BEP Paid and Incurred Claim PMPM from the midpoint of the experience period to the midpoint of the rating period.

Trended Claim PMPM

$$= [\text{BEP Paid and Incurred Claim PMPM}] \times (1 + [\text{Trend}\%])^{\text{Trend Months}/12}$$

5. Develop *Projected Paid and Incurred Claim PMPM*:

$$\begin{aligned} \text{Projected Paid and Incurred Claims PMPM} \\ = [\text{Trended Claim PMPM}] \times [\text{Benefit Adjustment}] \\ \times [\text{Morbidity Adjustment}] \times [\text{Other Adjustment}] \end{aligned}$$

The *Benefit Adjustment*, *Morbidity Adjustment*, and *Other Adjustment* are discussed in the Projections Factors section above.

6. Develop *Projected Claims PMPM by Benefit* as follows:

- a. KHPC 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 PMPM by service, summed for all services. The impact of global deductible, coinsurance, and out-of-pocket max is then measured based on cumulative probability distributions (CPDs), where the value of services that apply to the CPDs adjusts the level of the curve, as well as global utilization adjustments.

- b. This actuarial cost model derives a Manual Cost for each benefit design in the experience period, as well as plans being offered in the projection period. The average Manual Cost of the experience is compared to the Manual Cost of the base plan. The projected experience period data is then adjusted to the base plan:

$$\text{Benefit Level Adjustment} = \frac{\text{Average Manual Cost in Projection Period}}{\text{Manual Cost of Base Plan}}$$

- c. The *Projected Paid and Incurred Claim PMPM* (Step 5) is then adjusted to the Base Plan as follows:

$$\begin{aligned} &\text{Base Plan Paid and Incurred Claims PMPM} \\ &= \frac{\text{Benefit Adjusted Paid and Incurred Claims PMPM}}{\text{Benefit Level Adjustment}} \end{aligned}$$

- d. Each additional benefit design has its own unique Manual Cost, which can then be compared to the Base Plan to develop a Benefit Relativity:

$$\text{Benefit Relativity A} = \frac{\text{Manual Cost of Benefit A}}{\text{Manual Cost of Base Plan}}$$

- e. The Benefit Relativity developed in d. above is then used as a gauge to develop a final *Pricing Relativity*. This pricing relativity is developed using actuarial judgment including the following considerations:

- i. Final premium relativities must make sense based on benefits. For example, the annual cost difference between a PPO 2000 and PPO 1000 must be less than \$1000.
 - ii. Adjustments for plan designs that fall outside of the actuarial cost model.
- a. So the *Projected Claims PMPM by Benefit* is:

$$\begin{aligned} &\text{Projected Claims PMPM Benefit A} \\ &= \text{Projected Claims PMPM Base Plan} \\ &\times \text{Pricing Relativity A} \end{aligned}$$

- b. And to arrive at the *Total Projected Claims PMPM*, KHPC assumes a distribution of members across the benefit plans being offered in 2019. The *Total Projected Claims PMPM* :

$$= \text{Projected Claims PMPM Benefit A} \times \text{Expected Member Dist of Benefit A} \\ + \text{Projected Claims PMPM Benefit B} \\ \times \text{Expected Member Dis of Benefit B} + \dots$$

7. The Paid-To-Allowed Ratio is then:

$$\text{Paid to Allowed Ratio} = \frac{\text{Total Projected Claims PMPM}}{\text{Projected Allowed Claims at Current Benefits}}$$

See Exhibit G for the development of the *Paid-to-Allowed Ratio*. And see Exhibit L for the plan-level projected incurred amount development.

Risk Adjustment

Projected Risk Adjustments PMPM:

Relevant to 2019 pricing is the impact of Commercial Risk Adjustment (CRA) payment transfers that are expected to be earned in 2019. The pricing impact is:

$$[\text{Net Projected Risk Adjustments PMPM}] \\ = [\text{Projected CRA Transfer PMPM}] - [\text{Risk Adjustment Fee PMPM}]$$

The following items are those that we deem important in generating a CRA payment transfer adjustment:

1. Risk profile of the those enrolled in CRA eligible plans for the market or state (i.e. competitors) relative to risk profile of CRA eligible membership enrolled in our plans
2. Statewide average premiums
3. Current market penetration of this company and competitors in the market and in the state
4. 2016-2017 risk adjustment results
5. Market improvement in coding risk: CBC's ACA book of business has had a churn rate that makes a multi-year perspective of member diagnosis and risk very challenging. Because closing gaps in care and coding, and a myriad of other risk adjustment functions require more than a single year of data to facilitate an accurate depiction of risk, it is believed that CBC is disadvantaged in the market. This will drive CBC's relative risk to the market down over time.

To fund the HHS-risk adjustment program, issuers will remit to HHS a fee of \$0.13 PMPM. The Risk Adjustment Fee PMPM is included in the URRT Worksheet 1, "Projected Risk Adjustments PMPM", and is found on Exhibit K.

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,

$$\begin{aligned} &[\textit{Market Adjusted Index Rate}] \\ &= ([\textit{Index Rate}] \times [\textit{Paid to Allowed Ratio}] \\ &\quad - [\textit{Net Projected ACA Reinsurance Recoveries}] \\ &\quad - [\textit{Net Projected Risk Adjustments PMPM}] + [\textit{Exchange Fees PMPM}]) \\ &\quad \div [\textit{Paid to Allowed Ratio}] \end{aligned}$$

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

Retention Items

Administrative Expense Load:

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 what percentage of time is spent on PPO versus HMO versus Drug versus Medicare. And separately will ask what percentage of time 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 allocated to KHPC Individual products. Administrative expenses are included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6. Expense as a percentage of premium vary by plan because a fixed dollar admin PMPM is applied to each plan.
2. Broker Expense: Calculated based on KHPC's explicit per contract broker fee. Broker Expense is included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6. KHPC pays commissions for new business and renewal enrollment received during open enrollment, both on and off exchange, and in all geographic areas. Commission is less on catastrophic plans due to the lower premium. KHPC does not pay commission during Special Enrollment Periods (SEP). The 2019 broker commission schedule is yet to be finalized. Attached please find the 1/1/2018 copy of the broker agreement – redacted version. Files are as follows:
 - a. Redacted Agent Agreement: "Ind_18-11_Initial_KHPC_PPO_WBEBrokerIndRedacted_Supporting_20180518.pdf"
 - b. Redacted Preferred Producer Master Agreement: "Ind_18-11_Initial_KHPC_PPO_PPMABrokerIndRedacted_Supporting_20180518.pdf"
3. Member Out-Of-Pocket (OOP) and Ways to Save:
 - a. Description: These products offer enhanced transparency to cost savings potential both prospectively and retrospectively. These are new services included in each

of KHPC's plans that work to decrease costs by engaging members in their health care decisions. The Member OOP program will show a member, prospectively, the value of a service and the impact of member cost-sharing when that service is incurred. It allows a member to shop for the best price while introducing transparency related to the member's expected cost share at the time of service. The "Ways to Save" program allows members to receive alerts, retrospectively, informing them of cost savings that could have been incurred had they have known about competing medical providers in the area. The alerts are retrospective and offer transparency around member's healthcare options.

- b. Costs: Costs are aggregated into CBC's total administrative expense above. No additional fee is charged. The cost is approximately \$0.25 PMPM. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
4. Value-Based Benefits (VBB): Standard with each plan, Capital BlueCross includes wellness incentives to maximize the likelihood that consumers make positive behavioral changes, which lead to better health, and curbed health care costs for employers and employees alike. The incentive is as follows:
 - a. Complete Health Risk Assessment questionnaire and receive a gift card.
 - b. Participate in an online coaching program and receive a gift card reward.
 - c. The wellness program is administered through a vendor and costs are based on vendor fees, anticipated participation, and reward card amounts.
 - d. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
5. Identity Theft Coverage: Identity protection offering will include the following components:
 - a. Credit monitoring – Monitors activity that may affect credit
 - b. Fraud detection – Identifies potentially fraudulent use of identity or credit
 - c. Fraud resolution support – Assists members in addressing issues that arise in relation to credit monitoring and fraud detection
 - d. Included in the URRT Worksheet 1, "Administrative Load", and PA Rate Template Table 6.
6. Additional Quality Improvement: The Final Notice of Benefit and Payment Parameters (NBPP) for 2019 finalized the rule to allow issuers to apply a standard 0.8% of premium for quality improvement (QI) measures in the MLR calculation. Total QI amounts applied in rating equal 0.8%.

Profit (or Contribution to Surplus) & Risk Margin:

7. Contingency: Contingency is included in the URRT Worksheet 1, "Profit and Risk", and PA Rate Template Table 6.

Taxes and Fees:

1. Health Insurer Fee (HIF) – Section 9010 of PPACA and Section 1406 of the Reconciliation Act (which modified PPACA) refers to HIF. The fee is a fixed-dollar amount distributed across health insurance providers. This fee has been suspended for 2019.

2. Exchange Fee – All issuers participating in a federally-facilitated exchange will remit 3.5% of premium to HHS. The exchange user fee is applied as an adjustment to the Index Rate at the market level. The calculation and amount is found in Exhibit K. The amount is also found in PA Rate Template, Table 5.
3. Federal Income Tax: Federal Income Tax will be collected on the 2% contingency built into the premium. The projected Federal Income Tax is included in the URRT Worksheet 1, “Taxes and Fees”, and PA Rate Template, Table 6.

See Exhibit H for all retention values.

Plan Rate Development

The Plan Adjusted Index Rates are 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 KHPC’s actuarial cost model. KHPC 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. Induced Demand: Please see Table 8
3. Provider Network: The Provider network is the same across all PPO plans. A network factor is applied to the EPO plan.
 - a. The Capital Advantage EPO plan is a plan built around Pinnacle Health’s delivery system and is available in Cumberland, Dauphin, and Perry counties.
 - b. See Exhibit O1 for the development of the network factor.
4. Adjustment for benefits in addition to EHBs: No benefits other than EHBs are included in the plans, so no adjustment is necessary.
5. Catastrophic Plans: Applied to catastrophic plans to reflect lower morbidity.
6. Adjustment for distribution and administrative costs: Described in Non-Benefit Expenses and Profit & Risk section above.
7. Tobacco Adjustment: Calculated as the average tobacco factor applied across the risk pool.

The development of the Plan Adjusted Index rate is found in Exhibit L, and summarized in Exhibit M.

Plan Premium Development for 21-Year-Old Non-Tobacco User

Age Curve Calibration: The average age factor is calculated by taking the member-weighted average of current individual enrollment by age in KHPC. Age factors are applied in accordance with CMS's Standard Age Curve. The age calibration factor is adjusted for contracts with greater than three children under the age of 21. Please see file Ind_18-12_Initial_KHPC_PPO_List-Billed_Supporting_20180518 for the calculation.

Geographic Factor Calibration: The average geographic rating factor is calculated by taking the KHPC member-weighted average by region.

Geographic Factors: KHPC 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 found cost differentials between the regions, mostly due to differences in hospital contracting between regions. The data from the analysis is found in Exhibit Q.

Tobacco Factor Calibration: Average tobacco factor is calculated using 2017 member and smoking status data.

The calibration is:

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

Calibrated Plan Adjusted Index Rates are found on PA Rate Template Table 10.
The calibration factors and development are found on Exhibit N.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed as follows:

1. Member-Level Consumer Adjusted Premium Rate:

$$\begin{aligned} [\text{Member} - \text{Level Consumer Adjusted Premium Rate}] \\ = [\text{Calibrated Plan Adjusted Index Rate}] \times [\text{Age Factor}] \\ \times [\text{Geographic Factor}] \times [\text{Tobacco Factor}] \end{aligned}$$

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

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

All consumer-level adjustments are applied uniformly to all plans in the Single Risk Pool. These adjustments do not vary by plan. Age and Geographic factors are displayed in Exhibits O.

Base Rates, i.e. Calibrated Plan Adjusted Index Rates, are found on Exhibit P.

AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based on the federally issued AV Calculator.

AV Pricing Values

All AV Pricing values were developed using KHPC's actuarial cost model and actuarial judgment as described in section Paid to Allowed above. Differences in health status are not included.

Projected Loss Ratio

See Exhibit I for the projected loss ratio calculation. The projected loss ratio is calculated using the federally prescribed MLR methodology.

Membership Projection

The membership projections found in Worksheet 2 of the URRT were developed by assuming that moderate growth and similar distribution to current.

Attachments and Examples

The following is a list of Exhibits and Data to support this filing:

PA Rate Template Part I through Part V

Table 8

Exhibit A – Benefit Summary
Exhibit B – Benefit Change Summary
Exhibit C – Benefit Categories
Exhibit D – Benefit Mix
Exhibit E – Trend
Exhibit F – URRT
Exhibit F1 - Leveraging
Exhibit G – Paid-to-Allowed Development
Exhibit G1 – Transitional Data
Exhibit H – Retention
Exhibit I – Projected Loss Ratio
Exhibit J – Index Rate
Exhibit K – Market Adjusted Index Rate
Exhibit L – Rate Development by Plan
Exhibit M – Plan Adjusted Index Rates

Exhibit N – Calibration
Exhibit O – Rating Factors
Exhibit P – Quarterly Base Rates
Exhibit Q – Regional Analysis

Broker Contracts
List-Billed Data

Actuarial Statement

I, [REDACTED], 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, [REDACTED], ASA, MAAA, do hereby certify that:

1. This filing has been prepared in accordance with the following:
 - a. Actuarial Standard of Practice No. 5, “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 Accident and Health, Group Term Life, and Property/Casualty Coverage”
 - 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, and in accordance with CFR 156.135(b)(2) as necessary. For any plan requiring an alternative method, the

development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for benefits that deviate substantially from the parameters of the AVC and have a material impact on the actuarial value.

- a. The analysis was
 - i. conducted by a member of the American Academy of Actuaries, and
 - ii. performed in accordance with generally accepted actuarial principles and methods.
5. All factor, benefit and other changes from the prior approved filing have been disclosed in the actuarial memorandum.
6. New plans cannot be considered modifications of existing plans under the uniform modification standards in 45 CFR 147.106.
7. The information presented in the PA Actuarial Memorandum and PA Actuarial Memorandum Rate Exhibits is consistent with the information presented in the 2019 Rate Filing Justification.



██████████, ASA, MAAA
Actuarial Associate
Capital BlueCross



KEYSTONE HEALTH PLAN CENTRAL
RFJ Part II – Consumer Friendly Justification

Rate Decrease Considerations:

- Stabilization of the Individual market in recent years
- Suspension of the Health Insurer Fee in 2019

Changes being requested are based upon consideration of the factors that influence future period cost structures. The primary drivers of change in future costs are:

- Anticipated increase in facility and physician unit costs
- Anticipated changes in prescription drug unit costs
- Continuing change in utilization such as
 - Intensity of medical services rendered
 - Changes in place of service (e.g. continued migration of inpatient stays to outpatient setting)
 - Further migration from brand prescription drugs to generic prescription drugs
 - Favorable impacts of value based benefits designs
- Prescription drug patent expirations and new to market brand drugs
- Leveraging associated with unchanged cost share components such as deductible and copays
- Inflation adjustment to administrative expenses

53789PA0100008	Rating Area 7	Tobacco User/Non-Tobacco User	51	617.05	709.60
	Rating Area 7	Tobacco User/Non-Tobacco User	52	645.83	742.71
	Rating Area 7	Tobacco User/Non-Tobacco User	53	674.95	776.19
	Rating Area 7	Tobacco User/Non-Tobacco User	54	706.38	812.34
	Rating Area 7	Tobacco User/Non-Tobacco User	55	737.81	885.37
	Rating Area 7	Tobacco User/Non-Tobacco User	56	771.89	926.27
	Rating Area 7	Tobacco User/Non-Tobacco User	57	806.30	967.56
	Rating Area 7	Tobacco User/Non-Tobacco User	58	843.02	1011.63
	Rating Area 7	Tobacco User/Non-Tobacco User	59	861.22	1033.46
	Rating Area 7	Tobacco User/Non-Tobacco User	60	897.94	1122.43
	Rating Area 7	Tobacco User/Non-Tobacco User	61	929.71	1162.13
	Rating Area 7	Tobacco User/Non-Tobacco User	62	950.55	1188.19
	Rating Area 7	Tobacco User/Non-Tobacco User	63	976.69	1220.86
	Rating Area 7	Tobacco User/Non-Tobacco User	64 and over	992.57	1240.71
53789PA0100008	Rating Area 9	Tobacco User/Non-Tobacco User	0-14	265.39	265.39
	Rating Area 9	Tobacco User/Non-Tobacco User	15	288.98	288.98
	Rating Area 9	Tobacco User/Non-Tobacco User	16	298.00	298.00
	Rating Area 9	Tobacco User/Non-Tobacco User	17	307.02	307.02
	Rating Area 9	Tobacco User/Non-Tobacco User	18	316.74	316.74
	Rating Area 9	Tobacco User/Non-Tobacco User	19	326.45	326.45
	Rating Area 9	Tobacco User/Non-Tobacco User	20	336.51	336.51
	Rating Area 9	Tobacco User/Non-Tobacco User	21	346.92	355.59
	Rating Area 9	Tobacco User/Non-Tobacco User	22	346.92	355.59
	Rating Area 9	Tobacco User/Non-Tobacco User	23	346.92	355.59
	Rating Area 9	Tobacco User/Non-Tobacco User	24	346.92	355.59
	Rating Area 9	Tobacco User/Non-Tobacco User	25	348.31	357.01
	Rating Area 9	Tobacco User/Non-Tobacco User	26	355.24	364.12
	Rating Area 9	Tobacco User/Non-Tobacco User	27	363.57	372.66
	Rating Area 9	Tobacco User/Non-Tobacco User	28	377.10	386.53
	Rating Area 9	Tobacco User/Non-Tobacco User	29	388.20	397.91
	Rating Area 9	Tobacco User/Non-Tobacco User	30	393.75	403.60
	Rating Area 9	Tobacco User/Non-Tobacco User	31	402.08	412.13
	Rating Area 9	Tobacco User/Non-Tobacco User	32	410.40	420.66
	Rating Area 9	Tobacco User/Non-Tobacco User	33	415.61	426.00
	Rating Area 9	Tobacco User/Non-Tobacco User	34	421.16	431.69
	Rating Area 9	Tobacco User/Non-Tobacco User	35	423.93	434.53
	Rating Area 9	Tobacco User/Non-Tobacco User	36	426.71	437.38
	Rating Area 9	Tobacco User/Non-Tobacco User	37	429.48	440.22
	Rating Area 9	Tobacco User/Non-Tobacco User	38	432.26	443.07
	Rating Area 9	Tobacco User/Non-Tobacco User	39	437.81	448.76
	Rating Area 9	Tobacco User/Non-Tobacco User	40	443.36	476.61
	Rating Area 9	Tobacco User/Non-Tobacco User	41	451.69	485.56
	Rating Area 9	Tobacco User/Non-Tobacco User	42	459.67	494.14
	Rating Area 9	Tobacco User/Non-Tobacco User	43	470.77	506.07
	Rating Area 9	Tobacco User/Non-Tobacco User	44	484.64	520.99
	Rating Area 9	Tobacco User/Non-Tobacco User	45	500.95	551.04
	Rating Area 9	Tobacco User/Non-Tobacco User	46	520.38	572.41
	Rating Area 9	Tobacco User/Non-Tobacco User	47	542.23	596.46
	Rating Area 9	Tobacco User/Non-Tobacco User	48	567.21	623.93
	Rating Area 9	Tobacco User/Non-Tobacco User	49	591.84	651.03
	Rating Area 9	Tobacco User/Non-Tobacco User	50	619.59	712.53
	Rating Area 9	Tobacco User/Non-Tobacco User	51	647.00	744.05
	Rating Area 9	Tobacco User/Non-Tobacco User	52	677.18	778.76
	Rating Area 9	Tobacco User/Non-Tobacco User	53	707.71	813.87
	Rating Area 9	Tobacco User/Non-Tobacco User	54	740.67	851.77
	Rating Area 9	Tobacco User/Non-Tobacco User	55	773.63	928.35
	Rating Area 9	Tobacco User/Non-Tobacco User	56	809.36	971.23
	Rating Area 9	Tobacco User/Non-Tobacco User	57	845.44	1014.53
	Rating Area 9	Tobacco User/Non-Tobacco User	58	883.95	1060.74
	Rating Area 9	Tobacco User/Non-Tobacco User	59	903.03	1083.63
	Rating Area 9	Tobacco User/Non-Tobacco User	60	941.53	1176.92
	Rating Area 9	Tobacco User/Non-Tobacco User	61	974.84	1218.55
	Rating Area 9	Tobacco User/Non-Tobacco User	62	996.69	1245.87
	Rating Area 9	Tobacco User/Non-Tobacco User	63	1024.10	1280.13
	Rating Area 9	Tobacco User/Non-Tobacco User	64 and over	1040.75	1300.94

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INDIVIDUAL PORTFOLIO

Changes	Plan Name	HIOS ID		Deductible (2x Family)	Coinsurance	Out-of-Pocket Maximum	PCP	Specialist	Emergency Room	Urgent Care	IP Hospital per day, maximum of 5 days	Hi-Tech Imaging	Lab Ind Hos	OP Surgery ASC ACH	Small Group: Rx \$0 Individual: Rx	Small Group: Rx \$250 (brand only deductible) Individual: N/A
		Small Group: Rx \$0 Individual: Rx	Small Group: Rx \$250 (brand only deductible) Individual: N/A													
				In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network		
PLATINUM PRODUCTS																
GOLD PRODUCTS																
SILVER PRODUCTS																
BRONZE PRODUCTS																
1 Changes	Bronze HMO 7350/0/60	53789PA0100008		\$7,350	0%	\$7,350	\$60	\$85	D	D	N/A	D	D 25	D 250	Rx Ded: Combined, Rx Gen - Ded Applies? Y, Retail: 0/0/0/0, Mail: 0/0/0/0	
2 Changes	Catastrophic HMO 7900/0/75	53789PA0100004		\$7,900	0%	\$7,900	\$75	D	D	D	N/A	D	D D	D D	Rx Ded: Combined, Rx Gen - Ded Applies? Y, Retail: 0/0/0/0, Mail: 0/0/0/0	

1 Drug copays listed are Preferred Generic/Non-Preferred Generic/Preferred Brand/Non-Preferred Brand
2 Speciality drug coverage = 20% up to \$250 per fill/20% up to \$350 per fill/20% up to \$450 per fill
3 Tiered Lab benefits. Independent labs | Hospital based labs
4 D = Deductible D/S = Deductible applies first then a copay
5 Plan naming convention = Metal level, Plan type, Deductible/Coinsurance/Office Visit Copay - HRA funding
6 CareConnect copays listed are for PCP directed care

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Line	On/Off Exchange	New/Existing	HIOS	Med Description	Rx Description	AV		Metal Level		HRA Amount		Deductible(2x Family)		Coinsurance		MOOP	
						2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
1	On Exchange	Existing	45127PA0020013	Gold PPO 2000/10/20	Combined w/Med	76.3%	76.0%	Gold	Gold	0	0	2,000	2,000	10%	10%	7,350	7,350
2	Off Exchange	Existing	45127PA0020021	Silver PPO 4950/10/30	Combined w/Med	66.7%	68.3%	Silver	Silver	0	0	4,950	4,950	10%	10%	7,350	7,350
3	On Exchange	Existing	45127PA002000804	Silver PPO 5000 CSR73	Combined w/Med	72.3%	73.4%	Silver	Silver	0	0	4,500	4,500	8%	8%	5,850	5,850
4	On Exchange	Existing	45127PA002000805	Silver PPO 5000 CSR87	Combined w/Med	86.3%	86.6%	Gold	Gold	0	0	1,200	1,200	5%	5%	2,450	2,450
5	On Exchange	Existing	45127PA002000806	Silver PPO 5000 CSR94	Combined w/Med	94.5%	94.2%	Platinum	Platinum	0	0	250	250	0%	0%	1,250	1,250
6	On Exchange	Existing	45127PA0020008	Silver PPO 5000/10/30	Combined w/Med	66.6%	68.2%	Silver	Silver	0	0	5,000	5,000	10%	10%	7,350	7,350
7	Off Exchange	Existing	53789PA0100008	Bronze HMO 7350/0/60	Combined w/Med	61.3%	62.6%	Bronze	Bronze	0	0	7,350	7,350	0%	0%	7,350	7,350
8	On Exchange	Existing	45127PA0020020	Bronze PPO 7350/0/60	Combined w/Med	61.3%	62.6%	Bronze	Bronze	0	0	7,350	7,350	0%	0%	7,350	7,350
9	Off Exchange	Existing	53789PA0100004	Catastrophic HMO 7900/0/75	Combined w/Med	60.3%	60.0%	Catastrophic	Catastrophic	0	0	7,350	7,900	0%	0%	7,350	7,900
10	Off Exchange	New	82795PA0140001	Catastrophic PPO 7900/0/75	Combined w/Med		60.0%		Catastrophic		0		7,900		0%		7,900
11	On Exchange	New	45127PA0140001	Gold Capital Advantage EPO 2000/0/45	Combined w/Med		76.2%		Gold		0		2,000		0%		7,350

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Line	On/Off Exchange	New/Existing	HIOS	Med Description	Rx Description	ACA PCP		Non-ACA PCP		SPC		ER		UC		IP Hosp Copay Per Day		Hi-Tech Imaging		Low End Imaging		Lab Independent		Lab Hospital-Based		OP Su
						2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	
1	On Exchange	Existing	45127PA0020013	Gold PPO 2000/10/20	Combined w/Med	20	20	20	20	50	45	D/300	D/300	75	75	N/A	N/A	D/10%	D/25%	D/10%	D/10%	25	25	D/75	D/75	D
2	Off Exchange	Existing	45127PA0020021	Silver PPO 4950/10/30	Combined w/Med	30	30	30	30	75	75	D/400	D/400	75	75	N/A	N/A	D/10%	D/25%	D/10%	D/10%	25	25	D/75	D/75	D
3	On Exchange	Existing	45127PA002000804	Silver PPO 5000 CSR73	Combined w/Med	10	10	10	10	20	20	D/200	D/200	45	45	N/A	N/A	D/8%	D/18%	D/8%	D/8%	20	20	D/60	D/60	D
4	On Exchange	Existing	45127PA002000805	Silver PPO 5000 CSR87	Combined w/Med	5	5	5	5	10	10	D/75	D/75	35	35	N/A	N/A	D/5%	D/15%	D/5%	D/5%	15	15	D/40	D/40	D
5	On Exchange	Existing	45127PA002000806	Silver PPO 5000 CSR94	Combined w/Med	3	3	3	3	5	5	D/50	D/50	20	20	N/A	N/A	D/0%	D/10%	D	D	10	10	D/20	D/20	D
6	On Exchange	Existing	45127PA0020008	Silver PPO 5000/10/30	Combined w/Med	30	30	30	30	75	75	D/400	D/400	75	75	N/A	N/A	D/10%	D/25%	D/10%	D/10%	25	25	D/75	D/75	D
7	Off Exchange	Existing	53789PA0100008	Bronze HMO 7350/0/60	Combined w/Med	60	60	60	60	85	85	D	D	D	D	N/A	N/A	D	D	D	D	25	25	D	D	D
8	On Exchange	Existing	45127PA0020020	Bronze PPO 7350/0/60	Combined w/Med	60	60	60	60	85	85	D	D	D	D	N/A	N/A	D	D	D	D	25	25	D	D	D
9	Off Exchange	Existing	53789PA0100004	Catastrophic HMO 7900/0/75	Combined w/Med	75	75	75	75	D	D	D	D	D	D	N/A	N/A	D	D	D	D	25	D	D	D	D
10	Off Exchange	New	82795PA0140001	Catastrophic PPO 7900/0/75	Combined w/Med		75		75	D	D		D		D	N/A	N/A		D		D		D		D	
11	On Exchange	New	45127PA0140001	Gold Capital Advantage EPO 2000/0/45	Combined w/Med		25		25		50		D/300		75		N/A			D		D/25		D/25		

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Line	On/Off Exchange	New/Existing	HIOS	Med Description	Rx Description	g ASC	
							2019
1	On Exchange	Existing	45127PA0020013	Gold PPO 2000/10/20	Combined w/Med		250
2	Off Exchange	Existing	45127PA0020021	Silver PPO 4950/10/30	Combined w/Med		250
3	On Exchange	Existing	45127PA002000804	Silver PPO 5000 CSR73	Combined w/Med		200
4	On Exchange	Existing	45127PA002000805	Silver PPO 5000 CSR87	Combined w/Med		100
5	On Exchange	Existing	45127PA002000806	Silver PPO 5000 CSR94	Combined w/Med		50
6	On Exchange	Existing	45127PA0020008	Silver PPO 5000/10/30	Combined w/Med		250
7	Off Exchange	Existing	53789PA0100008	Bronze HMO 7350/0/60	Combined w/Med		250
8	On Exchange	Existing	45127PA0020020	Bronze PPO 7350/0/60	Combined w/Med		250
9	Off Exchange	Existing	53789PA0100004	Catastrophic HMO 7900/0/75	Combined w/Med		D
10	Off Exchange	New	82795PA0140001	Catastrophic PPO 7900/0/75	Combined w/Med		D
11	On Exchange	New	45127PA0140001	Gold Capital Advantage EPO 2000/0/45	Combined w/Med		D/100

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Line	On/Off Exchange	New/Existing	HIOS	Med Description	Rx Description	OP Surg AHC		Rx Ded		Rx Gen - Ded Applies?		Rx Gen Pref		Rx Gen Non-Pref		Rx Brand Pref		Rx Brand Non-Pref		Rx Specialty Coin Tier 1		Rx Specialty Max Tier 1		Rx Specialty Coin Tier 2		Rx Specialty
						2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	
1	On Exchange	Existing	45127PA0020013	Gold PPO 2000/10/20	Combined w/Med	D/10%	D/10%	Combined	Combined	N	N	3	10	3	0	25	25	75	75	40%	40%	1000	800	40%	40%	1000
2	Off Exchange	Existing	45127PA0020021	Silver PPO 4950/10/30	Combined w/Med	D/10%	D/10%	Combined	Combined	N	N	10	10	10	0	50	50	100	100	50%	50%	1000	800	50%	50%	1000
3	On Exchange	Existing	45127PA002000804	Silver PPO 5000 CSR73	Combined w/Med	D/8%	D/8%	Combined	Combined	N	N	5	5	5	0	25	25	55	55	40%	40%	800	700	40%	40%	800
4	On Exchange	Existing	45127PA002000805	Silver PPO 5000 CSR87	Combined w/Med	D/5%	D/5%	Combined	Combined	N	N	3	3	3	0	15	15	40	40	30%	30%	500	400	30%	30%	500
5	On Exchange	Existing	45127PA002000806	Silver PPO 5000 CSR94	Combined w/Med	D	D	Combined	Combined	N	N	2	2	2	0	10	10	25	25	10%	10%	300	200	10%	10%	300
6	On Exchange	Existing	45127PA0020008	Silver PPO 5000/10/30	Combined w/Med	D/10%	D/10%	Combined	Combined	N	N	10	10	10	0	50	50	100	100	50%	50%	1000	800	50%	50%	1000
7	Off Exchange	Existing	53789PA0100008	Bronze HMO 7350/0/60	Combined w/Med	D	D	Combined	Combined	Y	Y	0	0	0	0	0	0	0	0	50%	50%	0	0	50%	50%	0
8	On Exchange	Existing	45127PA0020020	Bronze PPO 7350/0/60	Combined w/Med	D	D	Combined	Combined	Y	Y	0	0	0	0	0	0	0	0	50%	50%	0	0	50%	50%	0
9	Off Exchange	Existing	53789PA0100004	Catastrophic HMO 7900/0/75	Combined w/Med	D	D	Combined	Combined	Y	Y	0	0	0	0	0	0	0	0	0%	0%	0	0	0%	0%	0
10	Off Exchange	New	82795PA0140001	Catastrophic PPO 7900/0/75	Combined w/Med		D		Combined		Y		0		0		0			0%		0		0%		
11	On Exchange	New	45127PA0140001	Gold Capital Advantage EPO 2000/0/45	Combined w/Med		D/100		Combined		N		10		0		50		100		50%		800		50%	

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Line	On/Off Exchange	New/Existing	HIOS		Med Description	Rx Description	Max Tier 2 2019	Rx Gen Pref Coins		Rx Gen Non-Pref Coins		Rx Brand Pref Coin		Rx Brand Non-Pref Coins		Rx Gen Pref Mail Copay		Rx Gen Non-Pref Mail Copay		Rx Brand Pref Mail Copay		Rx Brand Non-Pref Mail Copay	
								2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
1	On Exchange	Existing	45127PA0020013		Gold PPO 2000/10/20	Combined w/Med	1000	0%	0%	0%	25%	0%	0%	0%	0%	8	20	8	0	63	50	188	150
2	Off Exchange	Existing	45127PA0020021		Silver PPO 4950/10/30	Combined w/Med	1000	0%	0%	0%	25%	0%	0%	0%	0%	25	20	25	0	125	100	250	200
3	On Exchange	Existing	45127PA002000804		Silver PPO 5000 CSR73	Combined w/Med	800	0%	0%	0%	18%	0%	0%	0%	0%	13	10	13	0	63	50	138	110
4	On Exchange	Existing	45127PA002000805		Silver PPO 5000 CSR87	Combined w/Med	500	0%	0%	0%	15%	0%	0%	0%	0%	8	6	8	0	38	30	100	80
5	On Exchange	Existing	45127PA002000806		Silver PPO 5000 CSR94	Combined w/Med	300	0%	0%	0%	10%	0%	0%	0%	0%	5	4	5	0	25	20	63	50
6	On Exchange	Existing	45127PA0020008		Silver PPO 5000/10/30	Combined w/Med	1000	0%	0%	0%	25%	0%	0%	0%	0%	25	20	25	0	125	100	250	200
7	Off Exchange	Existing	53789PA0100008		Bronze HMO 7350/0/60	Combined w/Med	0	0%	0%	0%	0%	0%	0%	0%	0%	0	0	0	0	0	0	0	0
8	On Exchange	Existing	45127PA0020020		Bronze PPO 7350/0/60	Combined w/Med	0	0%	0%	0%	0%	0%	0%	0%	0%	0	0	0	0	0	0	0	0
9	Off Exchange	Existing	53789PA0100004		Catastrophic HMO 7900/0/75	Combined w/Med	0	0%	0%	0%	0%	0%	0%	0%	0%	0	0	0	0	0	0	0	0
10	Off Exchange	New	82795PA0140001		Catastrophic PPO 7900/0/75	Combined w/Med	0		0%	0%	0%	0%	0%	0%	0%	0	0	0	0	0	0	0	0
11	On Exchange	New	45127PA0140001		Gold Capital Advantage EPO 2000/0/45	Combined w/Med	1000		0%		25%		0%		0%	20		0		100		200	

IP-OP-Professional	Type of Service
Inpatient	IP - CABG
Inpatient	IP - Cesarean Maternity Delivery
Inpatient	IP - Major Joint Procedures of Lower Extremity
Inpatient	IP - Maternity Non-delivery
Inpatient	IP - Medical
Inpatient	IP - Neonatal
Inpatient	IP - Newborn
Inpatient	IP - Normal maternity delivery
Inpatient	IP - Other Cardiovascular Procedures
Inpatient	IP - Other Surgical
Inpatient	IP - Psychiatric
Inpatient	IP - Substance Abuse
Inpatient	IP - Unmappable
Outpatient	OP - Blood
Outpatient	OP - Cardiac Rehab
Outpatient	OP - Cardiovascular
Outpatient	OP - Dialysis
Outpatient	OP - Emergency Room
Outpatient	OP - Maternity Non-delivery Care
Outpatient	OP - Observation Room
Outpatient	OP - Other OP Services
Outpatient	OP - PT/OT/ST
Outpatient	OP - Pathology/Lab
Outpatient	OP - Pharmacy
Outpatient	OP - Psychiatric
Outpatient	OP - Radiology - CT/MRI/PET
Outpatient	OP - Radiology - General
Outpatient	OP - Substance Abuse
Outpatient	OP - Surgery
Outpatient	OP - Unmapped
Professional	ADDL Benefits Other
Professional	Hearing Aids
Professional	IP Visits - IP Psychiatric
Professional	IP Visits - IP Substance Abuse
Professional	IP Visits - Medical
Professional	Inpatient Surgery - Primary Surgeon
Professional	Inpatient Surgery - Anesthesia
Professional	Inpatient Surgery - Assistant Surgeon
Professional	Maternity - Cesarean Deliveries
Professional	Maternity - Non Deliveries
Professional	Maternity - Normal Deliveries
Professional	Office Administered Drugs
Professional	Office/Misc - Allergy Immunotherapy
Professional	Office/Misc - Allergy Testing
Professional	Office/Misc - Misc. Medical
Professional	Office/Misc - Office/Home Visits
Professional	Office/Misc - Urgent Care
Professional	Other Physician - Cardiovascular
Professional	Other Physician - Chiropractor
Professional	Other Physician - Consults
Professional	Other Physician - Emergency Room Visits
Professional	Other Physician - Physical Therapy
Professional	Pathology/Lab - IP
Professional	Preventive care - Hearing/Speech Exams
Professional	Preventive care - Immunization
Professional	Preventive care - Other
Professional	Preventive care - Physical Exams
Professional	Preventive care - Well Baby Exams
Professional	Radiology - IP
Professional	Unmapped
Professional	ADDL Benefits Other
Professional	Hearing Aids
Professional	IP Visits - Medical
Professional	Independent Lab
Professional	Maternity - Cesarean Deliveries
Professional	Maternity - Non Deliveries
Professional	Maternity - Normal Deliveries
Professional	OP Visits - OP Psychiatric
Professional	OP Visits - OP Substance Abuse
Professional	Office Administered Drugs
Professional	Office/Misc - Allergy Immunotherapy
Professional	Office/Misc - Allergy Testing
Professional	Office/Misc - Misc. Medical
Professional	Office/Misc - Office/Home Visits
Professional	Office/Misc - Urgent Care
Professional	Other Physician - Cardiovascular
Professional	Other Physician - Chiropractor
Professional	Other Physician - Consults
Professional	Other Physician - Emergency Room Visits
Professional	Other Physician - Physical Therapy
Professional	Outpatient Surgery - Anesthesia
Professional	Outpatient Surgery - Office
Professional	Outpatient Surgery - Outpatient Facility
Professional	Pathology/Lab - OP
Professional	Pathology/Lab - Office
Professional	Preventive care - Hearing/Speech Exams
Professional	Preventive care - Immunization
Professional	Preventive care - Other
Professional	Preventive care - Physical Exams
Professional	Preventive care - Well Baby Exams
Professional	Radiology - OP - CT/MRI/PET
Professional	Radiology - OP - General
Professional	Radiology - Office - CT/MRI/PET
Professional	Radiology - Office - General
Professional	Unmapped
Other Medical	Unmapped
Other Medical	OP - Ambulance
Other Medical	OP - DME
Other Medical	OP - Home Health/PDN
Other Medical	OP - Medical Surgical Supplies
Other Medical	Dental
Other Medical	Other - Ambulance
Other Medical	Other - DME
Other Medical	Other - Glasses/Contacts
Other Medical	Other - PDN/Home Health
Other Medical	Other - Prosthetics
Other Medical	Preventive care - Vision Exams
Other Medical	Dental
Other Medical	Other - Ambulance
Other Medical	Other - DME
Other Medical	Other - Glasses/Contacts
Other Medical	Other - PDN/Home Health
Other Medical	Other - Prosthetics
Other Medical	Preventive care - Vision Exams

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Benefit Mix Changes

Benefit Mix Calculation			
	Med Manual Cost	Rx Manual Cost	Manual Cost PMPM
Average in Experience Period			260.59
Average in Rating Period			251.44
Benefit Mix Adjustment			0.96

BEP Manual Cost Calculation							
Company	HIOS 14 Digit	Med Plan	Rx Plan	Med Man Cost PMPM	Rx Man Cost PMPM	Manual Cost PMPM	BEP MM
CAAC	45127PA002000800	PPOIJ310				333.29	57,247
CAAC	45127PA002000801	PPOIJ304				333.29	144,631
CAAC	45127PA002000802	PPOIJ305				333.29	83
CAAC	45127PA002000803	PPOIJ306				333.29	7
CAAC	45127PA002001300	PPOIJ335				350.57	35,325
CAAC	45127PA002001301	PPOIJ332				350.57	56,637
CAAC	45127PA002001302	PPOIJ333				350.57	1
CAAC	45127PA002001303	PPOIJ334				350.57	4
KHPC	53789PA010000400	HMOIJ712				295.6	8,616
KHPC	53789PA010000800	HMOIJ725				248.18	24,315
CAIC	82795PA012000100	PGOIJ500				356.26	1,816

Projected 2019 Manual Cost Calculation				251.44	26,652
Mapped 2019 Plan	Med Man Cost PMPM	Rx Man Cost PMPM		Total	Proj Member Dist
53789PA01000008				252.88	20,077
53789PA01000004				247.03	6,575

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Trend

Trend by Service Category

Category	Cost	Util	Induced Demand	Total	Weights	Total Weights
Inpatient Hospital	7.3%	0.0%	1.0%	8.4%	26%	\$0.20
Outpatient Hospital	7.0%	0.0%	1.0%	8.1%	46%	\$0.35
Professional	5.5%	1.0%	1.0%	7.6%	22%	\$0.17
Other Medical	7.0%	0.0%	1.0%	8.1%	6%	\$0.05
Capitation	3.0%	0.0%	0.0%	3.0%	0%	\$0.04
Prescription Drug	12.2%	0.8%	1.0%	14.2%	100%	\$0.20
Dental & Vision	1.0%	2.0%	0.0%	3.0%	100%	100%

Aggregate Pricing Trend	
Total	9.1%
Medical	8.1%
Drug	14.2%
Agg Med + Rx Trend	9.3%
Dental and Vision	3.0%

Raw Trends

*From Hospital Trend Model

URRT Categories	Cost	Utilization	Composite
Inpatient Hospital	5.2%	0.0%	5.2%
Outpatient Hospital	5.0%	0.0%	5.0%
Professional	3.4%	1.0%	4.4%
Other Medical	5.0%	0.0%	5.0%
Capitation	3.0%		3.0%
Prescription Drugs	6.8%	0.8%	7.7%
Dental & Vision	1.0%	2.0%	3.0%

Adjustments to Pricing Trend

*Adjustments in Drug Trend Model

Medical		Drug	
Intensity	0.5%	Contracting	-0.1%
Leveraging	1.6%	Leveraging	3.0%
Demographics	0.0%	Demographics	0.0%
Buy-Downs	0.0%	Buy-Downs	0.0%
Other	0.0%	Pipeline	2.5%
Total	2.1%	Total	5.4%

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Leveraging Calculation

Individual Leveraging Model

201803 Allowed 377.91 Allowed Trend: 6.5%

<u>Market</u>	<u>Date</u>	<u>Expected Cost</u>	<u>Enrollment</u>	<u>PMPM</u>	<u>Implied AV</u>	<u>Fixed Cost Share</u>	<u>Leveraging</u>
IND	201803	10,699,088.08	40,445	264.53	0.7000	0.3000	1.6%

2.82%

<u>Year</u>	<u>Issuer cost</u>	<u>Member Cost</u>	<u>Total</u>
2018	264.53	113.37	377.91
2019	285.90	116.57	402.47
Trend	8.1%	2.8%	6.5%

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URRT

Exhibit F_URRT

Section II: Allowed Claims, PMPM basis

Benefit Category	Experience Period				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections		
		Allowed			Pop'l risk MorbidityOther		CostUtil		Utilization per 1,000Average Cost/ServicePMPM		
	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM							
Inpatient Hospital	Admits	48.46	13,776.11	55.64	1.060	1.000	1.073	1.010	52.41	15,856.36	69.25
Outpatient Hospital	Visits	1,834.38	647.36	98.96	1.060	1.000	1.070	1.010	1,983.53	741.69	122.60
Professional	Visits	6,498.68	89.01	48.20	1.060	1.000	1.055	1.020	7,168.30	98.98	59.12
Other Medical	Services	1,589.14	99.92	13.23	1.060	1.000	1.070	1.010	1,718.35	114.48	16.39
Capitation	Benefit Period	0.36	347,616.96	10.56	1.060	1.000	1.030	1.000	0.39	368,786.83	11.87
Prescription Drug	Prescriptions	4,714.95	146.49	57.56	1.060	1.000	1.122	1.018	5,182.53	184.34	79.61
Total	\$284.15				\$358.84						

*Other

Change in Demographics	1.000
Change in Network	1.000
Change in Benefits	1.000
Change in Other	1.000

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Paid to Allowed Ratio Development

Medical Rate Development		
Base Experience Period:	1/1/2017-12/31/2017	
Data as of	3/31/2018	
Rating Period:	1/1/2019 - 12/31/2019	
Trend Months:	24	
Trend:	8.1%	

Drug Rate Development		
Base Experience Period:	1/1/2017-12/31/2017	
Data as of	3/31/2018	
Rating Period:	1/1/2019 - 12/31/2019	
Trend Months:	24	
Trend:	14.2%	

Pediatric Dental Rate Development		
Base Experience Period:	1/1/2017-12/31/2017	
Data as of	3/31/2018	
Rating Period:	1/1/2019 - 12/31/2019	
Trend Months:	24	
Trend:	3.0%	

Pediatric Vision Rate Development		
Base Experience Period:	1/1/2017-12/31/2017	
Data as of	3/31/2018	
Rating Period:	1/1/2019 - 12/31/2019	
Trend Months:	24	
Trend:	3.0%	

1	Medical Paid and Incurred Claims*	4,417,409
2	Completion Factor	0.99
3	BEP Completed Claims (1) / (2)	4,447,724
4	BEP Member Months	32,931
5	BEP Completed Claim PMPM (3) / (4)	135.06
6	Trend Factor	1.17
7	Trended Claim PMPM (5) x (6)	157.69
8	Benefit Change Factor	0.96
9	Morbidity Adjustment	1.06
10	Capitation	347,617
11	Capitation PMPM	10.56
12	Other Adjustment	1.000
13	Total Benefit Adjusted Claim PMPM [(7) x (8) x (9) x (10) + (11)] x (12)	171.84

1	BEP Paid and Incurred Claims	1,583,914
2	Completion Factor	1.000
3	BEP Completed Claims (1) / (2)	1,583,916
4	BEP Member Months	32,931
5	BEP Completed Claim PMPM (3) / (4)	48.10
6	Trend Factor	1.30
7	Trended Claim PMPM (5) x (6)	62.76
8	Benefit Change Factor	0.96
9	Morbidity Adjustment	1.06
10	Rx Rebates	211,352
11	Rx Rebates PMPM	6.42
12	Other Adjustment	1.000
13	Total Benefit Adjusted Claim PMPM [(7) x (8) x (9) x (10) + (11)] x (12)	70.61

1	BEP Paid and Incurred Claims	91,737
2	Completion Factor	0.989
3	BEP Completed Claims (1) / (2)	92,768
4	BEP Member Months	65,758
5	BEP Completed Claim PMPM (3) / (4)	1.41
6	Trend Factor	1.06
7	Trended Claim PMPM (5) x (6)	1.50
8	Benefit Change Factor	1.00
9	Morbidity Adjustment	1.06
10		
11		
12	Other Adjustment	1.000
13	Total Benefit Adjusted Claim PMPM [(7) x (8) x (9) x (10) + (11)] x (12)	1.59

1	BEP Paid and Incurred Claims	9,738
2	Completion Factor	0.983
3	BEP Completed Claims (1) / (2)	9,906
4	BEP Member Months	65,786
5	BEP Completed Claim PMPM (3) / (4)	0.15
6	Trend Factor	1.06
7	Trended Claim PMPM (5) x (6)	0.16
8	Benefit Change Factor	1.00
9	Morbidity Adjustment	1.06
10		
11		
12	Other Adjustment	1.000
13	Total Benefit Adjusted Claim PMPM [(7) x (8) x (9) x (10) + (11)] x (12)	0.17

Expected Claim PMPM in Rating Period	
Medical	171.84
Drug	70.61
Pediatric Dental	1.59
Pediatric Vision	0.17
Expected Distribution of Embedded Dental Benefit	
100%	
Total Expected Incurred in Rating Period	
244.20	
Total Expected Incurred in Rating Period Net RA	
435.87	
Projected Allowed	
358.84	
Paid to Allowed Ratio	
0.681	

*Medical Paid and Incurred Claims are net of CSR

Keystone Health Plan Central

Individual Rates

Effective 1/1/2019

Retention

Exhibit H_Ret

	<u>Medical + Rx</u>	<u>Dental</u>	<u>Vision</u>	<u>Total</u>	<u>% of Premium</u>
Reinsurance Contribution	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Risk Adjustment Fee	\$0.13	\$0.00	\$0.00	\$0.13	0.0%
Admin PMPM	\$39.56	\$0.60	\$0.09	\$40.25	8.0%
Broker PMPM	\$4.80	\$0.00	\$0.00	\$4.80	1.0%
Value Based Benefits	\$5.20	\$0.00	\$0.00	\$5.20	1.0%
BCBSA Identity Theft Protection	\$0.02	\$0.00	\$0.00	\$0.02	0.0%
Quality Improvement	0.4%	0.4%	0.4%	0.4%	0.4%
Contingency	2.0%	2.0%	2.0%	2.0%	2.0%
HRA Admin Fee PMPM *	\$2.66	\$0.00	\$0.00	\$2.66	0.5%
Patient-Centered Outcomes Research Trust Fund:	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Insurer Tax	0.0%	0.0%	0.0%	0.0%	0.0%
Exchange Fee	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Federal Income Tax	0.4%	0.4%	0.4%	0.4%	0.4%
Premium Tax	0.0%	0.0%	0.0%	0.0%	0.0%

* HRA Admin fee in charged to HRA plans only

Insurer Tax and Admin Fee Calc

Applied HIF to All Quarters			0.00%
<u>Quarter</u>	<u>% of Enrollees</u>	<u>HIF</u>	
1	100%	0.00%	
			2019 assessmen 2020 assessment
			0 0% 2.3%
			3 0% 2.3%
			6 0% 2.3%
			9 0% 2.3%

	<u>Admin</u>	<u>Profit</u>	<u>Taxes</u>
	10.0%	2.0%	0.4%
Claims	8.2%		
Broker	1.0%		
Filing 18-11	Quality Improvement	1.5%	20

Expected Incurred	435.87
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	Bronze HMO	Catastrophic
Plan	7350/0/60	HMO 7900/0/75
Deductible	7350	7900
Expected Claim Cost	280.15	136.83
Expected Premium PMPM *	\$537.25	\$389.77
<u>Allowed Adjustments to Premium for MLR</u>		
Reinsurance Contribution	0.00	0.00
Patient-Centered Outcomes Research Trust Fund:	0.00	0.00
Risk Adjustment Fee	0.13	0.13
Premium Tax	0.00	0.00
Insurer Tax	0.00	0.00
Exchange Fee	0.00	0.00
Quality Improvement	2.15	1.56
Federal Income Tax**	2.26	1.64
MLR Adjusted Premium	\$532.71	\$386.44
Expected Member Distribution	75.3%	24.7%

Unadjusted Premium	\$500.86
Expected MLR Adjusted Premium	\$496.63

MLR	87.8%
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* From Exhibit L
**21% of profit or contingency (assumed to be 2%)

Exhibit J_IndexRate

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Projected Index Rate

Projected Index Rate	\$358.84
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<u>Effective Date</u>	<u>Total Index Rate</u>	<u>Trend</u>	<u>Distribution of Members</u>	<u>Projected Allowed</u>	<u>Market Adjusted Index Rate</u>
January - December	\$358.84		100%	\$358.84	

Average for Projection Period	\$358.84			\$358.84	\$640.49
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* From URRT and Exhibit B

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Market Adjusted Index Rate

Exhibit K_MarketAdjInd

Development of Market Adjusted Index Rate

Q1 Index Rate	358.84
Paid to Allowed	0.68
Q1 Projected Claims	244.20
Net Projected ACA Reinsurace Recoveries	0.00
Net Projected Risk Adjustments PMPM	-191.67
Exchange User Fee Adjustment	0.00
Q1 Market-Adjusted Projected Paid EHB Claims PMPM	435.87
Q1 Market Adjusted Index Rate	640.49

Development of Exchange User Fee

Average Exchange Premium	\$779.75
Average Exchange Fee	\$27.29
Percentage of Membership on Exchange	0%
Exchange Fee to Add to Market Index Rate	\$0.00

Development of Risk Adjustment Projection

Projected 2019 Risk Adjustment Payment	-\$191.54	*10% increase for 2018 and 2019 premium changes
Projected 2017 Risk Adjustment	-\$5,734,115	
2017 MemberMonths	32,931	
Projected 2017 Risk Adjustment Payment PMPM	-\$174.13	
Capital Advantage Assurance Company	\$40,434,004	
Keystone Health Plan Central	-\$5,734,115	
Capital Advantage Insurance Company	-\$567,695	

Adjust Base Experience Period to Base Plan

	<u>Medical</u>	<u>Rx</u>	<u>Ped Dental</u>	<u>Ped Vision</u>	<u>Total</u>
Expected Claim PMPM in Rating Period	171.84	70.61	1.59	0.17	244.20
Adjustment to Base Plan	0.994	0.994	1.000	1.000	0.994
Adjustment for Network	1.000	1.000	1.000	1.000	1.000
Adjustment for Cat	0.877	0.877	0.877	0.877	0.877
Expected Claim Base Plan	197.14	81.00	1.81	0.19	280.15

ExhibitL_RateDev		
Rate Development by Benefit Option		
Level of Coverage	Off Exchange	Off Exchange
HIOS	Bronze	Catastrophic
	53789PA0100008	53789PA0100004
Med Plan Name:	Bronze HMO 7350/0/60	Catastrophic HMO
Rx:	7900/0/75	
Plan Type:	Combined	Combined
HRA	HMO	HMO
Q1 Market Adjusted Index Rate	N	N
	640.49	640.49
AV and Cost-Sharing Adjustment	0.55	0.53
Network	1.000	1.000
Catastrophic	1.000	0.500
Induced Demand	1.35	1.92
Plan Pricing Relativities:		
Manual PMPM	252.88	247.03
Pricing Relativity	1.000	0.488
Projected Claims	280.15	136.83
Total Projected Claims PMPM + Market Level Adjustments:	471.82	328.50
Retention		
Admin PMPM	\$40.25	\$40.25
Broker PMPM	\$4.80	\$4.80
Patient-Centered Outcomes Research Trust Fund:	\$0.00	\$0.00
HRA Admin Fee	\$0.00	\$0.00
Value-Based Benefits	\$5.20	\$5.20
BCBSA Identity Theft	\$0.02	\$0.02
Premium Tax	0.0%	0.0%
Federal Income Tax	0.4%	0.4%
Insurer Tax	0.0%	0.0%
Contingency	2.0%	2.0%
Quality Improvement	0.4%	0.4%
Premium Neutrality	1.67	1.67
Total Premium Single Rate:	\$321.23	\$233.05
Plan Adjusted Index Rates	\$537.25	\$389.77
Expected Member Distribution	75.3%	24.7%
Relativity Checks		
Claims	1.00	0.98
Premium	1.00	0.73
	\$50.27	\$50.27
Admin	10%	13%
Taxes	0.4%	0.4%

Benefit Plans																										
		100%	26,652																		Annual Trend					
#	Combo Description	Projected Membership	Proj MM	New or Existing	Product ID	Plan ID	On/Off Exchange	Metal Level	Metal Value	Pricing Value	Network	Induced Demand	Product	Med Plan Description	Deductible	Drug Plan	Pediatric Dental	Pediatric Vision	Average Plan Adj. Index Rate	Q1 Plan Adj. Index Rate	Q2 Plan Adj. Index Rate	Q3 Plan Adj. Index Rate	Q4 Plan Adj. Index Rate	Medical & Rx	Dental & Vision	Aggregate Trend
1	Bronze HMO 7350/0/60	75.3%	20,077	Existing	53789PA010	53789PA0100008	Off Exchange	Bronze	62.6%	54.7%	1.00	1.35	HMO	Bronze HMO 7350/0/60	7350	Combined	Embedded	Embedded	\$537.24	\$537.24				9.30%	3.0%	9.12%
2	Catastrophic HMO 7900/0/75	24.7%	6,575	Existing	53789PA010	53789PA0100004	Off Exchange	Catastrophic	60.0%	53.4%	1.00	1.92	HMO	Catastrophic HMO 7900/0/75	7900	Combined	Embedded	Embedded	\$389.76	\$389.76				9.30%	3.0%	9.12%

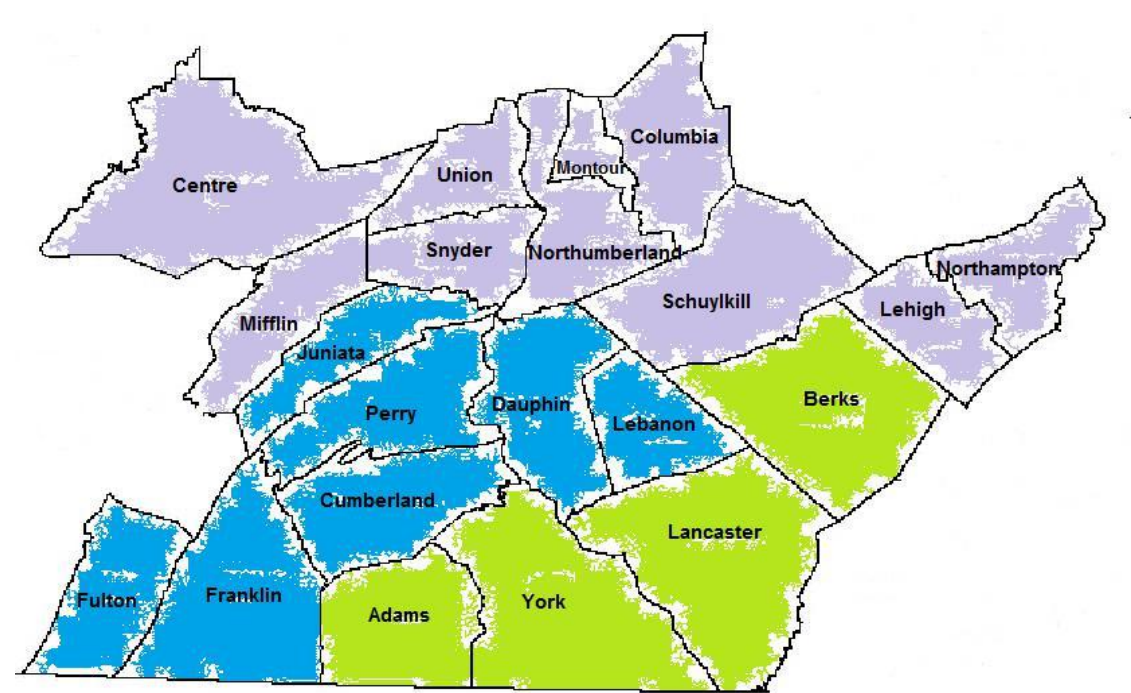
Expected Average Age Factor:	1.624
List-Billed Adjustment for Max 3 Children	1.004
Adjusted Average Age Factor	1.618
Expected Average Region Factor:	1.03
Expected Average Tobacco Factor	1.006
Cumulative Rating Factors (Premium Neutrality):	1.672

Age Factors			Region Factors			Tobacco		
Age	Distribution of Population	Age Factor	Region	Distribution of Population	Factor	PPQ	HMO	Final Factor
0-14	11.2%	0.7650	6	34.5%	1.00	1.007	1.003	1.006
15	0.9%	0.8330	7	50.2%	1.03	Product Type		
16	1.1%	0.8590	9	15.4%	1.08	PPO	HMO	
17	0.9%	0.8850				48622	2850	
18	1.6%	0.9130						
19	1.0%	0.9410				PPO	HMO	Tobacco Factor
20	1.5%	0.9700				45619	2738	1
21	1.7%	1.0000						
22	1.3%	1.0000				Members with Tobacco Surcharge		
23	1.7%	1.0000				Age	Members 2017/202	Tobacco Factor
24	1.4%	1.0000				0	0	1
25	1.3%	1.0040				1	0	1
26	3.2%	1.0240				2	0	1
27	3.9%	1.0480				3	0	1
28	3.8%	1.0670				4	0	1
29	3.5%	1.1190				5	0	1
30	1.2%	1.1350				6	0	1
31	1.3%	1.1590				7	0	1
32	1.1%	1.1830				8	0	1
33	0.5%	1.1980				9	0	1
34	0.6%	1.2140				10	0	1
35	1.0%	1.2220				11	0	1
36	1.0%	1.2300				12	0	1
37	1.5%	1.2380				13	0	1
38	1.2%	1.2460				14	0	1
39	1.1%	1.2620				15	0	1
40	1.2%	1.2780				16	0	1
41	0.8%	1.3020				17	0	1
42	1.3%	1.3250				18	1	1
43	0.8%	1.3570				19	3	1
44	0.8%	1.3970				20	6	1
45	1.7%	1.4440				21	6	1.025
46	1.6%	1.5000				22	13	1.025
47	1.9%	1.5630				23	26	1.025
48	1.6%	1.6350				24	31	1.025
49	1.4%	1.7060				25	33	1.025
50	1.7%	1.7860				26	74	1.025
51	1.4%	1.8650				27	10	1.025
52	1.8%	1.9520				28	95	1.025
53	1.9%	2.0400				29	73	1.025
54	2.2%	2.1350				30	59	1.025
55	1.8%	2.2300				31	63	1.025
56	2.0%	2.3330				32	43	1.025
57	2.3%	2.4370				33	67	1.025
58	2.4%	2.5480				34	63	1.025
59	2.5%	2.6030				35	81	1.025
60	2.3%	2.7140				36	73	1.025
61	2.4%	2.8100				37	78	1.025
62	3.3%	2.8730				38	79	1.025
63	3.4%	2.9520				39	71	1.025
64+	5.2%	3.0000				40	59	1.075
						41	74	1.075
						42	70	1.075
						43	68	1.075
						44	84	1.075
						45	74	1.1
						46	74	1.1
						47	91	1.1
						48	73	1.1
						49	87	1.1
						50	91	1.15
						51	76	1.15
						52	94	1.15
						53	76	1.15
						54	99	1.15
						55	61	1.2
						56	79	1.2
						57	65	1.2
						58	66	1.2
						59	85	1.2
						60	75	1.25
						61	61	1.25
						62	74	1.25
						63	75	1.25
						64	66	1.25
						65	0	1.25
						66	0	1.25
						67	3	1.25
						68	0	1.25
						69	0	1.25
						70	0	1.25
						71	0	1.25
						72	0	1.25
						73	0	1.25
						74	0	1.25
						75	0	1.25
						76	0	1.25
						77	0	1.25
						78	0	1.25
						79	0	1.25
						80	0	1.25
						81	0	1.25
						82	0	1.25
						83	0	1.25
						84	0	1.25
						85	0	1.25
						86	0	1.25
						87	0	1.25
						88	0	1.25
						89	0	1.25
						90	0	1.25

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Rating Factors

Age Factors									
Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio
0-14	0.765	24	1.000	34	1.214	44	1.397	54	2.135
15	0.833	25	1.004	35	1.222	45	1.444	55	2.230
16	0.859	26	1.024	36	1.230	46	1.500	56	2.333
17	0.885	27	1.048	37	1.238	47	1.563	57	2.437
18	0.913	28	1.087	38	1.246	48	1.635	58	2.548
19	0.941	29	1.119	39	1.262	49	1.706	59	2.603
20	0.970	30	1.135	40	1.278	50	1.786	60	2.714
21	1.000	31	1.159	41	1.302	51	1.865	61	2.810
22	1.000	32	1.183	42	1.325	52	1.952	62	2.873
23	1.000	33	1.198	43	1.357	53	2.040	63	2.952
								64+	3.000

Region



Region	Factor
6	1.00
7	1.03
9	1.08

Network	Factor
PPO	1.00
HMO	1.00

#	Plan Description	Projected Membership	Proj MM	New or Existing	Product ID	Plan ID	Out/Off Exchange	Metal Level	Metal Value	Pricing Value	Index of Demand	Product	Medical Plan Description	Deductible	Drug Plan Desc	Pediatric Dental	Pediatric Vision	Medical + Rx	Medical	Base Rates		Pediatric Vision	Total	Medical + Rx	Dental & Vision		
																				12/2022						12/31/2023	
																				Annual Total						Annual Total	
																				Annual Total						Annual Total	
1	Bronze HMO 7500/0/0	75.3%	20,077	Existing	53700P/A010	53700P/A0100003	Off Exchange	Bronze	62.0%	\$2.7%	1.58	HMO	Bronze HMO 7500/0/0	7500	Combined	Embedded	Embedded	\$108.73	\$262.16	\$37.55	\$1.33	\$0.16	\$324.22	9.3%	3.0%		
2	Catastrophic HMO 7500/0/75	24.7%	6,575	Existing	53700P/A010	53700P/A0100004	Off Exchange	Catastrophic	60.0%	\$1.6%	1.92	HMO	Catastrophic HMO 7500/0/75	7500	Combined	Embedded	Embedded	\$231.36	\$160.88	\$41.68	\$1.33	\$0.16	\$233.08	9.3%	3.0%		

Keystone Health Plan Central
Individual Rates
Effective 1/1/2019
Regional Analysis

Results

Region	DemoUnits	MemberMonths	AdjustedPaid	AllowedAmount	Adjusted Allowed	Allowed PMPM	Demo	Relative Demo	Normalized Allowed	Relative Value Normalized	Rating Factor
6	368,356	296,531	90,261,766	107,236,316	116,957,368	394.42	1.2422	1.00	393.16	-3.2%	1.00
7	362,378	294,970	89,289,240	107,114,203	118,932,154	403.20	1.2285	0.99	406.39	0.1%	1.03
9	248,747	199,516	64,263,901	75,473,210	85,405,208	428.06	1.2468	1.01	425.14	4.7%	1.08
						406.18	1.24	1.00	406.16	0.0%	

Data - Claims and Enrollment for 12 Months Ending December 2016 and Hospital and Physician Contracting thru 2018

Total		979,481	791,017	243,814,906	289,823,729	1.11	321,294,730	366.39	1.2383	1.00	405.98	
Region	Group County Name	DemoUnits	MemberMonths	AdjustedPaid	AllowedAmount	Contracted Increase	Adjusted Allowed	Allowed PMPM w Increase	Demo	Relative Demo	Normalized Allowed	Relative Value Normalized
7	ADAMS	13,679	10,443	3,394,184	3,973,174	1.14	4,512,605	432.12	1.3099	1.06	408.48	100.6%
7	BERKS	125,887	100,900	32,916,422	39,021,187	1.10	43,051,624	426.68	1.2476	1.01	423.47	104.3%
6	CENTRE	19,922	17,590	5,658,648	6,477,963	1.10	7,109,452	404.18	1.1326	0.91	441.89	108.8%
6	COLUMBIA	5,415	4,139	1,163,209	1,406,248	1.11	1,555,268	375.76	1.3082	1.06	355.67	87.6%
9	CUMBERLAND	74,534	61,189	19,135,213	22,553,892	1.11	25,078,821	409.86	1.2181	0.98	416.64	102.6%
9	DAUPHIN	95,161	75,619	26,105,853	30,417,196	1.13	34,369,550	454.51	1.2584	1.02	447.22	110.2%
9	FRANKLIN	39,366	31,689	8,899,778	10,555,168	1.15	12,097,676	381.76	1.2423	1.00	380.53	93.7%
9	FULTON	4,396	3,536	1,268,027	1,403,703	1.16	1,624,041	459.29	1.2431	1.00	457.49	112.7%
9	JUNIATA	2,419	1,763	1,007,291	1,112,588	1.03	1,145,491	649.74	1.3721	1.11	586.35	144.4%
7	LANCASTER	135,437	114,895	31,644,795	38,454,128	1.10	42,405,854	369.08	1.1788	0.95	387.70	95.5%
9	LEBANON	28,061	22,155	6,645,000	8,007,213	1.20	9,624,084	434.40	1.2666	1.02	424.68	104.6%
6	LEHIGH	155,388	125,195	36,288,278	43,695,605	1.09	47,444,604	378.97	1.2412	1.00	378.08	93.1%
6	MIFFLIN	4,933	4,057	1,125,642	1,281,771	1.11	1,420,226	350.07	1.2159	0.98	356.51	87.8%
6	MONTOUR	1,354	1,070	523,520	606,126	1.12	680,642	636.11	1.2650	1.02	622.65	153.4%
6	NORTHAMPTON	122,092	97,609	28,885,496	34,516,080	1.09	37,718,646	386.43	1.2508	1.01	382.54	94.2%
6	NORTHUMBERLAND	12,764	9,899	4,070,566	4,622,745	1.10	5,093,158	514.51	1.2894	1.04	494.09	121.7%
9	PERRY	4,810	3,565	1,202,738	1,423,449	1.03	1,465,544	411.09	1.3492	1.09	377.29	92.9%
6	SCHUYLKILL	34,409	27,296	9,431,239	11,009,074	1.10	12,089,177	442.89	1.2606	1.02	435.04	107.2%
6	SNYDER	7,182	5,779	2,054,579	2,351,995	1.03	2,421,549	419.03	1.2427	1.00	417.51	102.8%
6	UNION	4,898	3,897	1,060,590	1,268,710	1.12	1,424,644	365.57	1.2570	1.02	360.13	88.7%
7	YORK	87,375	68,732	21,333,839	25,665,715	1.13	28,962,071	421.38	1.2712	1.03	410.44	101.1%



June 22, 2018

██████████, Director
Bureau of Life, Accident and Health Insurance
Office of Insurance Product Regulation and Administration
Commonwealth of Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

**Re: Keystone Health Plan Central
Individual Rates
Filing No 18-11
TOI Code: H15I Individual Health – Hospital/Surgical/Medical Expense
Sub-TOI Code: H15I.001 - Hospital/Surgical/Medical Expense
Filing Type: Rate**

Dear ██████████:

KHPC received an objection letter from the Department dated June 15, 2018. KHPC is providing the following in response to the objection letter:

- Q&A written response
- Q&A exhibits
- Correction to List-Billed data file
- Correction to Actuarial Memo – correction to 2017 rate SERFF filing number
- Correction to Memo Exhibits, Exhibit E – Trend

These changes do not impact rates.

If you have any questions regarding this filing, please call me at ██████████ (or via email at ██████████) or ██████████ at ██████████ (██████████). Thank you for your assistance in this matter.

Sincerely,

██████████

██████████, ASA, MAAA
Manager, Actuarial Services
Capital BlueCross

Enclosures

Harrisburg, PA 17177 | capbluecross.com

cc: [REDACTED], FSA, MAAA, Senior Director, Actuarial Services
[REDACTED], ASA, MAAA, Vice President and Chief Actuary, Actuarial Services
[REDACTED], Corporate Counsel

KEYSTONE HEALTH PLAN CENTRAL, INC.

Question and Answer Individual Rates Effective January 1, 2019

With this response, please find corresponding Q&A Exhibits in Ind_18-11_Initial_KHP_HMO_Q&AExhibits1_Supporting_20180622.xlsx

Question 1. Please answer the following questions regarding the trend factors used (tab “Exhibit E_Trend”):

- a. The leveraging calculation assumes all member cost sharing is static (“Fixed Cost Share” column on tab “Exhibit E1_Lever”), but all plans have benefits which are subject to the deductible and/or coinsurance which would increase, to some extent, with allowed costs. Please explain why you think it is appropriate to assume all cost sharing is static.
- b. The leveraging calculation in “ExhibitE1_Lever” assumes allowed cost sharing is 5.5%. However, in the Raw Trends shown in “Exhibit E_Trend” none of the service categories have trends that high, and the weighted average, including drug but not dental/vision, appears to be closer to 5.3%. Please provide an explanation for why you used 5.5% in the calculation and a quantitative build-up of the 5.5% if it is not changing.
- c. The leveraging calculation in “ExhibitE1_Lever” compares projected paid costs by month to a plan with zero cost sharing (essentially an allowed amount since there is no cost sharing). However, it does not appear as if induced utilization is accounted for in the calculation. Based on the HHS curve, a zero cost sharing plan (1.00 AV) would have 24% higher utilization and, as a result, 24% higher allowed costs than a bronze plan (0.60 AV). Please provide an explanation for why induced utilization is not accounted for in the calculation.
- d. Please provide a quantitative buildup of the “leveraging adjustment” for the drug trend.
- e. Please provide a quantitative buildup of the “pipeline adjustment” for the drug trend and describe the adjustment and why it is necessary.
- f. Please explain the following regarding the dental and vision trends:
 - i. Please provide an explanation on the development of the final cost and utilization trends shown in cells B14 and C14 of the “Exhibit E_Trend” tab.
 - ii. Please provide an explanation on how the composite factor shown in cell C31 relates to the raw trends in cells B31 and C31.
- g. The final trends shown in cells B8:C14 tie to the trends on WS1 of the URRT as well as the rate development on tab “II Rate Development & Change.” These trends are applied to allowed claims. Please explain why you think it is necessary to make an adjustment to account for paid claim trend leveraging when trending allowed claims forward.
- h. Please provide an explanation and quantitative buildup of the induced demand adjustment. Include an explanation regarding how the higher utilization and, as a result, higher paid costs are accounted for in the calculation of the leveraging factor.

Answer 1.

- a. While, in some cases, the amount the consumer pays out of pocket increases as allowed claims increase, the consumer-paid percentage-of-total decreases due to fixed dollar cost-sharing such as deductible and copayments. For a member with a \$2,000 deductible, incurring \$1000 in allowed claims year 1 and \$1100 in year 2 (10% allowed trend, for example), their cost-sharing increased, and they paid 100% of allowed claims in both years. But if that same member incurred \$5,000 in allowed claims year 1 (paid \$2,000 in deductible), and \$5,500 year 2, the insurer's paid trend is $3,500/3,000 - 1 = 17\%$, and the member's out-of-pocket trend is 0%. This is because the member's percentage-of-total out-of-pocket expenses decrease when fixed deductibles and copays apply. The leveraging calculation factors in all scenarios, showing the average impact of cost-sharing on a large population, measuring in aggregate how paid claims rise faster than allowed as the insurer percentage-of-total claims rises over time.
- b. For this example, 5.5% allowed trend is used because it falls within the range of reasonable allowed trends. This small group filing is requesting a lower than average trend due to competitive pressures. While the raw trend shows 5.3%, induced demand drives that trend up 3 points.
- c. This calculation uses CBC's internal manual cost model to determine benefit relativities. While this model accounts for induced utilization as cost-sharing decreases, it does not use the same assumptions as the AV calculator.
- d. For Individual business, medical and Rx deductible are combined, and the average AV is Silver (approx. \$5,000 deductible on average). These larger deductibles applied to Rx creates leveraging values between 2% and 4%. Please see Q&A Exhibit 1 for a comparison of paid and allowed trends by market segment. While Individual historical trends do not reflect pricing trend (the high trend is attributable to a changes in morbidity), the difference between paid and allowed is 3%, attributable to leveraging.
- e. The pipeline adjustment is used to account for new drugs expected to enter the market in 2019. Since these drugs are new, their cost is not accounted for in the BEP. CBC has compiled pipeline reports from our PBM and Specialty Rx vendor to quantify which drugs could potentially be entering the market in 2019. While there are many unknowns as to which drugs will become available and utilization of those drugs, through this process, the group decided to apply 1% pipeline to the group market. For the individual market, it is reasonable to assume a higher pipeline adjustment due to higher specialty trend (the vast majority of pipeline drugs are specialty – low incidence, high cost). Please see Q&A Exhibit 2 for specialty trend by market segment.
- f.
 - i. We applied standard pricing trend to dental and vision. Because Individual and Small Group enrollment has fluctuated, and embedded pediatric dental and vision coverage is fairly new to the market, it is difficult to estimate changes in utilization and mix of services. Due to these factors, 3% pricing trend is applied to these components.
 - ii. The composite dental and vision trend is not correct. It is being corrected with this submission.

- g. While it is not necessary to apply paid trends to allowed claims, the format of the exhibits makes it preferable to do so. If I apply allowed trends to allowed claims, and paid trends to paid claims, the final proposed rates do not change, only the paid-to-allowed ratio changes.
- h. Induced Utilization: Induced utilization is CBC's best estimate for increased utilization in the individual market due to unknown future regulatory changes. CBC predicts that consumers will use more services in 2019 due to unknown coverage status in 2020. Association Health Plans also play a role in driving out healthier individuals from the ACA-compliant market, resulting in higher utilization trends over time. While induced utilization is not explicitly included in the leveraging calculation, it is reasonable to assume that induced utilization could further drive leveraging (paid costs).

Question 2. Please provide support for the assumption that all members with less than \$350 PMPM in paid costs, and only those members would move to a narrow network competitor between the experience and projection period.

Answer 2. Exhibit F1 – Risk Score Deficiency Calculation is designed to show how healthier members leaving the ACA pool completely (Association Health Plans) or moving to competitor's narrow network plans impact claim and risk scores differently, resulting in risk adjustment deficiency. The example was used to show the impact if the healthiest members (members with claims < \$350/year) left CBC. But the data shows that this difference in risk and claims is not only attributable to that one scenario. It is unlikely that a member that regularly uses services, has a known health issues, or expects to have a high cost service(s) in the upcoming year will move to a narrow network plan, with the risk of surprise high out-of-pocket costs and/or changing a trusted doctor. Individual market allows each consumer to make choices based on their own needs, so only healthy members will take the chance of a narrow network.

The example used (members with claims < \$350/year) shows a morbidity factor of 1.18 is justifiable. But the 1.10 morbidity (in addition to 1.06 for individual mandate) is applied in rating.

Question 3. Please provide quantitative and qualitative support for the 0.920 network factor on the "III Plan Rates" tab.

Answer 3. KHPC does not apply a network factors to any of its plans.

Question 4. Please provide the quantitative and qualitative development of the projected 2019 risk adjustment payment of \$42.00 shown in Exhibit K.

Answer 4. The PID released projected 2017 RA estimates in May of -\$174.13 PMPM. KHPC is submitting an estimate of -\$191.54 PMPM (10% annual increase 2019 over 2017) with the following considerations in mind:

- a) With significant annual premium increases 2017-2018, and KHPC only offering plans off-exchange (no subsidies), and only offering Bronze and Catastrophic plans, we will

continue to see the healthiest members move into these plans, causing risk adjustment payments to continue to rise.

- b) Capital BlueCross is a small plan with limited resources. The industry has commercially available services to improve coding efforts through exhaustive use of data and provider outreach programs. While CBC is engaged in the efforts of accurate, timely submission of RA data, we feel that the industry will outpace CBC in its ability to maximize value going into 2019.
- c) Internal coding difficulties: CBC's individual ACA book of business has had a churn rate that has made a multi-year perspective of member diagnosis and risk impossible. As of 2016, CBC had 70,000 members. In 2017, 50% of CBC Individual ACA business dropped coverage, and CBC gained roughly 30,000 new members. And in 2018, CBC lost 20,000 members and gained 10,000 new members. This places CBC at a disadvantage in terms of ability to assess a member's ability to assess a member's risk. Since risk adjustment, closing gaps in care and coding, and a myriad of other risk adjustment functions require more than a single year of data to facilitate an accurate depiction of risk, it is believe that CBC is disadvantaged in the market. The amount is ultimately unknown, but it is estimated that it will have an unfavorable impact.

Question 5. Please provide an explanation for the why the “Benefit Richness (induced demand)” information in column L of the “III Plan Rates” tab does not result in a weighted average factor of 1.0 as directed in the Rate Filing Guidance.

Answer 5. The induced demand factor is designed to adjust the AV and Cost-Sharing factors so that, in aggregate, they equate to the Paid-to-Allowed ratio. In this filing, the AV and Cost-Sharing factors aggregate to 0.66. But the Paid-to-Allowed ratio is 0.72. The induced demand factor of 1.10 is applied to 0.66 to bring claims up to 0.72 level. $0.66 \times 1.1 = 0.72$. So projected claims by plan aggregate to equal projected claims calculated in total. Projected claims were not increased by applying induced demand (impact of 1.0), which is demonstrated in the fact that projected claims = [allowed claims] x [average AV and cost-sharing factor] x [average induced demand]. This is demonstrated in Table B.

Question 6. Please review and update your calculation of the “List-Billed Adjustment for Max 3 Children” as the work provided has factors in column N which are different than those in column M even when there are 3 or fewer children (e.g., rows 8 and 612).

Answer 6. The List-Billed Adjustment for Max 3 Children file has been corrected with this response.

Question 7. The Federal Income Tax in “Exhibit H_Ret” is calculated as a subset of the Contingency amount (21% of the 2% Contingency). However, it is included in the rate development as an amount in addition to the 2% Contingency amount. Please provide an explanation as to why this approach is appropriate and does not double-count the impact of Federal Income Tax.

Answer 7. Please see Q&A Exhibit 3 for an example of how federal income tax and contingency are applied to establish a net contingency (net of taxes) that is still less than 2%.

The example shows a premium build with and without federal income tax applied. While federal income tax is applied “below the line” or to operating margin, creating a circular calculation, the goal in the premium build is to apply an assumption that accounts for this item. In the first calculation, net contingency falls to 1.58%. The second calculation results in a net contingency of 1.91%, closer to the 2% goal.

Question 8. Please provide an explanation of why the “AV and Cost-Sharing Adjustment” factors (row 26 of Exhibit L) are consistently lower than, and in some cases significantly lower than, the midpoint of the metal level ranges (e.g., 0.80 for a Gold plan).

Answer 8. The Actuarial Value and Cost Sharing Adjustment is determined using CBC’s actuarial cost model. CBC 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.

CBC’s model values high deductibles, by adjusting utilization, at a higher value than the AV calculator, creating consistently lower pricing AVs.

Question 9. Each response to a Department data call must contain a cover letter that details the changes made to the PA Actuarial Memorandum Exhibits and the reasons why the changes were made, e.g., in response to Department question number 5.

Answer 9. A cover letter is being provided with this response.

Question 10. Please confirm that you have tested to ensure that the rates in Table 11 of the Actuarial Memorandum Exhibits, the PA Plan Design Summary and Rate Tables, the Federal Rates Template, and in the binder are identical.

Answer 10. I confirm that I have tested to ensure the rates in Table 11 of the Actuarial Memorandum Exhibits, the PA Plan Design Summary and Rate Tables, the Federal Rates Template, and in the binder are identical.

Question 11. For the expanded bronze plans, please demonstrate that the copay is less than or equal to 50% coinsurance for that category.

Answer 11. The expanded bronze plan meets requirements under 45 CFR 156.140(c) because the plan covers specialty drugs at 50% coinsurance.

Question 12. Page 2 of the actuarial memo list a SERFF number for the rate filing effective 1/1/2017 that is incorrect. The SERFF number actually reference a form filing. Please correct this.

Answer 12. Changes have been made to the actuarial memo.

Question 13. In the 2019 Guidance published on the Department's website, the Department required that all issuers file uniform factors for the Individual Adjustment of 1.06 and the CSR Defunding Adjustment of 1.28. In addition, the Department indicated that as the rate review process moves forward and federal healthcare reform efforts are clarified, the Department would consider issuer specific requests. We can now advise that the aforementioned factors of 1.06 for the Individual Adjustment and 1.28 for CSR Defunding Adjustment constitute ceilings. If your company desires lower adjustments than those stated in the Department's 2019 Guidance, you may provide updated materials (PA Actuarial Memorandum and Exhibits, Part III Actuarial Memorandum, Part I URRT and corresponding rate tables – State and Federal) and justification for the lower Adjustment factor(s) with your first round response due June 22, 2018. The Department will not consider adjustment factors greater than those stated in the 2019 Guidance.

Answer 13. KHPC will continue to apply the recommended factors. No changes are being made.

Keystone Health Plan Central
Individual Rates
Q&A Exhibit 1
Rx Leveraging

Individual

All Drugs

	12 Months Ending 201703			12 Months Ending 201803			Trend		
	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM
Allowed	367,433	\$ 2.91	\$ 89.03	438,934	\$ 3.18	\$ 116.31	19.5%	9.4%	30.6%
Paid			\$ 70.43			\$ 94.00			33.5%

SmallGroup

All Drugs

	12 Months Ending 201703			12 Months Ending 201803			Trend		
	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM
Allowed	355,574	\$ 3.20	\$ 94.86	352,476	\$ 3.46	\$ 101.63	-0.9%	8.1%	7.1%
Paid			\$ 78.90			\$ 86.05			9.1%

Keystone Health Plan Central
Individual Rates
Q&A Exhibit 2
Specialty Trend Considerations for Pipeline Adjustment

Individual

Specialty Drugs

	12 Months Ending 201703			12 Months Ending 201803				Trend		
	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM		Days/1000	Cost/Day	PMPM
Allowed	1,852	\$ 251.86	\$ 38.86	2,831	\$ 236.69	\$ 55.83		52.9%	-6.0%	43.7%
Paid			\$ 36.39			\$ 94.97				161.0%

SmallGroup

Specialty Drugs

	12 Months Ending 201703			12 Months Ending 201803				Trend		
	Days/1000	Cost/Day	PMPM	Days/1000	Cost/Day	PMPM		Days/1000	Cost/Day	PMPM
Allowed	1,900	\$ 208.53	\$ 33.02	2,197	\$ 223.00	\$ 40.83		15.6%	6.9%	23.7%
Paid			\$ 31.64			\$ 38.76				22.5%

Keystone Health Plan Central
Individual Rates
Q&A Exhibit 3
Federal Income Tax and Contingency Examples

<u>Item</u>	<u>Without Fed Income Tax</u>	<u>With Fed Income Tax</u>
Claims	\$350.00	\$350.00
Admin	\$35.00	\$35.00
Contingency	2%	2%
Federal Taxes	0%	0.4%
Premium	\$392.86	\$394.55
Expected Profit	\$7.86	\$9.55
Federal Taxes	\$1.65	\$2.01
Profit Net Taxes	\$6.21	\$7.54
Net Contingency*	1.58%	1.91%

*Net Contingency is below 2% in both calculations, but adding an assumption for federal income tax increases contingency closer to the 2% goal.



July 13, 2018

██████████, Director
Bureau of Life, Accident and Health Insurance
Office of Insurance Product Regulation and Administration
Commonwealth of Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

**Re: Keystone Health Plan Central
Individual Rates
Filing No 18-11
TOI Code: H15I Individual Health – Hospital/Surgical/Medical Expense
Sub-TOI Code: H15I.001 - Hospital/Surgical/Medical Expense
Filing Type: Rate**

Dear ██████████:

KHPC received an objection letter from the Department dated July 6, 2018. KHPC is providing the following in response to the objection letter:

- Q&A written response
- Correction to list-billed portion of the age calibration, Memo Exhibits, Exhibit N Calibration
- Correction and modification to Memo Exhibits, Exhibit E – Trend
 - Correction to displayed dental and vision trend
 - Modification to leveraging adjustment, which impacts overall trend
- Updated rates based on trend and list-billed changes

If you have any questions regarding this filing, please call me at ██████████ (or via email at ██████████) or ██████████ at ██████████ (██████████). Thank you for your assistance in this matter.

Sincerely,

██████████

██████████, ASA, MAAA
Manager, Actuarial Services
Capital BlueCross

Enclosures

Harrisburg, PA 17177 | capbluecross.com

cc: [REDACTED], FSA, MAAA, Senior Director, Actuarial Services
[REDACTED], ASA, MAAA, Vice President and Chief Actuary, Actuarial Services
[REDACTED], Corporate Counsel

KEYSTONE HEALTH PLAN CENTRAL, INC.

Question and Answer Individual Rates Effective January 1, 2019

Questions from Actuarial Consultant:

Question 1. In response to Question 1a you state the leveraging calculation represents the “average impact of cost sharing on a large population.” This calculation assumes zero increase to member cost sharing from year to year. Your explanation indicates some members may see no change to their cost sharing (members with allowed claims over the deductible in your example) and some members would see increases to their cost sharing (members with allowed claims under the deductible in your example). Please provide quantitative support for the assumption that there is no change to the average member cost sharing percentage as that would assume all members had allowed claims above their deductible amount.

Answer 1. In reviewing the calculation, I see how the fixed cost sharing column did not account for member cost share increases as allowed claims increase. Exhibit E1_Lever has been updated to account for trend in member cost share. The assumption is that 20% of members see increase in their cost sharing due to allowed trend, or $5.5\% \times 0.2 = 1.1\%$ annual trend. With this change, leveraging is reduced from 4.5% to 3.6%.

Question 2. In response to Question 1b you state induced demand drives raw trend up by 3 points. The induced demand shown on the “Exhibit E_Trend” tab only shows induced demand at 1%. Please explain this discrepancy.

Answer 2. The response to Question 1b mistakenly said 3% for induced demand. Induced demand does account for 1%.

Question 3. In response to Question 1c you state your “model accounts for induced utilization as cost-sharing decreases.” However, in your calculation of the “Implied AV” on the “Exhibit E1_Lever” tab, the paid PMPM amount is always divided by the allowed amount for a plan with no cost sharing. This calculation does not appear to account for the lower allowed amount which would occur for leaner plans because of induced utilization. Please provide quantitative support for how the “Implied AV” amounts account for induced utilization when compared to a plan with no cost sharing or update the calculation accordingly if they currently do not.

Answer 3. In reviewing the calculation, induced utilization is not explicitly shown, as the allowed amount is static for all months. While Exhibit E1_Lever originally showed several months of data, the calculation only uses the most current month (201803). So to simplify the exhibit, I’ve removed the months prior to 201803. The implied AVs (developed in conjunction with the Zero Cost Share Manual rate) for that month are correct. The new exhibit also incorporates an annual increase in member cost share, as noted above.

Question 4. In response to Question 1f you updated the total composite trend for Dental and Vision to be 3%. It appears cost trend and utilization trend are still not consistent between rows 31 and 14 of the 'Exhibit E_Trend' tab. Please provide an explanation for which is the correct assumption and please ensure all other pricing and documentation files match, as this could have a slight impact on final rates.

Answer 4. With this submission, Exhibit E_Trend has been corrected to be consistent between rows 31 and 14.

Question 5. The Individual Adjustment factor prescribed by the Pennsylvania Insurance Department is a maximum of 1.06 and includes the impact of the \$0 individual mandate penalty, association health plans, and short term limited duration policies. In response to Question 2 you state the 1.10 morbidity factor separately applied includes the impact of association health plans. Please remove the portion of the morbidity factor caused by association health plans as they are prescribed to be included in the 1.06 morbidity factor separately included in the rate development.

Answer 5. My previous response mistakenly implied that KHPC applied a morbidity factor of 1.10 to its rate calculation. No morbidity factor (in addition to the Department's prescribed 1.06) was applied. I believe the question was meant to apply to CAAC. My response has been clarified in the CAAC second response.

Question 6. Please answer the following question regarding your response to Question 2 (morbidity assumption of 1.10):

- a. What historical benchmarks, experience, and/or studies did you use to determine which members will move to a competitor's narrow network plan?
- b. What is the justification for assuming only the lowest cost members, and no one else, will move to a competitor's narrow network plan?
- c. How was year-over-year reversion to the mean (i.e., a member with high claim costs in one year will have lower claim costs the next year) accounted for in the development of the factor?

Answer 6. KHPC did not apply a morbidity adjustment in addition to the Department's prescribed adjustment of 1.06.

Question 7. Thank you for correcting the List-Billed Adjustment file. Please explain why this change did not have a resulting impact on rates.

Answer 7. With this submission, the filing has been updated to include the impact of the List-Billed factor change.

Questions for PID:

Question 1. Each response to a Department data call must contain a cover letter that details the changes made to the PA Actuarial Memorandum Exhibits and the reasons why the changes were made, e.g., in response to Department question number 5.

Answer 1. A cover letter is being provided with this response.

Question 2. Please confirm that you have tested to ensure that the rates in Table 11 of the Actuarial Memorandum Exhibits, the PA Plan Design Summary and Rate Tables, the Federal Rates Template, and in the binder are identical.

Answer 2. I confirm that I have tested to ensure the rates in Table 11 of the Actuarial Memorandum Exhibits, the PA Plan Design Summary and Rate Tables, the Federal Rates Template, and in the binder are identical.

Question 3. Responses to the second round of questions are due July 13, 2018. No modifications other than risk adjustment due to the Federal Risk Adjustment Report and Department requested changes will be accepted.

Answer 3. With this submission, only changes requested by the Department have been made.



July 19, 2018

██████████, Director
Bureau of Life, Accident and Health Insurance
Office of Insurance Product Regulation and Administration
Commonwealth of Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

**Re: Keystone Health Plan Central
Individual Rates
Filing No 18-11
TOI Code: H15I Individual Health – Hospital/Surgical/Medical Expense
Sub-TOI Code: H15I.001 - Hospital/Surgical/Medical Expense
Filing Type: Rate**

Dear ██████████:

KHPC received an objection letter from the Department dated July 17, 2018. KHPC is providing the following in response to the objection letter:

- Q&A written response
- Q&A exhibits
- Modification to Memo Exhibits, Exhibit E – Trend and Exhibit E1 - Leveraging
 - Modification to leveraging adjustment, which impacts overall trend
 - In response to consultant questions 1 and 2

If you have any questions regarding this filing, please call me at ██████████ (or via email at ██████████) or ██████████ at ██████████ (██████████). Thank you for your assistance in this matter.

Sincerely,

██████████

██████████, ASA, MAAA
Manager, Actuarial Services
Capital BlueCross

Harrisburg, PA 17177 | capbluecross.com

Enclosures

cc: [REDACTED], FSA, MAAA, Senior Director, Actuarial Services
[REDACTED], ASA, MAAA, Vice President and Chief Actuary, Actuarial Services
[REDACTED], Corporate Counsel

KEYSTONE HEALTH PLAN CENTRAL, INC.

Question and Answer Individual Rates Effective January 1, 2019

With this response, please find corresponding Q&A Exhibits in Ind_18-11_Initial_KHP_HMO_Q&AExhibits3_Supporting_20180719.xlsx

Questions from Actuarial Consultant:

Question 1. In response to Question 1, you applied an adjustment to the calculation in the “Exhibit E1_Lever” tab to increase member cost sharing only 0.2% for every 1.0% increase in allowed costs. Please provide quantitative support for this assumption.

Answer 1. Please see Q&A Exhibit 1 for a new calculation of leveraging. In order to determine the future impact of leveraging, including the impact of increasing cost sharing due to allowed costs rising, I’m showing a claim probability distribution with allowed amounts by range. The data is for 2017 CBC ACA single risk pool population. While, the Individual average AV displayed in Exhibit E1 – Leveraging is 55%, that AV seemed too low when applying it the CBC’s ACA data. So, I applied a more reasonable average AV of 70%. From that, I can infer that a deductible (applying to all services) of \$5,519 is equal to 70% AV for this population. Using that deductible amount, I can measure incurred claims and member cost-sharing trend, given an allowed trend of 6.5%. Please note that allowed trend has been increased from 5.5% to 6.5% to account for higher utilization trends seen in the Individual market compared to the Small Group market. Claims are trended in a database in order to move claims into the correct buckets as they trend. You can see that the total allowed amounts are increasing at 6.5% annually (columns O and X). Given the deductible and allowed trend, incurred claims trend at 8.1%, member cost-share at 2.8% and leveraging is $8.1\% - 6.5\% = 1.6\%$. Exhibit E1 – Leveraging and Exhibit E – Trend are updated to reflect this revised amount.

Question 2. In response to Question 3 you state that “induced utilization is not explicitly shown, as the allowed amount is static for all months” in the calculation on the “Exhibit E1_Lever” tab. Our understanding with this calculation is that the paid amounts (\$264.53 in 201803) is reflective of the average manual rate paid costs based on Capital’s internal model and the allowed amount (\$479.20) is reflective of a plan with no cost sharing (1.000 AV). The member cost sharing amount is then calculated by subtracting the paid amount from the allowed amount ($\$479.20 - \$264.53 = \$214.67$). This subtraction assumes that the allowed amount for the mix of plans underlying each month is the same as the allowed amount for a plan with no cost sharing and does not account for induced utilization differences. As an example, a silver plan (0.700 AV) would have 17% lower utilization and allowed costs than a plan with no cost sharing (1.000 AV) if using the HHS induced demand factors. By not accounting for induced utilization in the allowed amounts, the member cost sharing amounts are being overstated, which then increases the calculated impact of leveraging. Please update the “Exhibit E1_Lever” to calculate member cost sharing based on allowed amounts reflective of the plan mix underlying each month instead

of allowed amounts reflective of a plan with no cost sharing or provide support for how induced utilization is accurately being accounted for in the current calculation.

Answer 2. Based on the calculation found in Q&A Exhibit 1, I have updated the 201803 AV to 70%. In order to accommodate this change, I have changed the allowed amount to \$377.91. 70% AV seems to be reasonable given KHPC subsidiary, CAAC's, paid-to-allowed ratio of 72%, with lower AVs in KHPC and CAIC. Leveraging is applied equally to trend across CAAC, CAIC and KHPC even though CAIC and KHPC offer lower AV plans.

Questions for PID:

Question 1. Each response to a Department data call must contain a cover letter that details the changes made to the PA Actuarial Memorandum Exhibits and the reasons why the changes were made, e.g., in response to Department question number 5.

Answer 1. A cover letter is being provided with this response, with details around the changes.

Question 2. Please confirm that you have tested to ensure that the rates in Table 11 of the Actuarial Memorandum Exhibits, the PA Plan Design Summary and Rate Tables, the Federal Rates Template, and in the binder are identical.

Answer 2. As discussed, Table 11 of the Actuarial Memorandum Exhibits are being updated with this submission. PA Plan Design Summary and Rate Tables and the Federal Rates Template will be updated at a future date. At that time, we will ensure that all templates are identical.

Member Pays	
CBC Pays	

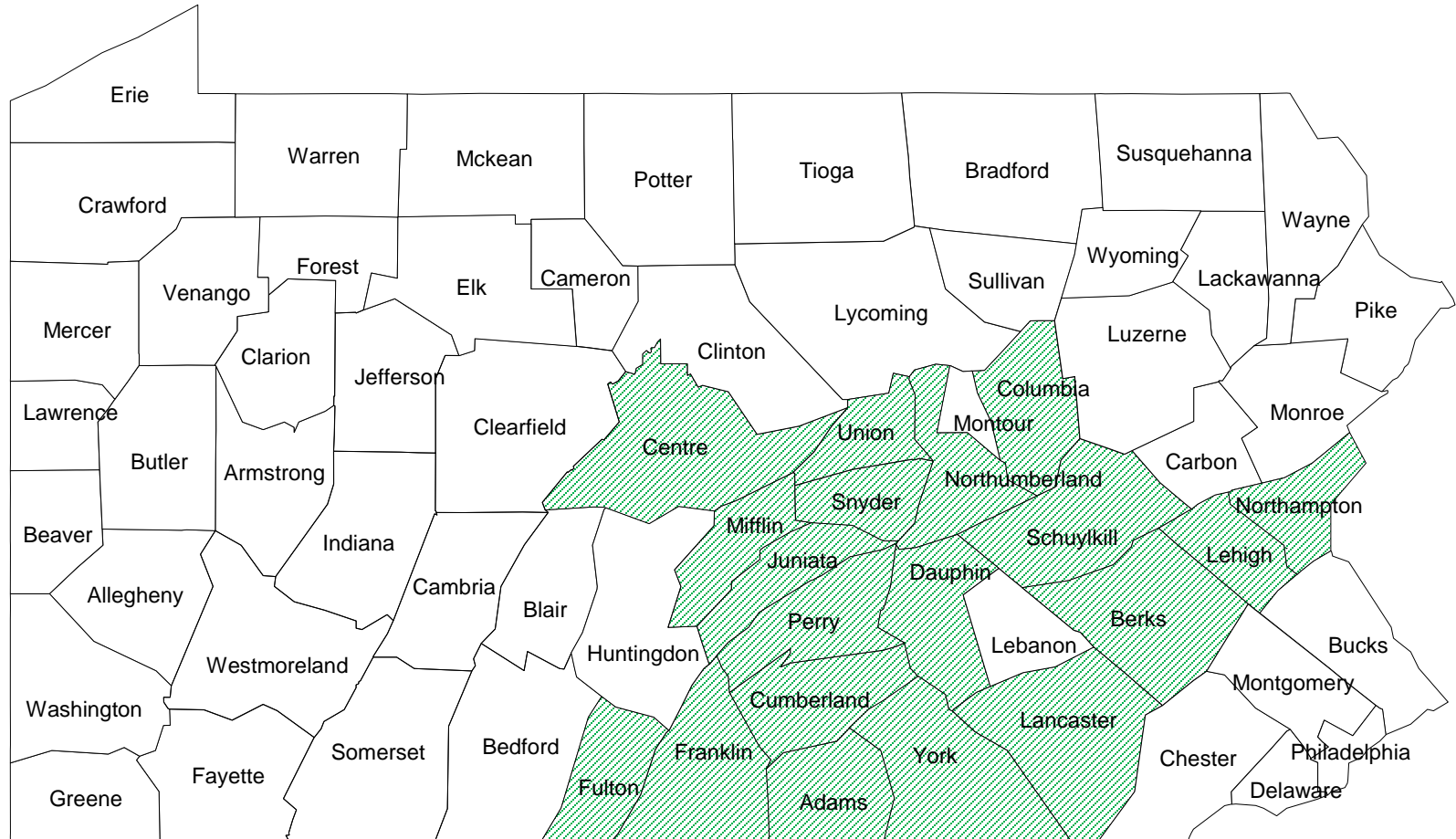
5,519
6.5%

Filing 18-12


2018 Service Area


Issuer: 53789

Market: Individual



Key *(modify as needed)*

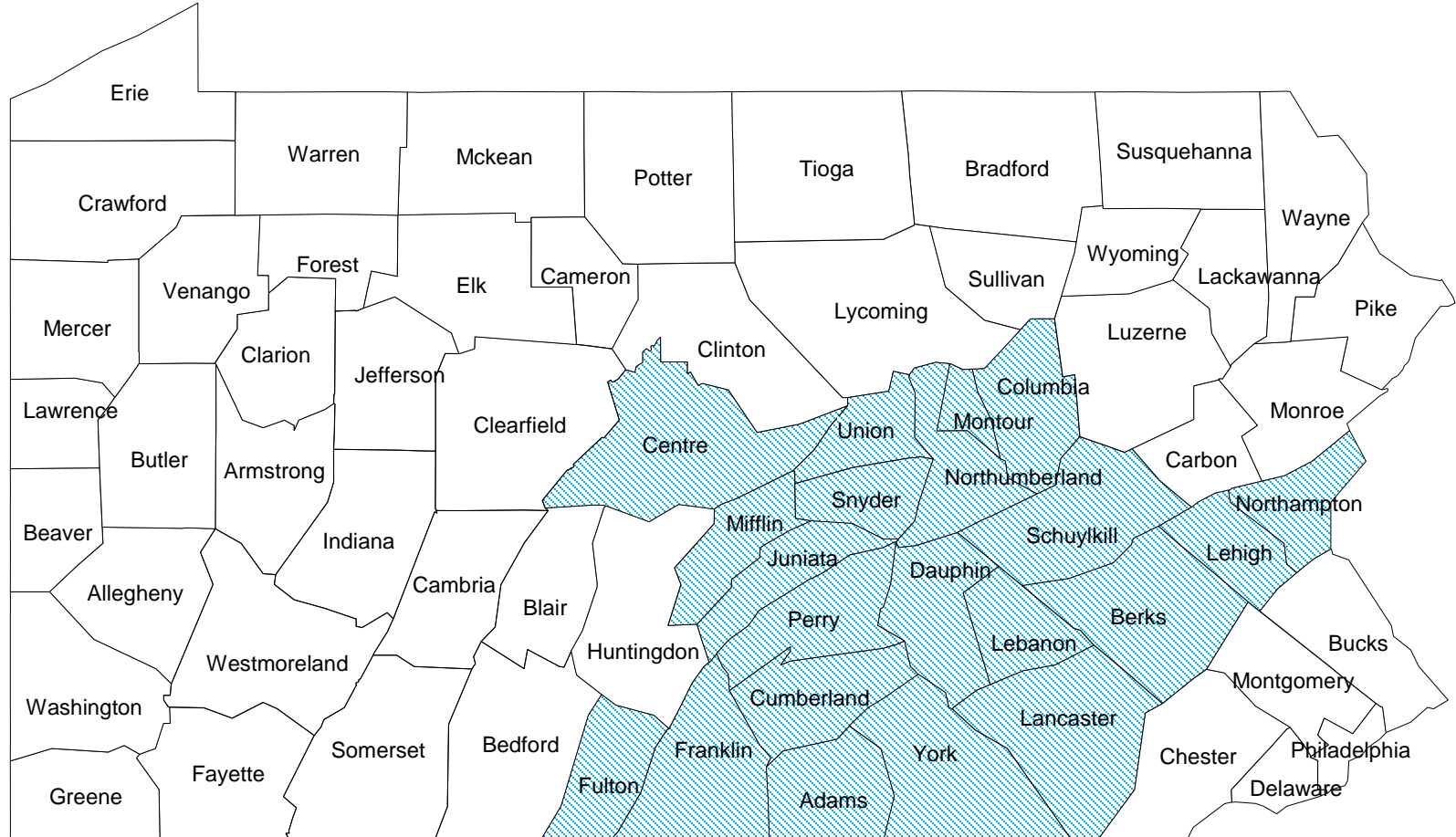
 : 2018 on-exchange service area

 : 2018 off-exchange only service area

2019 Service Area


Issuer: 53789

Market: Individual



Key (*modify as needed*)

 : 2019 on-exchange service area

 : 2019 off-exchange only service area