SERFF Tracking #:	*ARBB-131126999*	***State Tracking #:***	*ACA OFF EXCHANGE ONLY*	***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*USAble Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*2018 QHP Ind Off Exchange Rate Filing*		
Project Name/Number:	*2018 QHP Ind Off Exchange/17-309, 17-310, 17-313 1/18*		

Rate Information

Rate data applies to filing.

Filing Method:	Review and Approve
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	9.700%
Effective Date of Last Rate Revision:	01/01/2017
Filing Method of Last Filing:	Review and approve

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
USAble Mutual Insurance Company	Increase	7.800%	7.800%	$78,774,424	184,064	$1,088,917,428	104.400%	-22.400%

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Product Name:	*2018 QHP Ind Off Exchange Rate Filing*		
Project Name/Number:	*2018 QHP Ind Off Exchange/17-309, 17-310, 17-313 1/18*		

Supporting Document Schedules

Satisfied - Item:	Redacted Actuarial Memorandum for Public Disclosure
Comments:	Please see attached.
Attachment(s):	Actuarial_MemoCert_ACA_2018_PartIII_Objection2_Redacted.pdf
Item Status:	Approved
Status Date:	09/20/2017

Satisfied - Item:	Arkansas Plain Language Summary
Comments:	Please see attached.
Attachment(s):	PlainLanguageSummary_PartII.pdf
Item Status:	Approved
Status Date:	09/20/2017

Actuarial Memorandum

Company Information

Company Name: **USAble Mutual Insurance Company**
State: **Arkansas**
HIOS Issuer ID: **75293**
Market: **Individual**
Effective Date: **1/1/2018**

Company Contact Information

Primary Contact Name: **Christi Kittler**
Primary Contact Telephone Number: **501-378-2967**
Primary Contact Email Address: **cmkittler@arkbluecross.com**

Proposed Rate Increase(s):

Arkansas Blue Cross and Blue Shield is requesting a -----% average rate increase ranging from -----% to -----%. The main reasons for the differences in rate increases are due to the required use of the 2018 Federal AV, model which caused many of our benefits to no longer be qualified at their prior metallic level and thus needed to be brought into compliance, new area factors that were based on a more stable block of our ACA business, and updated HHS-provided Age Curve factors for individuals under 21.

In general the factors that drove the proposed -----% average rate change include:

1) The return of the Health Insurer's Tax
2) Changes in benefits due to new 2018 Federal AV model which caused many benefits that were previously qualified to be not qualified requiring a change to bring them into compliance;
3) The single risk pool experience was more adverse than previously assumed in the current rates as evidenced by higher utilization and cost trends, which was determined to be -----% annually, whereas the prior year was around -----%.;

4) The components that make up the reason for the proposed rate increase are demonstrated in attached Actuarial Memo Dataset.
5) **The most important assumption is that we are assuming that the CSR will be paid, otherwise our rates are not adequate and we will need to revise our filing.**

Experience Period Premium and Claims

Premiums and Member Months were accumulated from Arkansas Blue Cross and Blue Shield non-grandfathered (Transitional) and ACA actual data for the 2016 calendar year. Arkansas Blue Cross Claims experience was accumulated from actual non-grandfathered (Transitional) and ACA incurred data for the 2016 calendar year and paid through May 31, 2017, and then completed via completion factors.

1) Premiums: $-----
2) Member Months: -----
3) Allowed Claims: $-----
4) Paid Claims: $-----

The completion factors used were based on Arkansas BlueCross BlueShield ACA claims experience from Jan-2014 through May-2017.

Allowed claims were extracted from the claim records. In the table below, the benefit categories are determined by using Arkansas Blue Cross actual data and inputting it into Milliman's Health Cost Guidelines software program which sums up the utilization, allowed claims, and paid claims by benefit types, which are easily identified to match up to the benefit categories in the Unified Rate Review Template workbook. Listed in the table below are the Total Allowed Claims split by benefit category and components.

Projection Factors:

Population Risk Morbidity:

1) Implementation of a Utilization Management program reduces the expected claims by -----%.
2) An adjustment made to determine the factors necessary to remove the Transitional Experience that is not expected to join the ACA from the experience data. This factor varied by Benefit Category but the overall average was an increase of -----%.
3) Beginning in April 2017, we have liberalized our acceptance of HEP C prescriptions, and as such we are seeing increases that are not captured in our trends of -----% on the Rx component, such that the overall impact is of increasing utilization by -----%.

Other:

1) The historical benefit structure was richer than the benefit structure of the benefits in this filing. Therefore, the historical allowed claims have been adjusted resulting in a reduction of -----%. This was accomplished by taking the current benefits along with the projected benefits and running them through our current benefit model, then taking a weighted average of each that was based on current membership.
2) The overall adjustment due to benefit changes and projected benefits chosen was a -----% decrease.
3) Comparing the 5/31/2017 members by region to the 2016 members by region results in a slight decrease to the experience data by -----%.
4) The 2016 average age factor using the ACA Age Factors was calculated and compared to those members in force as of 5/31/2017. This resulted in a slight decrease to the experience data by -----% due to age changes.
5) It was estimated that the impact to the claims experience due to the removal of the individual mandate would be a -----% increase.
6) We have added smoker rates for 2018 and have adjusted our needed standard premiums by normalizing the smoker impact to claims by reducing them by -----%.
7) For HIOS# -----, -----, ----- and ----- we have removed our out of state discount card which resulted in reducing cost by -----%.
8) We had contractual changes that occurred in 2017 and some additional ones in 2018 resulting in a reduction in claims expense. The impact was a reduction of -----% (-----% was done during the 2017 year after the 2017 rate filing).

Trend Methodology:

Monthly ACA data from January, 2014, through December, 2016, were used to estimate future allowed trends. The analysis used rolling-12 monthly incurred allowed per-member per-month (PMPM) claim costs by category (IP, OP, Professional, Other, Rx). The monthly incurred values were completed by category using a lag development methodology.

Similarly, monthly utilization totals were calculated and completed using a lag development methodology. The units were days, claim counts, visits, and scripts for In-Patient, Out-Patient, Other, Professional, and Rx claim types. Cost trend is calculated by category as the residual required to achieve the overall estimated trend by category.

Projected Allowed Experience Claims PMPM

Credibility Manual Rate Development

We made the Credibility Manual equal to the ACA experience as we believe the data to be 100% credible.

Paid-to-Allowed Ratio

The paid-to-allowed ratio was calculated using the following formula:

Sum of (Arkansas Blue Cross' benefit factor times projected allowed PMPM times projected member months, by plan)

divided by

Sum of (projected allowed PMPM times projected member months, by plan).

The resulting factor of ----- is consistent with the weighted average AV Metal Value of ----- as we have found our actual benefit model consistently runs lower than the Federal AV

Model. The main difference between these factors is the calculation of the value of copays between the AV Calculator and Arkansas Blue Cross' pricing model.

Risk Adjustment

Risk Adjustment: An internal model was built to score each member based on their diagnosis codes and eligibility according to the federally released logic for calculating a member's risk adjustment score. The study was performed on those members of ABCBS Individual customers who are expected to be Non-Grandfathered in 2018 and for our current ACA members. The results of these was then used to adjust the input to a model that duplicate the Wakely model described below.

The Wakely Actuarial Consulting Group performed a market study estimating what the risk adjustment payments would be for the different competitors in the market that participated in the study. The results of our internal study for Non-Grandfathered business were compared to the results for the other insurers. The results of our internal study and the Wakely study lead to the conclusion that, for this population, we expect to make a payment of something close to $----- PMPM for risk adjustment in 2017. For 2016, we made a payment of $----- PMPM.

The fee associated with the risk-adjustment program is $----- PMPY. The $----- PMPM, shown on worksheet 1 of the URRT, we expect to pay out was reduced by $----- PMPM to account for the risk-adjustment fee. This equals the $----- PMPM.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: The starting point for expenses is the actual Arkansas Blue Cross 2016 Individual ACA expenses less premium taxes and fees. Then, we trended this value using -----% annual trend to get to the expected 2018 expenses. The resulting PMPM is then converted to a percent of premium (i.e., -----%), which is a reduction from the percent of premium used in the 2017 filing. It was then applied equally across all plans.

Contribution to Surplus & Risk Margin: Margin has been set at -----% after FIT and is applied equally across all plans.

Taxes and fees: Averages out to -----%

1) Insurer fee (direct): -----%

2) Insurer fee (income tax impact): -----%
3) PCORI Fee: $----- PMPY
4) Exchange fee: -----% (-----% of premium for on-exchange members)
5) Premium Tax: -----% (due to premium tax credits)
6) Additional Premium Tax -----% (removal of premium tax credits for FFM and Private Option)
7) FIT of -----%

Projected Federally-prescribed Medical Loss Ratio: -----%

Single Risk Pool

The claims and member months in the experience period of the URRT represents all of ABCBS' Non-Grandfathered members regardless of whether the member is on a fully ACA-compliant product or a transitional policy. The index rate has been adjusted, on a market-wide basis for the state, based on total required market-wide payments and charges under risk adjustment, reinsurance programs, and exchange user fees. The only adjustments to the market-wide adjusted index rate are:

- Actuarial value and cost-sharing design of the plan
- State mandated benefits provided under the plan that are in addition to the essential health benefits. These benefits are pooled with similar benefits within the single risk pool.
- Other non-EHB

Index Rate

Experience Period: The index rate for the experience period is represented by the average allowed claims (excluding non-EHB claims) divided by the member months.

Projected Period: The "Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)" applies only to the metallic plans and includes benefits that are not EHB. The non-EHB benefits are Adult Vision Exams and the state-mandated Craniofacial Surgery. We have adjusted the Index rate accordingly.

Market Adjusted Index Rate

Plan Adjusted Index Rate: (HIOS # - 75293AR1200019)

Craniofacial Surgery: based on a study by Oliver-Wyman
Adult Vision Exam: determined using Arkansas Blue Cross benefit model
Actuarial Benefit Factor: Based on Arkansas Blue Cross benefit model but then the factor was adjusted for Risk Adjustment Fees and retention differences. The Exchange User Fees were determined on an overall pool basis and uniformly distributed across all plans. Distribution and administration costs are the same percent of premium for plans.

Calibration

Area calibration: There was no area calibration made to the Plan Adjusted Index rate because the Index rate was normalized to a statewide level so as to be consistent with the 2017 filing. The normalization was done by taking Arkansas Blue Cross area factors times the membership by region divided by the same membership.

Age calibration: The age calibration was calculated by using current ACA membership limited to no more than three dependent children times the HHS-provided Age Factors divided by the total members. This produced an Age Calibration Factor of -----. Replacing the Age Factors with actual member ages gives an approximate weighted-average age of -----. This single factor is used for all plans to determine the actual rate by age for each plan.

Final Premium Rates

The calculation to go from the Uniform Rate Review Template to a Premium rate is as follows:

Lowest Premium: $-----
Highest Premium: $-----

Note: Actual rate submitted is $-----. This rate is higher because of the minor correction that results in an overall -----% reduction but as we feel this is a de minimis value we have not adjusted our actual rates.

AV Metal Values

These values were all based on the AV Calculator

AV Pricing Values

These values were all based on an internal Arkansas Blue Cross pricing model. The model only adjusts utilization of benefits based on the cost share associated with the benefit.

Membership Projections

The membership projections found in Worksheet 2 of the Part I Unified Rate Review Template were developed by using the current membership and then identifying any anticipated new sales and assigning accordingly.

Terminated Plans

Listed below are the 2017 terminated plans and the plans that they were cross walked to. In 2016 there was a need to redo the HIOS numbers, and as such these are the plans from which the actual experience emanates from. What is shown below are those 2016 HIOS numbers associated with the 2017 plans that were terminated and their respective membership counts (average monthly counts for 2016).

Warnings

There are no warnings.

Qualifications

I, -----, hold the position of Senior Actuary for Arkansas Blue Cross Blue Shield (ABCBS). I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The purpose of this memorandum is to demonstrate the needed premium rates and its compliance with applicable laws State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)) and (45 CFR 156.80(d)(2)). Assuming that the Cost Sharing Reduction (CSR) is paid by the federal government, the anticipated loss ratio of this product meets the minimum requirement of Arkansas as given in bulletin 12-81. This rate filing is not intended to be used for other purposes.

These policies are comprehensive major medical policies

Arkansas Blue Cross Blue Shield
320 W. Capitol Avenue, Suite 840
Little Rock, AR 72201

ACTUARIAL CERTIFICATION

I, -----, hold the position of Senior Actuary for Arkansas Blue Cross Blue Shield. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I have reviewed the filing of the rates contained in this document. To the best of my knowledge and judgment, I certify that

1) The projected index rate is:
   a. In compliance with applicable laws State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
   b. Developed in compliance with the applicable Actuarial Standards of Practice,
   c. Assuming that Cost Sharing Reduction (CSR) is paid by the federal government, then it is reasonable in relation to the benefits provided and the population anticipated to be covered,
   d. Neither excessive nor deficient.
   e. Developed using only the permitted rating classifications.

2) The geographic rating factors reflect only differences in the cost of delivery and do not include population morbidity by geographic area.

3) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

4) 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.

5) 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.

6) Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Arkansas Blue Cross Blue Shield
320 W. Capitol Avenue, Suite 840
Little Rock, AR 72201

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company: USAble Mutual Insurance Company

SERFF tracking number:

Submission Date: 8/7/2017

Product Name: Individual Major Medical PPO

Market Type: (•) Individual ( ) Small Group

Rate Filing Type: (•) Rate Increase ( ) New Filing

Scope and Range of the Increase:

The 7.80% increase is requested because:

In general, the factors that drove the proposed 7.80% rate change has been in large part the utilization and cost trend of this block of business which was determined to be 8.64% of allowed claims overall annually. Also, the actual experience for 2016 came in higher than what was expected. We had projected a loss ratio for 2016 of 83.34%, whereas actual experience resulted in a loss ratio of 96.62%. This worse-than-expected experience lead to higher projected claims for 2017 and 2018.

This filing will impact:

# of Arkansas policyholder's 184,064 # of Arkansas covered lives 202,005

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 7.80 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved -22.4%
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 104. %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

If the individual is a tobacco user, then the rate may be an additional 20% higher.

Financial Experience of Product

The overall financial experience of the product includes:

Our current estimate of the demand for medical services is running higher than was originally expected, which has impacted the needed rates for 2018. Some of the reasons for this higher demand are

• Rates Reflect Cost of Care. The cost of providing healthcare has the biggest impact on health

The rate increase will affect the projected financial experience of the product by:

We believe the requested rate increase is necessary to adequately support these products as well as for meeting the federal Minimum Loss Ratio (MLR) requirement.

Components of Increase

The request is made up of the following components:

Trend Increases – 18 % of the 7.80 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

   This component is 11 % of the 7.80 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

   This component is 7 % of the 7.80 % total filed increase.

Other Increases – 82 % of the 7.80 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

   This component is 0 % of the 7.80 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

   This component is 24 % of the 7.80 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

   This component is 0 % of the 7.80 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

   This component is 10 % of the 7.80 % total filed increase.

5. Other – Defined as:

   Included is the increased cost due to any Federal Taxes and Fees, impact of the constantly changing demographic makeup, and any enhanced benefits.

   This component is 46 % of the 7.80 % total filed increase.