Filing at a Glance

Company:	Capital Advantage Assurance Company
Product Name:	Rates - CAAC Small Group Base Rates
State:	Pennsylvania
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003A Small Group Only - PPO
Filing Type:	Rate - Small Group Base Rate Modification
Date Submitted:	05/13/2015
SERFF Tr Num:	CABC-130076031
SERFF Status:	Assigned
State Tr Num:	CABC-130076031
State Status:	Received Review in Progress
Co Tr Num:	15-40
Implementation Date Requested:	01/01/2016
Author(s):	Pam Day, Anna Fulginiti, Mary Leberknight
Reviewer(s):	Rashmi Mathur (AH) (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

Proposed aggregate -2.4% rate change on 2016 small group On/Off Exchange PPO.
Binder #: CABC-PA16-125046672

State: Pennsylvania **Filing Company:** Capital Advantage Assurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO
Product Name: Rates - CAAC Small Group Base Rates
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 05/14/2015
State Status Changed: 05/14/2015
Created By: Pam Day
Corresponding Filing Tracking Number: CABC-130077463

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Anna Fulginiti

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
Rates - CAAC Small Group Base Rates

Company and Contact

Filing Contact Information

Stephanie Gray, Actuarial Associate
2500 Elmerton Avenue
Harrisburg, PA 17110

stephanie.gray@capbluecross.com
717-541-7269 [Phone]

Filing Company Information

Capital Advantage Assurance Company
2500 Elmerton Avenue
Harrisburg, PA 17110
(717) 541-7000 ext. [Phone]

CoCode: 14411
Group Code:
Group Name:
FEIN Number: 45-5492167

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*CABC-130076031*	***State Tracking #:***	*CABC-130076031*	***Company Tracking #:***	*15-40*

State:	*Pennsylvania*	***Filing Company:***	*Capital Advantage Assurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*		
Product Name:	*Rates - CAAC Small Group Base Rates*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Transmittal Letter (A&H)
Comments:	
Attachment(s):	SG_15-40_Initial_CAAC_PPO_RateCvLtr_Supporting_20150511.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Actuarial Memorandum
Comments:	
Attachment(s):	45127_01012016_SG_RedactedAM.pdf
Item Status:	
Status Date:	

Capital BlueCross

May 11, 2015

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

Re: **Capital Advantage Assurance Company**
Small Group Base Rates
Filing No 15-40
TOI/Sub-TOI Code: H16G Group Health - Major Medical / H16G.003A Small Group Only - PPO

Dear Mr. Camacci:

By this filing Capital BlueCross, on behalf of its wholly owned subsidiary Capital Advantage Assurance Company (NAIC # 14411), submits to the Department its Small Group Base Rates effective January 1, 2016. Products submitted by this filing will be made available to all small groups on and after January 1, 2016.

The Patient Protection and Affordable Care Act (PPACA) sets forth market reform requirements for small groups with plan years beginning on or after January 1, 2014. This filing complies with the following parts of the Code of Federal Regulations (CFR):

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

In support of this filing, I have included an Actuarial Memorandum with supporting Exhibits, the Unified Rate Review Template, Rates Template, and Service Area Template.

If you have any questions regarding this filing, please call me at 717-541-7269 (or via email at Stephanie.Gray@capbluecross.com) or Mark Spitler at 717-541-6613 (Mark.Spitler@capbluecross.com. Thank you for your assistance in this matter.

Sincerely,

Stephanie Gray, ASA, MAAA
Actuarial Associate
Capital BlueCross

Enclosures

cc: Mark Spitler, FSA, MAAA, Senior Director, Actuarial Services
Mell McKelvey, ASA, MAAA, Vice President, Actuarial Services
Patricia Wong, Corporate Counsel

CAPITAL ADVANTAGE ASSURANCE COMPANY, INC.

ACTUARIAL MEMORANDUM
Small Group Rates
Effective January 1, 2016

General Information

Company Information

- Company Legal Name: Capital Advantage Assurance Company – CAAC
- State: PA
- HIOS Issuer ID: 45127
- Market: Small Group
- Effective Date: 1/1/2016

Company Contact Information

- Primary Contact Name: Stephanie Gray
- Primary Contact Telephone Number: (717) 541 – 7269
- Primary Contact Email Address: Stephanie.Gray@capbluecross.com

Scope and Purpose

By this filing, Capital Advantage Assurance Company (CAAC), a subsidiary of Capital BlueCross (CBC), submits rates for products to be made available to all small groups on and after January 1, 2016. CAAC will offer small group products both on and off the federally-facilitated exchange (SHOP).

Proposed Rate Increases

CAAC is proposing an aggregate [redacted] rate change from fourth quarter 2015, equating to an aggregate annual increase of [redacted]. The rate change does vary by plan.

There are several benefit changes being implemented in 2016. 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. All terminated plans are listed in Exhibit R, and a summary of proposed 2016 benefits is included in Exhibit A.

Experience Period Premium and Claims

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

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

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

Allowed and Incurred Claims during the Experience Period:

	Incurred	Allowed
Amount of claims processed through the issuer's claim system:	[redacted]	[redacted]
Amount of claims processed outside of the issuer's claim system:	[redacted]	[redacted]
Amount of claims that represent best estimate of incurred but not paid:	[redacted]	[redacted]

Allowed claims are developed by combining paid claims with member cost-sharing.

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.

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

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

Benefit Categories

Claims in the benefit categories displayed in the URRT come directly from CBC's data warehouse. See Exhibit B for a description of benefits by benefit category.

Projection Factors

Changes in Morbidity of the Population Insured: CAAC expects changes in morbidity in its small group population from the experience period. This is a direct impact of the transitional policy. The transitional policy, which was first released in November 2013 and extended by a letter released in March 2014, allows small groups to keep their current coverage through 2016. For CAAC, this policy impacts groups renewing June through December, with December being CAAC's largest renewal month. The transitional policy will allow groups to select the lowest premium, with the lowest morbidity groups keeping their current coverage and the highest morbidity groups opting for ACA-compliant coverage. CAAC's transitional selection impact estimate is found in the URRT, Worksheet 1,"Pop'l Risk Morbidity".

Changes in Benefits:

1. Pediatric Dental and Pediatric Vision: The following PMPM allowed charges are added to the projection period allowed claims PMPM:

   - Pediatric dental coverage: [redacted]
   - Pediatric vision coverage [redacted]

   These were added to the projected allowed claims in Exhibit B by applying a factor of 1.52 to the experience period, "Other Medical" claims. The development of pediatric dental and vision projected claims are described below.

   Pediatric Dental Rating: The first step in the pediatric dental rating was to gather utilization data, by procedure code, for members under the age of 20 from CAAC's subsidiary dental company for calendar year 2014. The utilization was then adjusted to reflect the change in utilization due to the difference in benefits between the underlying population and the plan being priced. This adjusted utilization was then aligned with scheduled reimbursement levels and coinsurance levels. It was also adjusted for in-network and out-of-network usage, assuming [redacted] out-of-network utilization for each procedure code. Multiplying the expected utilization by the copayment and blended coinsurance gives an estimate of claim costs for each procedure per member per year. Summing these amounts for all procedure codes gives an estimated claim cost per

member per year. A vendor-sourced claim probability distribution was used to value any deductible.

Pediatric Vision Rating: In accordance with EHB guidelines, CAAC annually covers one vision exam, one set of eyeglass frames, and one set of contact lenses for each covered child. The following assumptions were made to develop premium rates:

- [redacted] percent of children will need glasses and/or contacts.
- Each child in need of glasses and/or contacts will receive them annually.

Given these assumptions, we can conclude that each time a child gets new glasses, CAAC will be liable for a [redacted] exam, [redacted] for frames, and [redacted] for lenses. This means CAAC will pay [redacted] per year for approximately [redacted] of the pediatric population. So:

Per Child Per Month Claim Cost = [redacted].
This translates into $0.46 incurred claims PMPM ([redacted] allowed PMPM).

Dental and Vision Vendor Services Background: Dental and vision benefit services are handled by vendors with claims systems, networks and general expertise in those specialized markets. The dental vendor is Dominion Dental Services (DDS) located in Alexandria, VA. Vision vendor services are handled by National Vision Administrators (NVA), located in Clifton, NJ. The categories of expertise each specialty vendor offers are as follows:

- Network credentialing and contracting
- Claim adjudication
- Claim reporting
- Customer Service
- General expertise

CBC performs all underwriting, premium billing, group reporting and risk bearing functions. CBC is treated as an Administrative Services Only (ASO) group by the specialty vendors, meaning CBC retains the insurance risk while the vendors administer the tasks bulleted above. Since CBC retains the insurance risk on these programs, CBC also calculates and reports outstanding claims liabilities. When CBC performs the underwriting for our individual and group business, underwriters reach out to the vendors to understand the impact of future contracting increases (when deriving pricing trends), and use the information calculated in outstanding claims liability estimation to apply an Incurred But Not Reported (IBNR) factor to incomplete claims.

See Exhibit C for the pediatric dental and vision rate development.

Changes in Demographics: CAAC does not expect changes in demographics in its small group population.

Other Adjustments: Found in URRT, Worksheet 1, "Other".

- List-Billed Adjustment: CAAC is adjusting the claim experience for the impact of the list-billing rating methodology required under CFR Part 147.102. This section requires that family rates are calculated by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account. This rating rule requires an adjustment to premium.

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

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

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

Year 2012

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

Year 2013

Type of Service	Units	Cost per Unit
X-Ray	0	$200

MRI	2	$5,000
Total	2	$10,000

Total Annual Trend	92%

2. 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. CAAC strives to mitigate the underwriting cycle by keeping trends consistent through times of increasing and decreasing claim costs and utilization.

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

Credibility Manual Rate Development

For the purpose of rate development, [redacted]. Combining the experience is actuarially justifiable for several reasons:

[redacted]

[redacted] All data is trended and benefit-adjusted in the same manner as the experience data (same projection factors and trend).

Credibility of Experience

Credibility Manual Rate Development: As seen in the URRT, the CAAC experience data and the credibility manual are very closely aligned. [redacted].

Paid to Allowed Ratio

CAAC used the prescribed URRT allowed claims 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, CAAC 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
    b. BEP Member Months

2. Develop BEP *Paid and Incurred Claims*:

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

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

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

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

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.

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

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

$$Projected\ Paid\ and\ Incurred\ Claims\ PMPM = [Trended\ Claim\ PMPM] \times [Benefit\ Adjustment] \times [Morbidity\ Adjustment] \times [List - Billed\ Adjustment]$$

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

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

    a. CAAC 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 (Healthy Benefits PPO 0.0 15 | Rx $250). The projected experience period data is then adjusted to the base plan:

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

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

$$Base\ Plan\ Paid\ and\ Incurred\ Claims\ PMPM = \frac{Benefit\ Adjusted\ Paid\ and\ Incurred\ Claims\ PMPM}{Benefit\ Level\ Adjustment}$$

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:

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

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:

$$Projected\ Claims\ PMPM\ Benefit\ A = Projected\ Claims\ PMPM\ Base\ Plan \times Pricing\ Relativity\ A$$

b. And to arrive at the *Total Projected Claims PMPM*, CAAC assumes a distribution of members across the benefit plans being offered in 2016. The *Total Projected Claims PMPM* :

$$= Projected\ Claims\ PMPM\ Benefit\ A \times Expected\ Member\ Dist\ of\ Benefit\ A + Projected\ Claims\ PMPM\ Benefit\ B \times Expected\ Member\ Dis\ of\ Benefit\ B + \cdots$$

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

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

See Exhibit G for the development of the *Paid-to-Allowed Ratio*.

Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

Relevant to 2016 pricing is the impact of Commercial Risk Adjustment (CRA) payment transfers that are expected to be earned in 2016. The 2016 pricing impact is:

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

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. The impact of transitional policies throughout the remainder of 2015 and 2016
5. The impact sequestration may plan on CRA payment transfers

[redacted].

To fund the HHS-risk adjustment program, issuers will remit to HHS a fee of $0.15 PMPM. The Risk Adjustment Fee PMPM is included in the URRT Worksheet 1, "Projected Risk Adjustments PMPM".

[redacted]

Projected ACA Reinsurance Recoveries:

$$[Net\ Projected\ ACA\ Reinsurance\ Recoveries\ PMPM] = [Projected\ ACA\ Reinsurance\ Recoveries\ PMPM] - [Reinsurance\ Contribution\ PMPM]$$

Reinsurance recoveries are equal to $0 in the small group market. The required reinsurance contribution to be paid in 2016 is $27 PMPY or $2.25 PMPM for each insured and self-insured enrollee in 2016. The reinsurance contribution amount is included in the URRT Worksheet 1, "Projected ACA reinsurance recoveries, net of rein prem, PMPM".

$$[Net\ Projected\ ACA\ Reinsurance\ Recoveries\ PMPM] = 0 - 2.25 = -2.25\ PMPM$$

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

1. Administrative Expense: Calculated using an allocation method from CAAC'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 for the percentage of time spent on PPO versus HMO versus Drug versus Medicare. And separately will ask for the percentage of time 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 CAAC small group products. Administrative expenses are included in the URRT Worksheet 1, "Administrative Load".
2. Broker Expense: Calculated based on CAAC's explicit per contract broker fee. See Exhibit E for historical CBC broker PMPMs in the small group market. Broker Expense is included in the URRT Worksheet 1, "Administrative Load".
3. [redacted]

Profit (or Contribution to Surplus) & Risk Margin:

4. Contingency: Contingency is included in the URRT Worksheet 1, "Profit and Risk".

Taxes and Fees:

5. Fee for Patient-Centered Outcomes Research Trust Fund (PCOR): As per the Notice of Proposed Rulemaking for Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund (REG-136008-11), 77 Fed. Reg. 22691: For policy years ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount in $2 per member per year ($0.17 PMPM), trended annually. At an estimated trend of 4%, the 2016 projected fee is $0.18 PMPM. PCOR is included in the URRT Worksheet 1, "Taxes and Fees".
6. Health Insurer Tax (HIT) – Section 9010 of PPACA and Section 1406 of the Reconciliation Act (which modified PPACA) refer to HIT. The fee is a fixed-dollar amount distributed across health insurance providers: $8 billion in 2014, $11.3 billion in 2015-2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, HIF rises according to an index based on net premium growth. . The HIT is included in the URRT Worksheet 1, "Taxes and Fees".
7. Exchange Fee – All issuers participating in a federally-facilitated exchange will remit 3.5% of premium to HHS. . The Exchange fee is included in the URRT Worksheet 1, "Taxes and Fees". The exchange user fee is applied as an adjustment to the Index Rate at the market level.
8. Federal Income Tax: Projected that 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".

Additional Fee:

1. Health Reimbursement Account (HRA) Administrative Fee: Charged to HRA plans to cover the administration of bank accounts linked to these plans. Because this is a financial service offered by CAAC and not a service that is required to obtain health care, the HRA admin fee is only applied to HRA plans, and should not be spread across all plans.

See Exhibit H for all CAAC small group retention values.

Projected Loss Ratio

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

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 CAAC in the small group market segment. The single risk pool includes transitional products/plans for purposes of base rate experience. The projection period reflects experience of transitional policies to the extent that CAAC anticipates the members in those policies to be enrolled in fully ACA-complaint plans during the projection period. The impact of transitional policies is discussed in Projection Factors section above.

Index Rate

The experience period index rate is CAAC's allowed claims PMPM, set in accordance with the single risk pool provision. All CAAC covered benefits are categorized as Essential Health Benefits (EHBs), therefore no adjustment was made to the experience period index. Only two EHB categories are not included in the experience period: pediatric dental and pediatric vision. Pediatric dental and pediatric vision claim PMPMs are added to the projected index rate as described in the Projection Factors section above.

Projected Allowed Claims: The CAAC 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 groups renewing January – March (Index 1).
3. Trend Index 1 quarterly for the remainder of 2016. This results in Index 2 (April – June), Index 3 (July – September), and Index 4 (October – December).
4. The final projected index rate is the member weighted average of Index 1, Index 2, Index 3, and Index 4. Member distribution is based on CAAC's current enrollment by renewal month.

See Exhibit J for the calculation of the Index Rate.

Market Adjusted Index Rate

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

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

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

Plan Adjusted Index Rate

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

5. Adjustment for distribution and administrative costs: Described in Non-Benefit Expenses and Profit & Risk section above.
6. Tobacco Adjustment: No tobacco factor is applied, so no adjustment is necessary.

The development of the Plan Adjusted Index rate is found in Exhibit L. The average projected 2016 Plan Adjusted Index Rate is found in Exhibit M .

Calibration

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

Age Curve Calibration: The projected average age factor is [redacted]. This is calculated by taking the member-weighted average of current small group enrollment by age in CAAC, CAIC, and KHPC combined. Age factors are applied in accordance with CMS's Standard Age Curve.

Geographic Factor Calibration: The projected average geographic factor is 1.002. This is calculated by taking the member-weighted average of current small group enrollment by employer geographic location in CAAC, CAIC, and KHPC combined.

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

The calibration is:

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

All consumer-level adjustments are applied uniformly to all plans in the Single Risk Pool. These adjustments do not vary by plan. The calibration factors and development are found on Exhibit N and Exhibit O.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed as follows:

1. Member-Level Consumer Adjusted Premium Rate:

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

2. $[Family\ Consumer\ Adjusted\ Premium\ Rate] = \sum[Member - Level\ Consumer\ Adjusted\ Premium\ Rate]$
   With no more than three child dependents under age 21 taken into account

Small Group Plan Premium Rates: CAAC is filing quarterly small group rates with trend. Therefore, the Index Rate, Market Adjusted Index Rate, and Plan Adjusted Index Rate reflect the member-weighted average premium of the calendar year. The trend used to develop the quarterly rates is shown in Exhibit M.

Quarterly 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 entirely based on the federally issued AV Calculator.

AV Pricing Values

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

Membership Projection

The membership projections found in Worksheet 2 of the URRT were developed by assuming that a percentage of current small group members will purchases coverage through CAAC. This is consistent with current enrollment, but reflects new 2016 plan offerings in CBC-subsidiaries. The projection also considers transitional policies. Of the percentage of members projected to purchase through CAAC, some will remain in transitional policies, lessening the projected ACA-compliant membership. Projected membership on Worksheet 2 was entered as a product average, instead of by plan.

Terminated Products

See Exhibit R for a list of terminated products.

Warning Alerts

Warning alerts occur in Worksheet 2, Section IV: Projected (12 months following effective date). This is because the URRT allows product average member-month projections to be

entered, but does not allow product average Plan Adjusted Index Rates to be entered. Therefore, the composite projected Plan Adjusted Index Rate and Total Projected Premium do not match Worksheet 1.

Attachments and Examples

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

Exhibit A – Benefit Summary
Exhibit B – Benefit Categories
Exhibit C – Pediatric Dental and Vision Rate Development
Exhibit D – Benefit Changes
Exhibit E – Trend
Exhibit F – Credibility Manual Development
Exhibit G – Paid-to-Allowed Development
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
Exhibit R – Terminated Products

Actuarial Statement

I, Stephanie Gray, 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, Stephanie Gray, 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.

Stephanie Gray, ASA, MAAA
Actuarial Associate
Capital BlueCross

SERFF Tracking #:	*CABC-130076031*	***State Tracking #:***	*CABC-130076031*	***Company Tracking #:***	*15-40*

State:	*Pennsylvania*	***Filing Company:***	*Capital Advantage Assurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*		
Product Name:	*Rates - CAAC Small Group Base Rates*		
Project Name/Number:	*/*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Data Request Sent	Rashmi Mathur	07/07/2015	07/07/2015

Response Letters

Responded By	Created On	Date Submitted
Pam Day	07/21/2015	07/21/2015

State: Pennsylvania **Filing Company:** Capital Advantage Assurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO
Product Name: Rates - CAAC Small Group Base Rates
Project Name/Number: /

Objection Letter

Objection Letter Status	Data Request Sent
Objection Letter Date	07/07/2015
Submitted Date	07/07/2015
Respond By Date	07/21/2015

Dear Stephanie Gray,

Introduction:

The Pennsylvania Insurance Department has received and conducted a review of the above captioned filing. In order to complete the review, we are requesting the following information. To facilitate a timely review, we request this information be provided within 14 days of the date of this letter. If you have any questions or difficulties in providing the data within this time frame, please call me.

1.Please list all factor changes proposed in this filing relative to the approved 2015 rate filing and discuss the rationale for the changes.
2.Please discuss the plan design changes (benefit and cost sharing) for the new plans and the uniform modifications to the existing plans and discuss why these changes have been proposed? What is the net cost change to benefits?
3.Please demonstrate that the plans included in this filing are uniform benefit modifications to existing plans offered in 2015 and, further, that the modifications are consistent with the CMS guidance (CMS-9949-P) regarding uniform benefit modifications as identified below:
•(2) For purposes of this paragraph (f), modifications made solely pursuant to applicable Federal or State law are considered a uniform modification of coverage. Other types of modifications are considered a uniform modification of coverage if the product that has been modified meets all of the following criteria:
(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act).
(ii) The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO)).
(iii) The product covers a majority of the same counties in its service area;
(iv) The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act.
(v) The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

4.Please provide the AV screenshoots, and the schedule of benefits for each plan offered in 2016. Please include the contract form number on each schedule of benefit. Also, provide the 2015 schedule of benefits for each currently offered plan including the corresponding contract form number on each schedule of benefit.
5.Please provide the quantitative development of the factor 1.521 in the Projection Period Adjustment "Other" in the Other Medical Benefit category on URRT Worksheet I.
6.Worksheet II of the URRT does not show the terminated plans. Please discuss why they are not shown.
7.Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding and certify that you are in compliance.
8.Was base data adjusted for high or low volume of large claims?
9.Please provide the quantitative development of the morbidity as shown in Exhibit G (1.028=1.11/1.08).
10.For the January 1, 2016, through October 1, 2016 will CAAC allow current enrolled groups of size 51-100 transitional relief? That is, will you allow a particular enrolled group to continue under the large group rating process? What is your current (2015) definition of small group? Please be advised that the experience period data should only include groups that meet the 2-50 group size. However, in the projection period, expected claims experience should reflect group policies for employers with 100 or fewer employees that the issuer expects to be enrolled in single risk pool compliant plans during the projection period. This may be done through the projection factors, use of a manual rate, or combination of the two. Please acknowledge your company's understanding and compliance.

State: Pennsylvania **Filing Company:** Capital Advantage Assurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO
Product Name: Rates - CAAC Small Group Base Rates
Project Name/Number: /

Conclusion:

Upon receipt of your responses to the above requested data, the Department will continue to review your filing. Please note that there may be additional questions and/or requirements after reviewing the above data.
Should you have any questions regarding this correspondence, please contact me at (717) 783-0675 or e-mail at rmathur@pa.gov.
Sincerely,

Rashmi Mathur, ASA, MAAA
Actuary
Bureau of Life, Accident & Health Insurance
Office of Insurance Product Regulation & Administration

Sincerely,
Rashmi Mathur

SERFF Tracking #:	*CABC-130076031*	***State Tracking #:***	*CABC-130076031*	***Company Tracking #:***	*15-40*

State:	*Pennsylvania*	***Filing Company:***	*Capital Advantage Assurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*		
Product Name:	*Rates - CAAC Small Group Base Rates*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Rate Response Redacted
Comments:	
Attachment(s):	SG_15-40_Revised_CAAC_PPO_RateResponseRedacted_Supporting_20150729.pdf
Item Status:	
Status Date:	

CAPITAL ADVANTAGE ASSURANCE COMPANY, INC.

Question and Answer

Small Group Rates

Effective January 1, 2016

Please note that all Q&A exhibits related to this discussion are found in file, "SG_15-40_Initial_CAAC_PPO_RateResponseExhibits_Supporting_CONF_20150729" unless otherwise noted.

Also, "SG_15-40_Revised_CAAC_PPO_RateDev_Supporting_CONF_20150729" is being submitted with this Q&A to address some changes to the rate development noted in the answers below.

Question 1. Please list all factor changes proposed in this filing relative to the approved 2015 rate filing and discuss the rationale for the changes.

Answer 1. The following bullets describe the rating elements being changed by this filing as well as rationale for the changes.

1. Base Experience Data (BEP): With this filing, CAAC is submitting updated BEP data. The BEP includes completed fee-for-service paid and incurred claims for dates of service between January 1, 2014 and December 31, 2014, paid through March 31, 2015. The previously submitted BEP for rates effective 1/1/2015 was for paid and incurred claims for dates of service between January 1, 2013 and December 31, 2013, paid through April 30, 2014.

2. Trend: CAAC is using the following pricing trends is this filing:

   Medical: 7% (changed from 9% in 1/1/2015 filing)
   Drug: 12% (changed from 5% in 1/1/2015 filing)

   The updated trend levels reflect our best estimate of changes in utilization, provider reimbursement contracts, the network of facilities and providers, disease management initiatives and the impact of utilization management. Note that the rise in drug trends are supported by historical data. While CAAC anticipates historical drug trends to temper, higher than normal trends are expected to continue.

3. Retention: The following retention items are changing with this filing:

a. Admin: [redacted]

b. Broker Commissions: [redacted]

c. Reinsurance Contribution: $2.25 changed from $3.67. This is due to changes in Reinsurance Contribution fees from 2015 to 2016.

d. Risk Adjustment Fee: $0.15 changed from $0.08. This is due to changes in Risk Adjustment fees from 2015 to 2016.

e. Patient-Centered Outcomes Research Trust Fund (PCORTF): [redacted]. This is due to changes in PCORTF fees from 2015 to 2016.

f. Health Insurer Fee (HIF): [redacted]. This is due to updated estimates of what CAAC will pay for HIF in 2016 versus 2015.

4. Adjustment for Adverse Selection Caused by Transitional Policy: The adjustment to BEP claims is [redacted], changed from [redacted] in the 1/1/2015 filing. [redacted].

5. Regional Rating Factors: Regional Rating Factors are being updated with this filing to reflect current data showing differences in cost by region. Regional rating factors are changing as follows:

   a. Region 6: The factor is 1.0 – no change from the 1/1/2015 filing.

   b. Region 7: The factor is [redacted], changing from [redacted].

   c. Region 9: The factor is [redacted], changing from [redacted].

   The development of regional rating factors is found in the exhibits submitted with the actuarial memorandum – Exhibit Q – Regional Analysis. The differences in regional rating factors reflect only differences in cost of delivery, and do not include population morbidity differences by geographic area.

6. Calibration: Please see the exhibits submitted with the actuarial memorandum – Exhibit N – Calibration, as well as the Calibration section of the actuarial memorandum starting on page 13. A calibration must be performed in order to apply the allowable rating factors (age and geography) to the Plan Adjusted Rate in order to calculate the Consumer Adjusted Premium Rates.

   The calibration factor is 1.465, changing from 1.524. [redacted]. It also is changing slightly due to the updated age distribution expectation in the projection period, which changes the aggregate expected age factor impact.

7. Actuarial Value and Cost Sharing adjustment: The Actuarial Value and Cost Sharing Adjustment is determined using CAAC's actuarial cost model. CAAC 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.

Per this filing, Actuarial Value and Cost Sharing adjustments are changing, and the change varies by plan. The adjustments are updated to reflect changes in CAAC's actuarial cost model. Differences in health status are not included in these adjustments.

Question 2. Please discuss the plan design changes (benefit and cost sharing) for the new plans and the uniform modifications to the existing plans and discuss why these changes have been proposed? What is the net cost change to benefits?

Answer 2. Q&A Exhibit 2 shows the cost-sharing changes by plan. Every cost-sharing change was made in order to maintain the same level of coverage (metal level) as in 2015. Any 2015 plan that could not be modified to meet the same metal level in 2016 was terminated. These changes meet bullet (iv) of CMS guidance (CMS-9949-P) regarding uniform benefit modifications. Note that most changes are minor changes to copays in order to meet AV. In some cases, changes were made to the deductible, coinsurance, and/or out-of-pocket max.

A benefit change being implemented across all small group plans in 2016 is the inclusion of coverage for Autism Spectrum Disorder (ASD). PA Autism Insurance Act (Act 62) requires private health insurance companies to cover the cost of diagnostic assessment and treatment of ASD for children under the age of 21. Act 62 applies to insured employer groups having 51 or more employees. Because groups with less than 100 employees will be able to purchase small group ACA-compliant plans in 2016, CAAC included mandated ASD coverage across all plans. This benefit change meets bullet (v) of CMS guidance (CMS-9949-P) regarding uniform modification.

Question 3. Please demonstrate that the plans included in this filing are uniform benefit modifications to existing plans offered in 2015 and, further, that the modifications are consistent with the CMS guidance (CMS-9949-P) regarding uniform benefit modifications as identified below:

(2) For purposes of this paragraph (f), modifications made solely pursuant to applicable Federal or State law are considered a uniform modification of coverage. Other types of modifications are considered a uniform modification of coverage if the product that has been modified meets all of the following criteria:

> (i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act).
> (ii) The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO)).
> (iii) The product covers a majority of the same counties in its service area;
> (iv) The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act.
> (v) The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

Answer 3. See Answer 2 above. Each benefit change (benefit and cost-sharing) meets CMS-9949-P stated above.

Question 4. Please provide the AV screenshots, and the schedule of benefits for each plan offered in 2016. Please include the contract form number on each schedule of benefit. Also, provide the 2015 schedule of benefits for each currently offered plan including the corresponding contract form number on each schedule of benefit.

Answer 4. Please see attachment "SG_15-40_Initial_CAAC_PPO_RateExhAVScreenShots_Supporting_CONF_20150721.xlsm" for AV screenshots for each small group plan. The 2016 schedule of benefits is found in form filing 15-66, CABC-130077463, and the 2015 schedule of benefit is found in form filing 14-43, CABC-126641135.

Question 5. Please provide the quantitative development of the factor 1.521 in the Projection Period Adjustment "Other" in the Other Medical Benefit category on URRT Worksheet I.

Answer 5. The factor of 1.521 in the Projection Period Adjustment "Other" is being changed to 1.414 due to data changes in the Credibility Manual development (Exhibit F – Credibility Manual Development for URRT), and a correction to the projected pediatric dental and vision allowed amounts. The initial development of the credibility manual did not include pediatric dental and vision claims and utilization in the BEP. The updated development fixes this issue, and therefore decreases the projection factor needed in the "Other" category. The projection factor in the "Other" category is designed to adjust experience period claims for pediatric dental and pediatric vision coverage in 2014. While coverage for these benefits began 1/1/2014, the claims experience is not credible. So the projection factor is designed to take claims in the "Other" category and adjust them up for these benefits. See Q&A Exhibit 3 for the development of 1.414.

Please note that the projection factor does not impact the final rates. The projection factor is meant to align the URRT allowed amounts with projected paid amounts. The change to the projection factor in this category has a minor impact to the total allowed claims PMPM, and subsequently has a minor impact to the calculated Paid-to-Allowed factor shown in Exhibit G – Paid to Allowed Ratio Development. Also, Exhibit F – Credibility Manual Development for URRT, Exhibit J – Index Rate (for corrected pediatric dental and vision allowed PMPMs), Exhibit K – Market Adjusted Index Rate, Exhibit L – Rate Development (for AV and Cost-Sharing adjustments based on the corrected Index Rate), and the Actuarial Memorandum are being updated to reflect this change. All Exhibit changes are found in "SG_15-40_Revised_CAAC_PPO_RateDev_Supporting_CONF_20150721.xlsx".

Question 6. Worksheet II of the URRT does not show the terminated plans. Please discuss why they are not shown.

Answer 6. The URRT instructions state the following:

Each single risk pool compliant plan that was effective during the experience period and is terminated prior to the rating period and "mapped" (i.e. auto-enrolled) into another single risk pool compliant plan in the Projection Period must be completed in a separate column with the plan name in the following manner:

- *Information in Section 1 and II should be completed for the plan ID effective in the projection period. The rate increase should be measured from the terminated plan ID to the new Plan ID. Section III should reflect the experience associated with the terminated plan ID.*
- *Information in Section IV should reflect the expected projections of the new Plan ID.*

Every single risk pool terminated plan has been mapped (auto-enrolled) into another single-risk pool plan, therefore the URRT has been completed correctly with data in the experience period and projection period completed according to the instructions.

Question 7. Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding and certify that you are in compliance.

Answer 7. I acknowledge that I understand the above, and certify that the CAAC small group URRT is in compliance. The URRTs in SERFF and in HIOS are the same. I also certify that any future updates to the URRT will comply by this rule.

Question 8. Was base data adjusted for high or low volume of large claims?

Answer 8. [redacted]. Prevalence of high claims within market segments and blocks of business are routinely reviewed for purposes other than rating, such as liability estimation/accrual, fraud and up-coding detection, provider contracting provisions - such as outlier claim provisions. [redacted].

Question 9. Please provide the quantitative development of the morbidity as shown in Exhibit G (1.028=1.11/1.08).

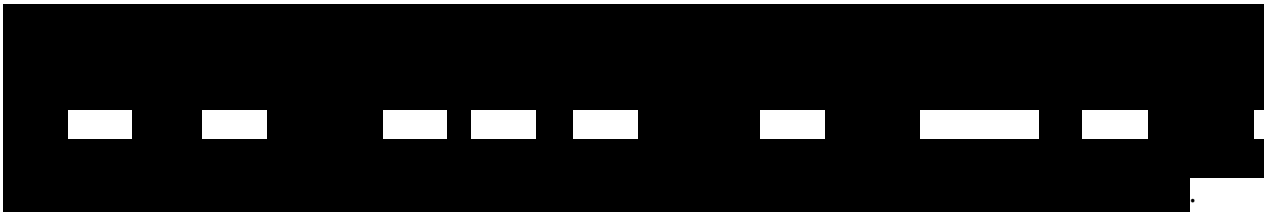
Answer 9. The adverse selection factor of [redacted] was applied to 2015 rates in order to cover the adverse selection associated with transitional policies. [redacted].

Question 10. For the January 1, 2016, through October 1, 2016 will CAAC allow current enrolled groups of size 51-100 transitional relief? That is, will you allow a particular enrolled group to continue under the large group rating process? What is your current (2015) definition of small group? Please be advised that the experience period data should only include groups that meet the 2-50 group size. However, in the projection period, expected claims experience should reflect group policies for employers with 100 or fewer employees that the issuer expects to be enrolled in single risk pool compliant plans during the projection period. This may be done through the projection factors, use of a manual rate, or combination of the two. Please acknowledge your company's understanding and compliance.

Answer 10. [redacted].

Our 2014-2015 definition of small group was any employer with less than 51 employees. CAAC's currently submitted URRT contains small group data for employers under 100 contracts, not under 51. CAAC is resubmitting a URRT to both SERFF and HIOS in order to adjust the experience period data to

only include groups with less than 51 employees. We are using the credibility manual to adjust the experience period to the projection period.



Question 11. Please provide a certification that the geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

Answer 11. I certify that geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area. Please see file, "SG_15-40_Revised_CAAC_PPO_RateDev_Supporting_CONF_20150729". The allowed claim PMPMs by county are normalized for demographics, which in a large data sample is the same as normalizing for risk.

If you have any questions regarding this filing, please call me at 717-541-7269 (or via email at Stephanie.Gray@capbluecross.com).

Sincerely,

Stephanie Gray, ASA, MAAA

Actuarial Associate

Capital BlueCross