Tammy Tomczyk, FSA, MAAA

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4412
414 223 7988 Fax 414 223 3244
tammy.tomczyk@oliverwyman.com
www.oliverwyman.com

October 3, 2014

Ms. Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority
1100 15th Street, NW, 8th Floor
Washington, DC 20005

Subject:
Actuarial Review of CareFirst BlueCross BlueShield's January 2015 Rate Filings (BlueChoice Individual CFAP-129554176, BlueChoice Small Group CFAP-129567877, GHMSI Individual CFAP-129554331, and GHMSI Small Group CFAP-129567873)

Dear Executive Director Kofman:

At your request, we have undertaken a detailed review of the above four captioned filings submitted by CareFirst BlueCross Blue Shield (CareFirst) for products that are proposed to be offered in the individual and small group markets in the District of Columbia (the District) effective January 1, 2015. Two filings are for products proposed to be offered by Blue Choice, Inc. (BlueChoice) in the individual and small group markets and two are for products proposed to be offered by Group Hospitalization & Medical Services, Inc. (GHMSI) in the individual and small group markets. Our work was intended to be independent, but to also supplement the reviews conducted by the Department of Insurance, Securities and Banking (DISB), the District regulator tasked with rate approval authority, and assist them in conducting the volume of reviews that needed to be completed in short order. This letter summarizes the analysis we performed.

It is our understanding that only the information submitted in association with CareFirst's initial proposed and final proposed rates are considered to represent publicly available information, and that all correspondence between DISB and CareFirst throughout the review process is considered confidential. Given this version of our report will be made public, some detailed information that appear in the more thorough confidential version of this report have been redacted in order to comply with confidentiality requirements in the District. Therefore, in some cases we are unable to include a discussion of additional information provided by CareFirst that ultimately led us to agree or disagree with an assumption that was made.

Oliver Wyman is not engaged in the practice of law and this letter, which may include commentary on regulations, does not constitute, nor is it a substitute for, legal advice. There are no third party beneficiaries with respect to this letter, and Oliver Wyman does not accept any

liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect to the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

At your request, our review focused on the prescribed 15 items which are required in an effective rate review program, as highlighted in HHS regulation at 45 CFR 154.301, to the extent the necessary information was made available to us. The list is contained in Appendix A for reference, along with other District-specific items that were considered in our review. To ensure internal consistency in our reviews, we used a comprehensive effective rate review check list which we have developed in working with our various state clients.

Summary of Analysis Performed

Using the information in the filings, and notwithstanding the limitations that follow, it is our opinion that the rates for both BlueChoice and GHMSI could be reduced from the initially proposed levels. We estimate that the rates for BlueChoice could, on average, be reduced up to 9.9% in the Individual market and 4.4% in the Small Group market from originally proposed 2015 levels. We estimate that the rates for GHMSI could, on average, be reduced up to 7.2% in the Individual market and 5.2% in the Small Group market from originally proposed 2015 levels. The estimated reductions come primarily from potentially conservative trend assumptions, double counting of the District's Exchange assessment tax, not including an adjustment to base period experience to recognize lower average benefits in the projection period, and an unsupported load to rates attributable to adverse selection resulting from the early renewal of small groups.

Lastly, we note that additional adjustments, both positive and negative, could be made to individual plans if an adjustment factor, based on whether a health savings account (HSA) could be attached to a plan, were found to be unreasonable. It is also our opinion that the rates for the Catastrophic plan may be significantly underpriced. A table summarizing the key areas where we have found that assumptions could vary from those assumed by CareFirst, can be found in Appendix B.

Information Received and Data Limitations

While we were able to review and comment on the rate filings in most of the 15 key areas listed in Appendix A, there were some areas where we were not able to conduct an in-depth analysis due to data limitations.

On June 16, 2014, we received access to the four filings through SERFF. After downloading the filings, we performed an initial high level review for missing information and forwarded a listing of these items to both the DC Health Benefit Exchange (DC HBX) and DISB on June 20, 2014. While waiting for the carrier to provide the missing information we conducted a detailed review of the filing. We employed our standard effective rate review checklist and completed our initial review on June 30, 2014 at which time we forwarded a set of 10 questions to DISB for consideration. An additional 10 questions were sent on July 1, 2014.These questions ranged from requests for clarification of information provided in the filings to requests for information to

support or test various key assumptions made in the filings. On August 11, 2014 we received CareFirst's responses to these questions, as well as a revised filing.
We held the first of two calls with actuarial staff from CareFirst on August 18, 2014. During the call we discussed key remaining issues related to the filings, and assumptions for which we felt additional support or clarification was required. In follow-up to the call CareFirst provided additional information on August 22, 2014. A second call was held on August 25, 2014, and a second revised filing was submitted on August 28, 2014.

Our analysis was limited to the information included in the filings and CareFirst's responses to the questions posed. If additional information or clarification were to be provided, the results of our analysis may change. A detailed discussion of our analysis follows.

Analysis Performed

In this section we discuss each of the assumptions reviewed. Where sufficient information was provided to perform analysis and arrive at an independent estimate, we present the results of our analysis and a comparison with CareFirst's assumption(s), in those cases where CareFirst's assumptions are included in the publicly available information. In other areas, we indicate whether or not CareFirst's assumption appears reasonable or whether it appears over or understated. Unless specifically noted, the review applies to both the BlueChoice and GHMSI legal entities.

Rating Methodology

A reasonable methodology was utilized by CareFirst in developing the proposed 2015 rates, consistent with our understanding of the rating rules of the Affordable Care Act (ACA). An allowed claim cost per member per month (PMPM) was first developed for each specific legal entity based on claims experience for the period of calendar year 2013. The experience of the individual and small group markets for each legal entity was pooled, consistent with requirements of the District. The experience for both BlueChoice and GHMSI is considered by CareFirst to be fully credible; therefore a manual rate was not developed.

The following adjustments were then applied to the base claims experience to develop the projected Index Rate, which represents an allowed claim cost consistent with demographics and benefit levels anticipated in 2015:

- Allowed Claims Trend
  - Cost
  - Utilization
- Impact of Change in Pharmacy Benefits Manager
- Reduction in Fee Schedule for Out-of-Network Services
- Future Population Morbidity Changes
  - Change in Demographics
  - Impact of early renewing small groups
- Essential Health Benefit (EHB) Adjustment
- Impact of New Medical Incentive Program

Next, a Market Adjusted Index Rate was calculated as required by the ACA. In developing the Market Adjusted Index Rate, the following adjustments were applied to the Index Rate:

- Market Level Reinsurance Recoveries (Individual Market Only)
- Market Level Risk Adjustment

We note that both the reinsurance and risk adjustment factors were applied on a market wide basis consistent with ACA rules. While Exchange user fees are also to be applied on a market wide basis, CareFirst did not incorporate the cost of any Exchange user fees at the market level given the fee assessed to finance DC Health Link is a broad based tax applied to all health insurance policies sold within the District. CareFirst views this assessment as a tax and therefore accounts for it as an adjustment at the plan level. Since the adjustment applied at the plan level is the same for all plans, the impact on rates is the same as if it were applied at the market level.

Next, a Plan Adjusted Index Rate was calculated for each plan design as required by the ACA. The allowable plan level adjustments as outlined in 45 CFR 156.80(d)(2) are:

- Cost Sharing Design of the Plan
- Provider Network and Delivery System Characteristics of the Plan
- Benefits in Addition to EHB
- Administrative Costs, excluding exchange user fees
- For Catastrophic Plans, the Expected Impact of the Eligibility Categories for the Plan

We discuss the reasonability of the adjustments and assumptions which were utilized in developing the proposed rates in the sections that follow.

Index Rate Development

According to 45 CFR 156.80(d), the index rate is to reflect the average expected allowed cost for EHBs during the projection period. While Federal regulations require that the individual and small group markets within a state be either separate or merged for all purposes, the District has received Federal approval to implement a quasi-merged market. District rule requires that the combined experience of a carrier's individual and small group business must be used to develop a single index rate that applies to both markets, however market level and plan level modifiers specific to the applicable market, as applicable, must be used. In developing the index rate, there are several adjustments that must be made to the base period experience to reflect differences between the population, provider costs and benefits underlying the single risk pool and those expected in the projection period. These include but are not limited to changes in covered services, morbidity, demographics, trend, and induced demand based on the actuarial value (AV) of the average plan in force during both periods.

Base Period Experience

As previously described, an allowed claim cost PMPM was first developed separately for each legal entity (BlueChoice and GHMSI) based on non-grandfathered claims experience in the District for the period of January 2013 through December 2013. Consistent with District

requirements, the individual and small group experience of each entity was pooled. For BlueChoice this amount was equal to $312.41 while for GHMSI this amount was equal to $413.02.

Opinion: The base period experience used in the rate development utilizes non-grandfathered claims, consistent with Federal regulations, and are reasonable in relation to amounts reported in the statutory financial statements. The experience of the individual and small group markets has been combined into a single risk pool for each legal entity, consistent with District rule.

Changes in Covered Services

CareFirst has increased its rates to reflect the addition of benefits required to be provided as part of the EHB package in 2015 that were not covered in the base period. The adjustments made are summarized in the following table.

EHB Adjustments to Base Period Experience

	BlueChoice	GHMSI
Pediatric Dental	$3.89	$3.89
Pediatric Vision	$0.27	$0.27
Autism	$4.81	$4.80
Maternity	-$0.17	$0.00
Sovaldi	$3.12	$4.13
Total	**$11.92**	**$13.09**

CareFirst does not offer any plans without pediatric dental coverage. Therefore the amount added to the base experience assumes all members age 19 and under that are covered in the individual or small group market will receive pediatric dental benefits. The additional amount for autism coverage represents the cost associated with the expanded definition of habilitative services under the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013” passed by the District. A small reduction was made to the BlueChoice experience to reflect the fact that utilization of maternity coverage offered in the individual market during the base period, which was more generous than competition offered, is projected to decrease to levels observed in the small group market in 2015 when full maternity coverage will be required to be offered by all insurers. Finally, CareFirst added an amount to the base experience to reflect the high cost of coverage for new Hepatitis C drug, Sovaldi.

In addition to cost increases for the EHBs described above, CareFirst left $0.10 PMPM and $0.11 PMPM in the BlueChoice and GHMSI base period capitation, respectively, which represent the cost for an adult vision benefit covered in the individual market only. This benefit is a non-EHB benefit and should therefore not be included in the development of the index rate. Further, these amounts are added to the experience again as a plan level non-EHB adjustment and are therefore being double counted.

Opinion: CareFirst has made reasonable adjustments to the base period experience of the merged individual and small group risk pool for each entity to reflect the EHB package of benefits that must be provided in 2015. However, in making the adjustment for the pediatric

vision benefit, CareFirst did not remove $0.10 PMPM and $0.11 PMPM for adult vision benefits from the BlueChoice and GHMSI base period capitation, respectively. Since adult vision is not an EHB it should not be included in the index rate development and is further double counted when included again as a plan level non-EHB adjustment in a later step of the rate development.

Change in Morbidity

CareFirst has included factors that represent changes in morbidity through two separate factors. First, an estimate of the change in morbidity relative to the 2013 non-grandfathered pool was calculated due to the impact of anticipated new entrants. In a second step CareFirst estimates the change in morbidity levels relative to the 2013 non-grandfathered pool due to some small groups that renewed early in 2013 not entering the ACA pool in 2015.

CareFirst's combined individual and small group pool across both BlueChoice and GHMSI consisted of approximately 73,000 members in 2013 and is projected to increase to roughly 94,000 members in 2015. The roughly 21,000 new entrants anticipated in 2015 are projected to come from various sources; however, almost half of the members are assumed to represent members of Congress and their staff who will purchase coverage through the SHOP, some of which already have in early 2014. Another 4,600 represent individuals currently insured with a competitor and 3,000 represent members who were previously uninsured. The average morbidity of the 94,000 individuals anticipated to be insured in 2015 is estimated to be roughly equal to the roughly 73,000 members insured in 2013. While CareFirst did not provide any specific support for this assumption, it is not unreasonable given the sources of prior coverage for these individuals. Therefore, a 1.00 morbidity adjustment factor was applied in this step.

In a second step, CareFirst estimated that the morbidity of the pool in 2015 is expected to be higher than the 2013 experience due to some groups that elected an early renewal in late 2013 not entering the ACA pool. When spread across the individual and small group markets, the calculated impact on claims is 1.5% for BlueChoice and 1.7% for GHMSI. CareFirst estimated the impact across both BlueChoice and GHMSI by comparing the average 2013 allowed claims PMPM of those groups that renewed early to the average allowed claims PMPM of the entire pool in 2013. The difference in the estimated impact on claims by legal entity is due to different mixes of individual and small group membership.

We find that CareFirst has not supported this adjustment for several reasons. First, the two allowed PMPM figures being compared were not adjusted in any way. Therefore, any underlying difference in average age, gender, benefits and possibly provider network between the two cohorts also underlies the difference in the PMPMs being compared. While the detail available to normalize the data for these differences was not made available to us, it is not unreasonable to expect that the early renewing cohort may be younger and skewed more toward males given younger males would be most disadvantaged by the new rating requirements that became effective January 1, 2014. This means that a portion of the lower observed allowed PMPM of the early renewing cohort could be attributable to lower cost demographics, all else equal.

Second, the adjustment as calculated and applied assumes that none of the early renewing groups will enter the ACA pool in 2015 when they can no longer renew their existing pre-ACA

policy. In addition, given the merged risk pool requirement in the District, CareFirst's methodology implicitly also assumes that not a single individual in the groups that drop coverage will enter the pool through the individual market. The assumption that none of these groups will enter the ACA market in 2015 and further that none of the individuals within the groups that drop coverage will enter the individual market as a result represents the most conservative assumption within a reasonable range of assumptions that could be made, and support for selecting this assumption was not provided.

CareFirst revised this assumption in their amended submission with final proposed rates to reflect 50% of the impact of the early renewing cohort, which implicitly assumes that some individuals will enter the ACA market in 2015 either through their current group or through the individual market. The revised submission did not provide any additional information to normalize the allowed PMPMs for differences in demographics and benefits so the impact of that component is still unknown and also embedded in the assumption.

Opinion: CareFirst has projected no change in the average morbidity of the merged risk pool resulting from new entrants in 2015. In our opinion, based on the information provided, this assumption is reasonable. They did assume a 1.5% increase in morbidity for BlueChoice and a 1.7% increase in morbidity for GHMSI relative to the base period experience due to groups that renewed early in late 2013 electing to drop coverage or self-insure in 2015 rather than enter the ACA market, and further assuming that none of the individuals currently covered by one of the employers that would elect to drop coverage would subsequently enter through the individual market. In addition, the allowed claim information used to estimate the morbidity impact was not normalized for differences in demographics and benefits, which could represent a portion of the calculated difference in allowed claims. In our opinion the 1.5% and 1.7% assumptions for BlueChoice and GHMSI, respectively made by CareFirst represent the most conservative estimates that could be made and still fall within a reasonable range. In our opinion CareFirst's revised assumption reflecting 50% of the impact of the early renewing cohort is reasonable.

Change in Demographics

CareFirst examined the observed change in average age from the experience period to March 31, 2014. The average age for BlueChoice increased 0.6 years, from 33.7 to 34.3. The average age for GHMSI increased 0.2 years, from 33.9 to 34.1. CareFirst used an internally developed age and gender cost curve to determine the impact of projected demographic changes, not the standard District age curve that is used in determining the premium rate differential and does not reflect expected changes in claims costs by age.

CareFirst estimates that the increase in average age for BlueChoice will lead to a 1.1% increase in average expected allowed claims while the increase in average age for GHMSI will lead to a 0.3% increase in average expected claims. CareFirst did not provide the details of their calculations, however based on our internal pricing models it is not unreasonable to expect the stated changes in average age will lead to the estimated changes in claims costs.

Opinion: CareFirst adjusted its 2013 experience to reflect observed changes in the average age of its population as of March 31, 2014. CareFirst did not include any information related to

the observed shift among males/females, if any, however the adjustments applied to claims are within a reasonable range based on the change in age observed.

Trend

CareFirst indicates that they used the combined individual and small group non-grandfathered experience for each legal entity to calculate trends by type of service for the respective BlueChoice and GHMSI filings. It is reasonable to combine the individual and small group experience for purposes of calculating trend given the single risk pool requirement in the District, and to enhance credibility. CareFirst did not normalize the claims for underlying changes in benefits and demographics when calculating their trend estimates. Therefore, if there were any significant shifts in demographics or benefits during the period of claims used for the calculation, the resulting trends that were calculated could be skewed.

While the Actuarial Memorandum states the trend assumptions that were applied in projecting claims to 2015, it does not include a discussion of the methodology employed to select the trend factors ultimately used. From the exhibits provided in the filing, it appears that the trend rate was selected by focusing on an analysis of rolling 12-month trends and adjusting actual experience based on judgment. A description of the judgment applied or the information upon which it was based was not provided. The overall observed rolling 12-month trends for the period ending December 31, 2013 were 7.2% for BlueChoice and 8.4% for GHMSI. The actual overall annual trend rates applied to project claims from 2013 to 2015 were 7.0% for BlueChoice and 7.0% for GHMSI.

For Blue Choice, we noticed that there appeared to be an unusually large inpatient claim in March 2013, and possibly July 2013, that were not adjusted for when performing the trend analysis. We also noticed that the proposed prescription drug trend was much higher than had been historically observed. For GHMSI, there appeared to be an unusually large claim in September 2013 that was not adjusted for. These large claims in the latter half of the projection period could falsely appear to indicate increasing secular trends and contribute to the higher observed trends for the 12 months ending December 31, 2013 stated above.

We made adjustments to remove these apparent large claims. The following table compares the observed rolling 12-month inpatient trends for the period ending December 31, 2013 from the original filing to those with the unusually large claims removed, and shows the lower trends observed when they are removed.

Observed Inpatient Trends

	BlueChoice	GHMSI
Original Filing	9.9%	8.6%
With Large Claims Removed	1.5%	7.9%

While the rolling 12-month PMPM prescription drug costs increased steadily throughout 2013, the rolling 12-month PMPMs were relatively flat in 2012, in fact decreasing during the second half of that year. The decrease in 2012 followed by an increase in 2013 can exacerbate measured results, making the trends appear higher than they actually are. Further, CareFirst did not provide any analysis to support the assumption that these higher trends will continue into

the future and discounts an assumption that what is being measured is a one-time impact on claims. For example, the rolling 12-month cost per script for four periods ending December 2013 through March 2014 is essentially unchanged. There is a noticeable increase in the cost per script in December of 2013 when high cost Hepatitis drug Sovaldi was approved for sale, and could be contributing to the observed increase, however it is not appropriate to account for these higher costs in the trend assumption when the impact of Sovaldi has already be accounted for as a separate benefit adjustment to the base period claims. Similar results can be observed for the GHMSI filing.

We utilized the monthly claims information in the filings to calculate an independent estimate of trend. We were not able to normalize for underlying shifts in benefits or demographics as we would have liked. However, our analysis is consistent with CareFirst's in this regard. We only used claims experience through December 31, 2013 and paid through March 2014 given concerns over the large completion factors applied during the first quarter 2014 experience. The following table summarizes our analysis. The output from our trend analysis tool and a more detailed summary by type of service, which includes 90% confidence intervals, is included in Appendix C.

Oliver Wyman Calculated Trends

	BlueChoice	GHMSI
Rolling 12 Mo. Data – Most Recent 12 Data Points	4.9%	10.5%
Monthly Data – Most Recent 24 Data Points	4.1%	7.3%
Rolling 12 Mo. Data – Most Recent 24 Data Points	3.6%	5.1%
Monthly Data – Most Recent 36 Data Points	3.4%	4.6%

The observed trends we have calculated are significantly lower than those applied by CareFirst in the rate development for BlueChoice and somewhat varied for GHMSI. In our opinion, the very low and in some cases negative underlying inpatient trends we have calculated for BlueChoice are not likely sustainable and put downward pressures on the measured trends in the table above. For similar reasons, we do not believe it is reasonable to assume that the higher trends calculated from the shorter 24 month information (first two estimates in the table above) are a good indicator of future trends for GHMSI, and therefore place more weight on the estimates calculated from the longer 36 month period (last two estimates in the table above).

A portion of the measured trends could reflect changes in demographics of the population over the period used to measure medical trends and should be removed from the calculation so as not to double count the effect, as demographic shifts are considered elsewhere in the rating formula. However, since we do not have the detail necessary to normalize for any observed change in average age, we are not able to measure the impact they could have on the observed trends. In addition, benefit buy downs over the experience period are likely contributing downward pressure to the measured trends. Normally, we would argue this impact should be removed from the calculated trend estimates, however in its revised submission CareFirst applies an adjustment for the impact that benefit buy downs has on the trends in a later step of the pricing process, so in this case it is appropriate to not normalize the trends for the impact of benefit buy downs. Taking all of this into consideration, along with observed 90% confidence intervals of measured trends, and absent any further support from CareFirst as to why it is

reasonable to assume higher trends in the future, our best estimate trend assumption for both BlueChoice and GHMSI is 6.0%.

Opinion: In our opinion the trends utilized by CareFirst are not supported given, the lack of support for assuming the very recent increase in prescription drug costs will lead to higher trends in the future, the lack of normalization for the impact of demographic changes, other information provided in the filings and our independent analysis. In our opinion, absent additional information, our best estimate of annual trends is 6.0% for both BlueChoice and GHMSI are more reasonable and consistent with the data. Utilizing these trend rates would reduce the rates for all plans by roughly 1.5% for both BlueChoice individual and small group filings, by 1.4% for the GHMSI individual filing and by 1.3% for the GHMSI small group filing, all else equal.

Change in Pharmacy Benefit Manager

CareFirst will utilize a different pharmacy benefit manager (PBM) in 2015 than that which underlies its 2013 base period experience. Therefore, an adjustment was applied to the 2013 pharmacy claims to restate them to the levels that CareFirst expects would have been observed had the new PBM been utilized during 2013. This resulted in a 7.6% downward restatement to pharmacy claims for both BlueChoice and GHMSI. It is difficult to measure the interaction between the PBM change and the observed pharmacy trends which are based on claims covered under the old PBM contract. However, we agree with the approach of treating the PBM change as having a one-time impact on claims, separate from the trend assumption which is an estimate of how the cost of scripts contracted with the new PBM will change in the future.

Opinion: In our opinion the methodology CareFirst has applied in restating its 2013 claims to levels they anticipated would have been incurred had the new PBM been utilized during 2013 is reasonable. The filing does not contain enough detail to opine on the reasonableness of the reduction assumed.

Out-of-Network Re-Contracting Adjustment

For the BlueChoice filing, CareFirst includes a small 0.2% overall reduction to the base period claims to reflect recent re-contracting efforts which resulted in a reduction to a portion of its fee schedule utilized with out-of-network providers. The 0.2% reduction is applied equally to all service categories except capitated claims. While theoretically the impact would likely vary by type of service and should not be applied to prescription drugs in the allocation, given the small size of the adjustment the impact on rates from using the methodology employed by CareFirst is likely negligible.

Opinion: In our opinion it is reasonable to apply an adjustment to base period claims to reflect a reduction in the out-of-network fee schedule going forward. The filing did not contain enough detail for us to offer an opinion regarding the reasonableness of the 0.2% calculated impact.

Incentive Program

The last base period adjustment applied by CareFirst relates to a new incentive program that will be implemented in 2015. Through the program members can earn medical expense debit

cards of as much as $150 annually for an individual and $400 for a family which may be used to pay for qualified out-of-pocket costs such as deductibles and copayments. The program is being implemented in a revenue neutral way in that the incentive payments were chosen so that they match the expected savings from more efficacious delivery of care. The experience of a similar program called “HealthyBlue” was used in developing the savings estimates for this program. A 2.9% reduction was applied to the base period experience for BlueChoice and a 3.0% reduction was applied for GHMSI. The offsetting cost associated with the program is included in the rates as part of the general administrative expense.

Opinion: In our opinion it is reasonable to apply an adjustment to base period claims to reflect a reduction in the assumed cost of care due to more efficacious delivery of care as a result of the program. The filing did not contain detail for us to offer an opinion regarding the reasonableness of the adjustment applied.

Projected Average Benefit

There is one final adjustment which in our opinion should have been made to the base period experience but was not made by CareFirst in its original filing. According to 45 CFR 156.80(d), the index rate is to reflect the average allowed cost anticipated during the projection period, and should therefore reflect the average utilization demand expected. Induced demand can occur when cost-sharing elements of a plan affect utilization behavior. For example, it generally is assumed that individuals in plans with lower cost-sharing requirements will use more services, even after controlling for differences in health status. CareFirst did not make an adjustment in developing the index rate to reflect differences in induced demand between the experience period and the projection period. Therefore, the corresponding BlueChoice and GHMSI index rates reflect utilization levels consistent with the higher average benefits in force during the base period rather than the utilization levels consistent with the lower average benefits anticipated to be in force during the projection period. When making adjustments in a later step to develop rates for each specific plan, the adjustments applied assume the index rate reflects utilization levels consistent with the lower average benefits anticipated to be in force during the projection period. Therefore, this reduction in utilization is never accounted for in the development of rates.

CMS guidance “allows for the consideration of induced demand,” but does not indicate that an adjustment is a requirement. However, we also observe that it is generally accepted actuarial practice to adjust for induced demand when developing rates. Further, it does not seem reasonable that CareFirst should be inconsistent in its position on the effect of induced demand. Specifically, it is not reasonable to assume induced demand has no impact on utilization due to differences in benefits between the base period and the projection period, while at the same time including an adjustment in the development of rates at the plan level, reflecting differences in behavior among members selecting a Platinum plan as compared to those same members selecting a Bronze plan.

In its revised submission, CareFirst included an induced demand adjustment. In calculating the adjustment CareFirst asserted that their historical experience which underlies their development of trends reflects a certain level of benefit buy down which has an embedded induced demand impact, and that the only explicit induced demand adjustment needed is for projected changes in benefit richness above and beyond what is implied in the experience underlying the trend

assumptions. While our preference, as previously noted, would have been to calculate trends based on claims experience which has been normalized for changes in benefits so that the impact of induced demand could be more explicitly adjusted for, CareFirst did not do this. Therefore, we agree that both CareFirst's and our independent estimates of trend reflect the impact of historical changes in induced demand.

CareFirst estimated the average induced demand that underlies their trend calculations by first comparing the average AV in place in 2012 to the average AV in place in 2013. In both cases the average AV was calculated using the HHS AV Calculator. In our opinion we believe the AVs should have been calculated using the same pricing model that was used to develop the pricing paid-to-allowed ratios at the plan level as described later on. Using the AV Calculator for pricing purposes has several drawbacks, most of which are outlined in the American Academy of Actuaries Practice note on the topic of Minimum Value and Actuarial Value.[1] These include but are not limited to the following:

- The AV Calculator's purpose is to determine compliance with Federal metal level requirements, not to serve as a pricing tool.
- Underlying the AV Calculator is a standard nationwide population; it may not accurately reflect the population that is expected to be insured by a given carrier.
- The AV Calculator reflects nationwide average costs which may not reflect the provider payments negotiated by the carrier and in some cases may vary significantly.
- The AV Calculator reflects only a subset of the possible benefit categories for which cost sharing parameters may be modeled to vary, and as a result the AV Calculator may assign the same value to two plans with differences in expected incurred claims.
- The AV Calculator does not consider out-of-network benefits.
- The AV Calculator cannot accommodate many value based plan designs.
- The AV Calculator is known to produce counterintuitive results (e.g., producing higher actuarial values when increasing a prescription drug deductible).

Notwithstanding the concerns outlined above, CareFirst did not provide the paid-to-allowed ratios for the 2012 and 2013 historical periods calculated using their pricing model and therefore we relied on the estimated AVs provided. HHS developed an estimated induced demand curve that can be expressed using the formula:

$$\text{Induced Demand} = (\text{Paid to Allowed Ratio})^2 - \text{Paid to Allowed Ratio} + 1.24$$

While use of this induced demand formula is not mandated, in our experience we find that most carriers do rely on it. Using this formula, CareFirst calculated the following estimate of the impact of benefit change utilization embedded in the calculated trends.

[1] The practice note was released in exposure format in August 2013 and in final format in April 2014. http://www.actuary.org/category/site-section/public-policy/practice-notes

Induced Demand Factors Embedded in Trend Estimates

	2012 AV	2012 Induced Demand	2013 AV	2013 Induced Demand	2 Year Change in Induced Demand in Trends
BlueChoice	0.8887	1.142	0.8717	1.130	-2.1%
GHMSI	0.8700	1.127	0.8628	1.122	-0.9%

Absent any further information, we calculated the additional explicit induced demand adjustment necessary to be applied to the base period experience by first calculating the full expected change in induced demand between the 2013 base period and the 2015 projection period and then backing out the amounts from the far right column in the table above which are assumed to be reflected in the trend assumption. In calculating the total change in induced demand between the base period and the projection period, we relied on the projection period paid-to-allowed ratios for the merged risk pool included in the filing, which are calculated using CareFirst's pricing model and are consistent with the paid-to-allowed ratios CareFirst used to calculate the induced demand underlying the rates at the plan level. For the base period paid-to allowed ratios we used the 2013 averages provided by CareFirst from the table above.

Induced Demand Change Between Base Period and Projection Period

	2013 AV	2013 Induced Demand	2015 Paid-to-Allowed Estimate	2015 Induced Demand Factor	Change in Induced Demand	Induced Demand in Trend Factor	Additional Induced Demand Required
BlueChoice	0.8717	1.130	0.7554	1.055	-6.6%	-2.1%	-4.6%
GHMSI	0.8628	1.122	0.7968	1.078	-3.9%	-0.9%	-3.0%

The far right column of the table above indicates that we believe the index rate for the BlueChoice filings should have been reduced an additional 4.6% and the index rate for the GHMSI filings should have been reduced an additional 3.0% to reflect lower assumed utilization associated with lower average benefits in the projection period. The reductions in projected claims cost translate to a 3.7% reduction to the proposed rates for BlueChoice and a 2.4% reduction to the proposed rates for GHMSI, all else equal.

We acknowledge that there is arguably an inconsistency in the table above in that the 2013 factors were developed from the AV Calculator and the 2015 Factors were developed from CareFirst's pricing factors. However, we believe it is important that the projection period paid-to-allowed ratios be on the same basis as the paid-to-allowed factors utilized at the plan level or further inconsistencies will occur. While we do not agree with using the AV Calculator for pricing for the reasons previously stated, to satisfy our comfort level with using the average 2013 AV developed from the AV Calculator as provided by CareFirst we compared the 2013 observed paid-to-allowed ratios with those estimated by CareFirst using the AV Calculator. Given the size of CareFirst's block and the fact that they deemed the experience 100% credible, the observed paid-to-allowed rates in 2013 should not be significantly different what would have been expected. A comparison is shown in the following table.

Base Period Paid-to-Allowed Ratios

	CareFirst 2013 AV Calculated from AVC	Observed 2013 Paid-to-Allowed Ratio
BlueChoice	0.872	0.888
GHMSI	0.863	0.883

The table above shows that these values are not widely different for each carrier. In addition, the observed paid-to-allowed ratios are higher for both legal entities which means had we used them in place of the values CareFirst calculated using the AV Calculator, the calculated reductions to the rates would have been greater.

In CareFirst's revised submission, an additional explicit induced demand adjustment was included; however it was less than what we calculated. Given CareFirst used the AV Calculator to develop this adjustment, we do not feel the results are reliable for the reasons previously stated. The following table compares the explicit adjustment to claims applied by CareFirst with the adjustment we independently calculated.

Comparison of Base Period Additional Induced Demand Adjustment

	CareFirst	Oliver Wyman
BlueChoice	-2.8%	-4.6%
GHMSI	-1.9%	-3.0%

Finally, we note that despite the fact that CareFirst included this adjustment, for both small group filings the adjustments were negated in a further step in the rating formula in the revised submission; the previously certified actuarial values were increased in the revised small group filings to offset these reductions, with no explanation or support for changing them.

Opinion: CareFirst did not initially adjust the index rates to reflect the difference between the utilization associated with the average benefits underlying the base period experience and the utilization associated with the average benefits anticipated to be in force during the projection period for each market in the initial filing. CareFirst did eventually include an adjustment of a lesser magnitude than we would have expected. In our opinion, the level of this adjustment included in the final submission results in rates in the individual market for BlueChoice being overstated by roughly 1.5% and for GHMSI being overstated by roughly 0.9%, when utilizing the HHS induced utilization factors to estimate the difference in expected utilization. However, since CareFirst made offsetting adjustments to the actuarial values for reductions they included in the small group filings, it results in rates in the small group market being overstated by 3.8% for BlueChoice and 2.4% for GHMSI.

Risk Adjustment

The ACA establishes a risk adjustment program intended to transfer funds from carriers that attract lower than average risk to carriers that attract higher than average risk within the same

state and market. 45 CFR 156.80(d) states that the index rate must be adjusted on a marketwide basis based on the total expected market-wide payments and charges under the risk adjustment program." The intent of this requirement is that carriers who anticipate receiving money from other carriers under the risk transfer program reflect these payments in their rate development, leading to lower premiums due to the fact that these payments from other carriers will cover a portion of the anticipated claims cost. The same is true for carriers anticipated to make payments to other carriers in that they must collect additional premium to cover the cost of the anticipated payments and these additional costs are to be recognized in the premium development. This allows the premiums charged by all carriers to reflect a risk closer to the market average and does not disadvantage carriers that attract a higher than average risk.

It is admittedly difficult for carriers to estimate what these transfer payments might be in 2015 given there is limited information available on what the market composition may look like and further what the carrier's risk portfolio may look like relative to the rest of the market. However, CareFirst is in the somewhat unique position of being the parent to two of the largest carriers in the District and can therefore assess how the risk of the population projected to enroll in each of their legal entities compares to each other. Significant differences in the projected risk profiles of BlueChoice and GHMSI provides CareFirst with some indication of the anticipated direction of risk transfer payments.

Unlike their 2014 filings, CareFirst has included an adjustment for risk transfer payments and receipts in the rate development for its 2015 small group filings. CareFirst relied on a marketwide analysis conducted by Wakely Consulting Group (Wakely) where CareFirst's normalized risk scores for BlueChoice and GHMSI were projected to be 0.92 and 1.08, respectively. CareFirst assigned 75% credibility to this analysis. This led CareFirst to include in its rate development the assumption that BlueChoice would make a 2015 risk transfer payment of $19.01 PMPM and that GHMSI would receive a 2015 risk transfer receipt of $21.00 PMPM. We performed a high level market wide risk transfer calculation based on the information included in the Uniform Rate Review Templates (URRTs) submitted by all carriers filing small group rates and found that the assumptions made by CareFirst are directionally consistent with our analysis.

CareFirst did not include an assumption of a risk transfer payment or receipt in its individual filings due to "uncertainty."

For both the individual and small group filings CareFirst included the $0.08 PMPM risk adjustment user fee in their rate development calculations, however they did not make this adjustment at the market level as required. Instead this fee was included at the plan level as part of the load for administrative expenses. While inconsistent with Federal requirements, there is no impact on the calculated rates.

Opinion: Given the limited information that is available to date, it is our opinion that CareFirst's approach to reflecting a risk transfer payment in the rate development for 2015 is reasonable. For the small group market, CareFirst relied on a DC specific market analysis conducted by Wakely Consulting which produced results that are directionally similar to the high level analysis we conducted using information in the URRTs from all carriers. CareFirst did not assume any risk transfers would occur in the individual market. CareFirst did not include the $0.08 PMPM

risk adjustment user fee as a market wide adjustment as required, but rather as a plan level adjustment. This had no impact on the rates.

Transitional Reinsurance

A transitional reinsurance program will be in effect in the individual market for the years 2014-2016. CareFirst has assumed an adjustment factor equal to 0.962 for its individual BlueChoice rates and 0.957 for its individual GHMSI rates. These adjustments have the effect of reducing projected claims to reflect anticipated recoveries in 2015 due to the transitional reinsurance program, net of the required $3.67 contribution. In developing this adjustment, CareFirst utilized an internal model based on small group claims data, adjusted to the average allowed cost anticipated in the District's individual market, separately for BlueChoice and GHMSI. The estimated recoveries were based on as assumed attachment point of $70,000. While this is the attachment point currently in place for 2015, CCIIO has indicated its intent to reduce it to $45,000.

We independently calculated estimates of reinsurance recoveries by scaling our internal claim probability distributions developed from the Truven Health Analytics MarketScan database to our best estimate of the index rate.[2] Based on this analysis, it is our opinion that the reinsurance recoveries estimated by CareFirst are within a reasonable range.

We note that, appropriately, no adjustment was made for recoveries in developing the small group rates as the transitional reinsurance program does not apply to the small group market. The $3.67 PMPM reinsurance fee was added to rates for the small group market, which was also appropriate.

Opinion: In our opinion the adjustments made to reflect the anticipated impact of the transitional reinsurance program are reasonable and consistent with the provisions of the program. If the attachment point is reduced by HHS from $70,000 to $45,000, actual recoveries would be expected to be greater than those assumed by CareFirst.

The small group factors result in amounts consistent with the 2015 reinsurance contribution amount of $3.67 PMPM and are therefore reasonable.

DC Health Link User Fee

CareFirst did not include an Exchange user fee as a market level adjustment. In lieu of an Exchange user fee the District recently approved a broad based 1% tax on all health-related premium in the District. Therefore CareFirst included this tax as a plan level adjustment along with other taxes and fees. Given this broad based tax differs from the exchange user fee contemplated in 45 CFR 156.80, it is reasonable to apply a load for the tax as a plan level adjustment. However, CareFirst include a 2% load for this tax in developing its initial 2015 rates, citing the tax which is also payable on 2014 premium was not known at the time the 2014 rates were developed and therefore an additional load to cover the 2014 tax was needed. In our opinion the 2015 rates should reflect only the anticipated tax that will be paid on 2015 premiums. In its revised submission CareFirst appropriately reduced this load to 1%.

[2] The Truven Health Analytics database contains over 53 million members covered under group health plans.

Opinion: Since the District's exchange fee is applied as a broad based tax rather than as a user fee, we agree that the plan level administrative adjustment is the more appropriate placement of this tax. In our opinion the revised load of 1% included in CareFirst's final rate filing is reasonable and appropriate.

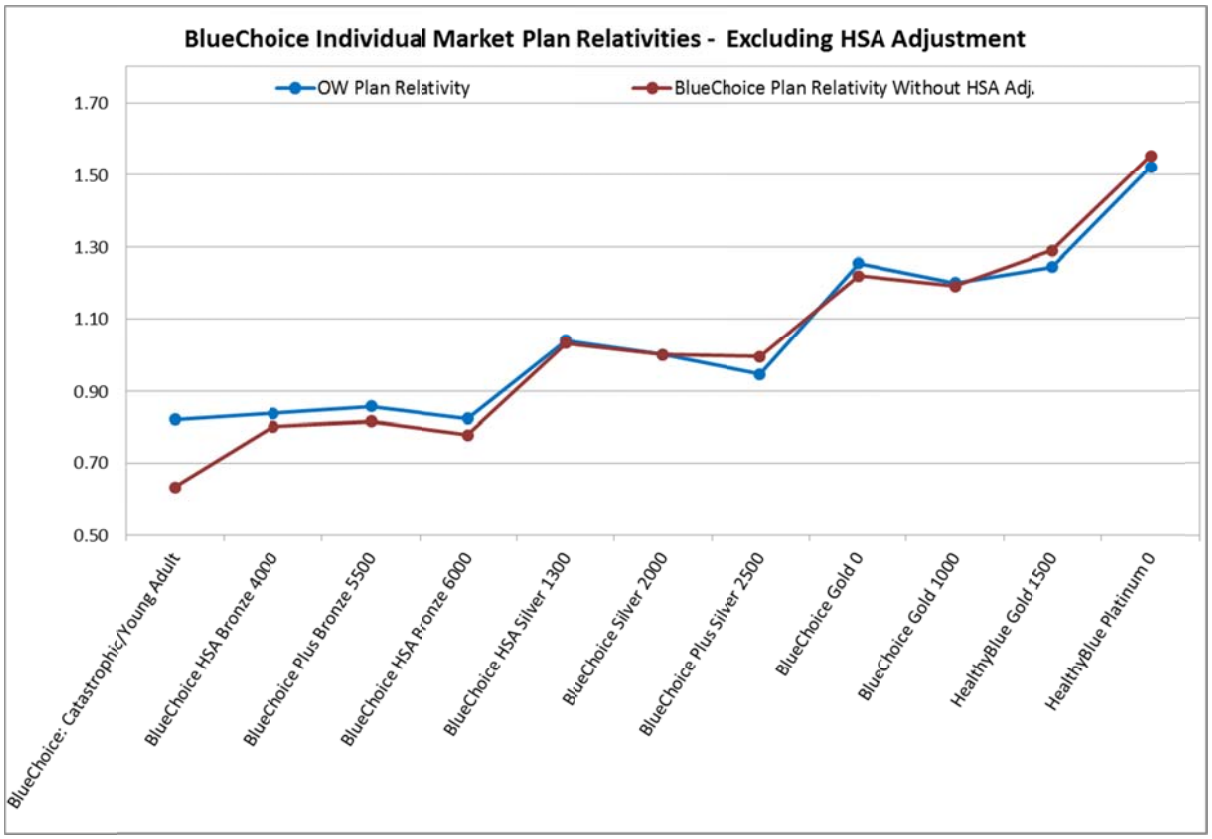
Cost Sharing Design of the Plan

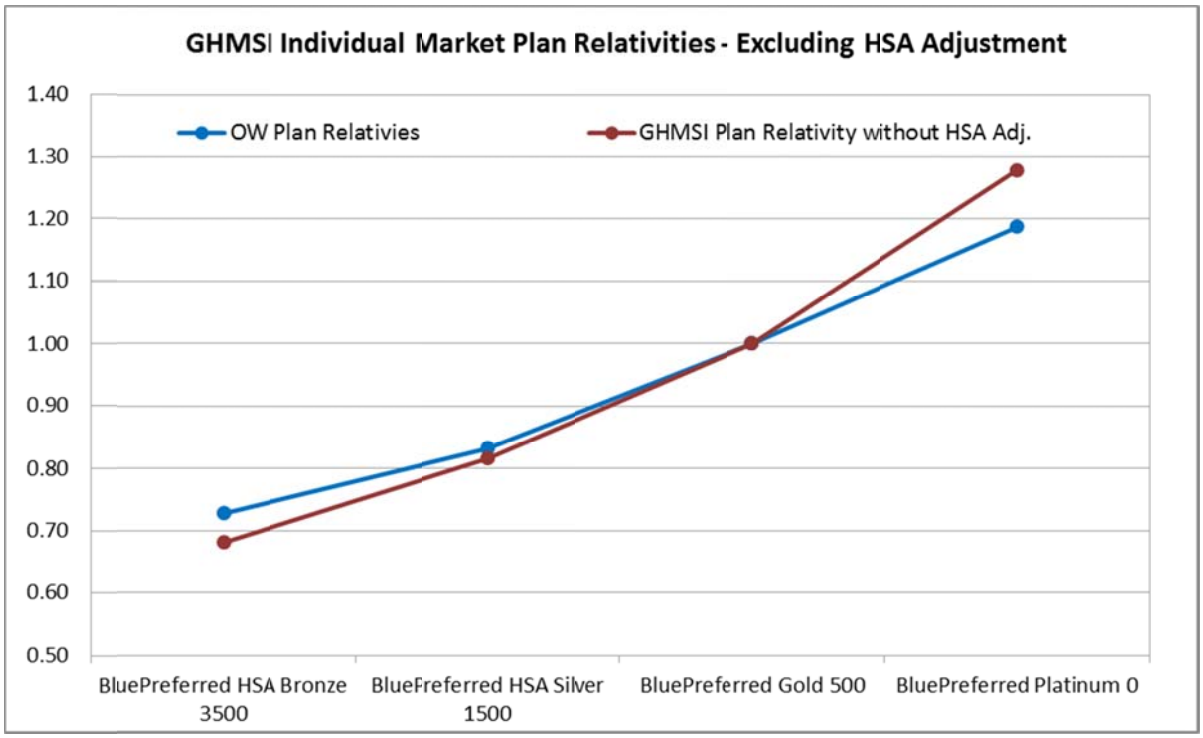
The adjustment for cost sharing design of the plan has the effect of converting the index rate to expected incurred claims PMPM rather than allowed claims PMPM. The adjustment reflects both the member liability and expected differences in utilization by plan based on the cost sharing design. These are both allowable plan level adjustments under the 45 CFR 156.80(d)(2). Federal guidance in the instructions to the Unified Rate Review Template indicates issuers are to also convert the projected claims to those of a non-tobacco user when tobacco loads are used in setting premiums. CareFirst does not use tobacco loads, consistent with District requirements, so this adjustment was not necessary.

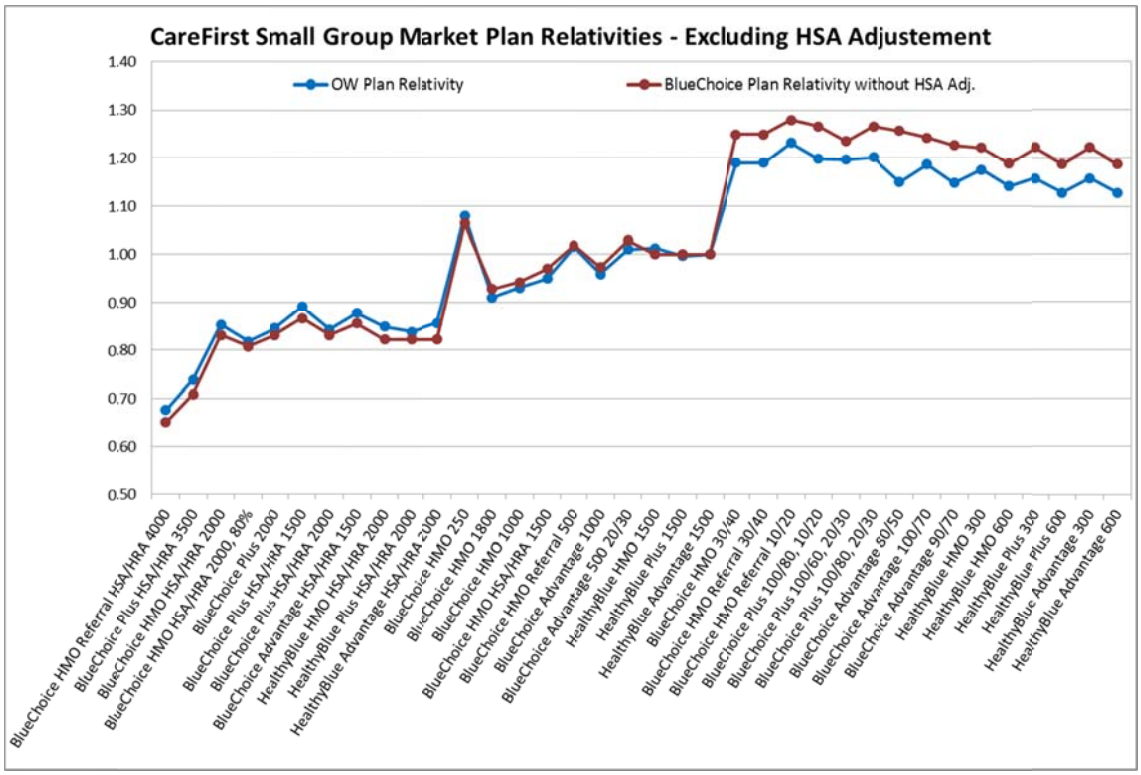
Paid-to-Allowed Ratios

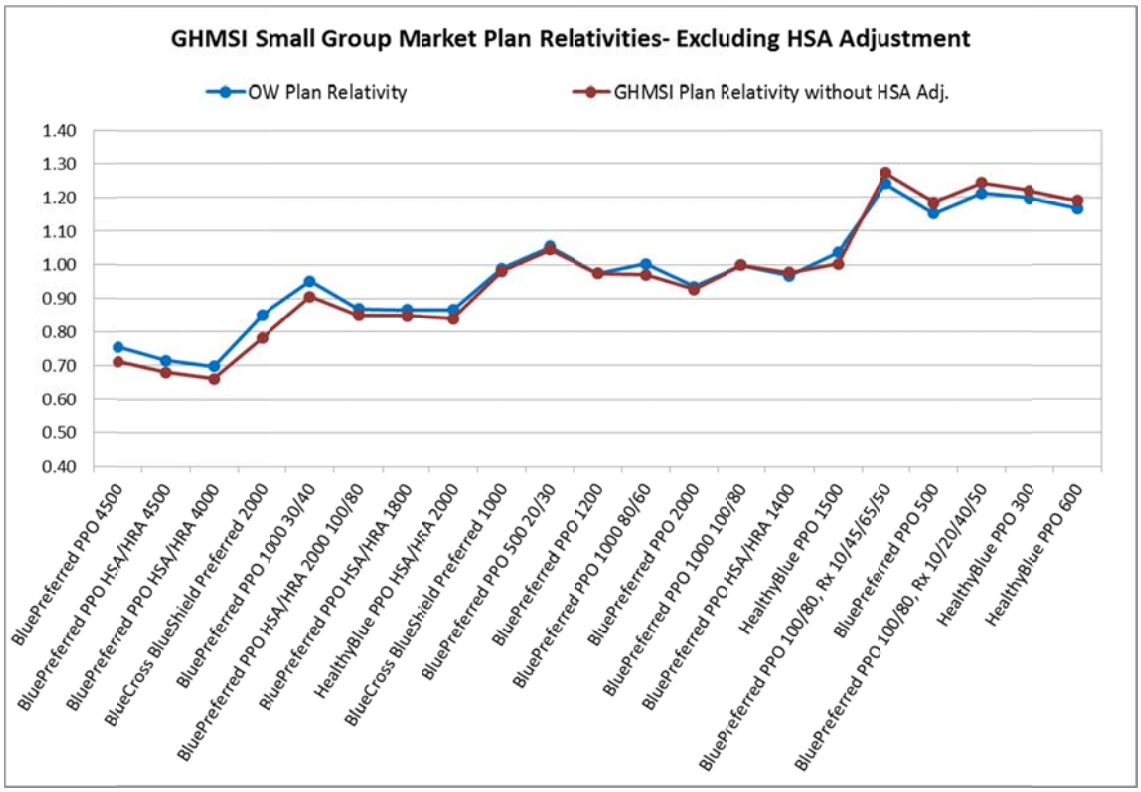
Using Oliver Wyman's proprietary pricing model, we independently calculated paid-to-allowed ratios for each plan. We calibrated the model to reflect the overall projected allowed cost for each entity prior to calculating the factors. We utilized induced demand factors consistent with the HHS induced demand curve. However, the results in this section should be used with some caution. While we utilized the benefit summaries provided by CareFirst, these summaries were communicated through screen shots of the AV Calculator input and may not reflect all of the details of the cost sharing parameters for each plan given the limited benefit parameters analyzed by the AV Calculator. Therefore, there is the potential that not all aspects of the benefit plans were fully considered.

Notwithstanding this limitation, an analysis was conducted to perform a reasonableness check on the relative difference in the factors among plans. We selected a plan for each legal entity and market to serve as the reference plan and scaled both the results of our modeling and the proposed CareFirst paid-to-allowed ratios such that the value for the reference plan was 1.00 under both sets of factors. This allowed us to compare the relative change in projected cost assumed from the reference plan to all other plans. The following four charts compare the results for each legal entity, and separately for the individual and small group markets. It is important to note that while the adjustments in the graphs that follow do reflect the corresponding estimate of differences in induced demand between plans, they do not include the impact of an additional HSA/Non-HSA adjustment which is described later.


BlueChoice Individual Market Plan Relativities - Excluding HSA Adjustment
OW Plan Relativity
BlueChoice Plan Relativity Without HSA Adj.
1.70
1.50
1.30
1.10
0.90
0.70
0.50
BlueChoice: Catastrophic/Young Adult
BlueChoice HSA Bronze 4000
BlueChoice Plus Bronze 5500
BlueChoice HSA Bronze 6000
BlueChoice HSA Silver 1300
BlueChoice Silver 2000
BlueChoice Plus Silver 2500
BlueChoice Gold 0
BlueChoice Gold 1000
HealthyBlue Gold 1500
HealthyBlue Platinum 0


GHMSI Individual Market Plan Relativities - Excluding HSA Adjustment
OW Plan Relativies
GHMSI Plan Relativity without HSA Adj.
1.40
1.30
1.20
1.10
1.00
0.90
0.80
0.70
0.60
0.50
BluePreferred HSA Bronze 3500
BlueFreferred HSA Silver 1500
BluePreferred Gold 500
BluePreferred Platinum 0


CareFirst Small Group Market Plan Relativities - Excluding HSA Adjustement
OW Plan Relativity
BlueChoice Plan Relativity without HSA Adj.
1.40
1.30
1.20
1.10
1.00
0.90
0.80
0.70
0.60
0.50
BlueChoice HMO Referral HSA/HRA 4000
BlueChoice Plus HSA/HRA 3500
BlueChoice HMO HSA/HRA 2000
BlueChoice HMO HSA/HRA 2000, 80%
BlueChoice Plus 2000
BlueChoice Plus HSA/HRA 1500
BlueChoice Plus HSA/HRA 2000
BlueChoice Advantage HSA/HRA 1500
HealthyBlue HMO HSA/HRA 1500
HealthyBlue Plus HSA/HRA 2000
HealthyBlue Advantage HSA/HRA 2000
BlueChoice HMO 250
BlueChoice HMO 1800
BlueChoice HMO 1000
BlueChoice HMO HSA/HRA 1500
BlueChoice HMO Referral 500
BlueChoice Advantage 1000
BlueChoice Advantage 500 20/30
HealthyBlue HMO 1500
HealthyBlue Plus 1500
HealthyBlue Advantage 1500
BlueChoice HMO 30/40
BlueChoice HMO Referral 30/40
BlueChoice HMO Referral 10/20
BlueChoice Plus 100/80, 10/20
BlueChoice Plus 100/60, 20/30
BlueChoice Plus 100/80, 20/30
BlueChoice Advantage 80/50
BlueChoice Advantage 100/70
BlueChoice Advantage 90/70
HealthyBlue HMO 300
HealthyBlue HMO 600
HealthyBlue Plus 300
HealthyBlue Plus 600
HealthyBlue Advantage 300
HealthyBlue Advantage 600


GHMSI Small Group Market Plan Relativities- Excluding HSA Adjustment
OW Plan Relativity
GHMSI Plan Relativity without HSA Adj.
1.40
1.30
1.20
1.10
1.00
0.90
0.80
0.70
0.60
0.50
0.40
BluePreferred PPO 4500
BluePreferred PPO HSA/HRA 4500
BluePreferred PPO HSA/HRA 4000
BlueCross BlueShield Preferred 2000
BluePreferred PPO 1000 30/40
BluePreferred PPO HSA/HRA 2000 100/80
BluePreferred PPO HSA/HRA 1800
HealthyBlue PPO HSA/HRA 2000
BlueCross BlueShield Preferred 1000
BluePreferred PPO 500 20/30
BluePreferred PPO 1200
BluePreferred PPO 1000 80/60
BluePreferred PPO 2000
BluePreferred PPO 1000 100/80
BluePreferred PPO HSA/HRA 1400
HealthyBlue PPO 1500
BluePreferred PPO 100/80, Rx 10/45/65/50
BluePreferred PPO 500
BluePreferred PPO 100/80, Rx 10/20/40/50
HealthyBlue PPO 300
HealthyBlue PPO 600

While the Oliver Wyman and CareFirst scaled factors in the graphs above don't match exactly, for the most part the slope aligns very well given the data limitations previously mentioned. Again, the comparison above does not include the additional HSA adjustment applied by CareFirst. The Catastrophic/Young Adult plan stands out as an outlier on the low end. The benefits for this plan are defined by regulation and HHS has indicated their modeling predicts the actuarial value to be relatively the same as Bronze plans. The BlueChoice graph for the individual market above shows that CareFirst's pricing is assuming the benefits are about 20% leaner that the Bronze plans immediately to the right of it in the graph. Further discussion of the Catastrophic/Young Adult plan follows later in this report. The BlueChoice small group Platinum plans also stand out as outliers. While the BlueChoice Bronze, Silver and Gold plans align very well with the slope of the Oliver Wyman's factors, most of the BlueChoice Platinum plans are 3-4% higher. This difference is not present for the GHMSI small group plans.

Opinion: In our opinion, based on the information provided in the filings, the paid-to-allowed ratios inclusive of adjustments for induced demand among plans are reasonable with the exception of the Catastrophic plan and the BlueChoice small group Platinum plans. The assumed ratio for the Catastrophic plan is roughly 20% lower than the Bronze plans, despite HHS guidance that the paid-to-allowed ratio for the Catastrophic coverage is expected to be reasonably equivalent to that for Bronze coverage. Oliver Wyman's model also produced a ratio for the Catastrophic plan much higher than that produced by CareFirst. CareFirst's anticipated paid-to-allowed ratios, inclusive of adjustments for induced demand, for the small group BlueChoice Platinum plans are 3-4% higher than Oliver Wyman's model suggests and 15-20% higher than CareFirst's own factors for BlueChoice Gold coverage.

Induced Utilization Demand

In making the induced demand adjustments that underlie the paid-to-allowed ratios in the previous section, CareFirst incorrectly scaled the adjustments so that they average to 1.00 separately within the individual and small group markets for each legal entity rather than scaling them to 1.00 across both the individual and small group markets for the legal entity. This creates an inconsistency with the index rate to which they are applied, which represents the average benefit across both the individual and small group markets. This led to an overstatement of rates in the individual market and an understatement of rates in the small group market. While the combined individual and small group experience for each entity must be used to develop a single index rate that reflects the blended average morbidity, demographics and benefits of the combined individual and small group markets, plan level modifiers are to be applied to the index rate separately for each market.[3] CareFirst made revisions in its revised submission. Using the HHS induced demand curve the following table summarizes we estimated the overall impact on rates for each legal entity and market as a result of correcting this error.

[3] Pages 3 and 4 of the DC Carrier Reference Manual

Market Level Induced Demand Adjustments Required

	AV Underlying Index Rate	Index Rate Induced Demand Factor	Market Average AV	Market Average Induced Demand Factor	Required Market Level Adjustment
Blue Choice – Individual	0.7554	1.055	0.6652	1.017	-3.6%
Blue Choice – Small Group	0.7554	1.055	0.8039	1.082	+2.6%
GHMSI – Individual	0.7968	1.078	0.7458	1.050	-2.6%
GHMSI – Small Group	0.7968	1.078	0.8025	1.082	+0.3%

The adjustments in the far right column above reflect adjustments to claims costs. The corresponding adjustments to premium for BlueChoice are approximately a 2.9% reduction for the individual market and a 2.1% increase for the small group market. The corresponding adjustments to premium for GHMSI are approximately a 2.1% reduction for the individual market and a 0.3% increase for the small group market.

Opinion: CareFirst initially scaled the plan level induced demand factors to 1.00 within each legal entity and market rather than across both the individual and small group markets for each legal entity. By doing so, the plan level calculations applied within each market did not adjust for differences in average benefits underlying the index rate and the respective market. Due to the lower average benefits projected in the individual market this had the effect of overstating rates in the individual market and understating rates in the small group market. We estimate that correcting this error resulted in premium reductions in the individual market of approximately a 2.9% for BlueChoice and 2.1% for GHMSI. Rates in the small group market likewise increased by 2.1% for BlueChoice and 0.3% for GHMSI.

HSA/Non-HSA Factor

In addition to the adjustment for the actuarial value and cost-sharing design of the plan which is allowed under 45 CFR 156.80(d)(2)(i), CareFirst has included an additional plan level adjustment called an HSA/Non-HSA Factor. This factor results in roughly a 9-10% premium differential in the individual market and a 5% differential in the small group market between plans designated as HSA plans as compared to plans that are not, all else equal. CareFirst characterizes this adjustment as reflecting the impact of an individually owned savings account on members' utilization.

We note that this is not one of the five plan level adjustments allowed under 45 CFR 156.80(d)(2). In our experience working with other states they have pointed to a couple of items in addition to these regulations. First, the Federal AV Calculator does not make an adjustment to utilization based on whether a plan can be paired with a qualified HSA account. The argument is that if HHS had intended these plans to be valued differently an adjustment would be reflected in the AV Calculator. Second, since higher income and healthier individuals tend to be attracted to HSA plans due to the tax advantages, all else equal, they view it as potentially discriminatory to charge those enrolled in non-HSA plans more for a benefit package with the same actuarial value. Finally, HSA qualified plans are required to include front end deductibles that apply to all covered services where as many if not most non-HSA plans will have some first

dollar coverage, subject to copayments only, for services such as office visits, emergency room visits and prescription drugs. It can be argued that, all else equal, individuals in poorer health will be more likely to migrate toward the plans with some first dollar coverage which are by default non-HSA plans. Given one of the underlying goals of the ACA is to spread morbidity across all insureds and that differences in premium due to actuarial value and cost sharing design should be based on a standard population; charging more for those enrolled in non-HSA plans relative to HSA plans does not conform to this principal. The following table summarizes the rate discount or load for HSA and non-HSA plans, respectively.

HSA Adjustments Applied in Rate Development

	HSA Discount	Non-HSA Load	% in HSA Plans	% in Non-HSA Plans
Blue Choice – Individual	-5.0%	+4.0%	40%	60%
Blue Choice – Small Group	-4.0%	+0.5%	12%	88%
GHMSI – Individual	-6.0%	+4.0%	78%	22%
GHMSI – Small Group	-4.0%	+0.4%	8%	92%

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We note that the instructions for preparing the Part III Actuarial Memorandum indicate that any utilization adjustment must be a function of differences in cost sharing. The HSA or non-HSA adjustment being applied by CareFirst is not a function of the plan's cost sharing. The same HSA adjustment is being applied to all HSA eligible plans and the same non-HSA adjustment is being applied to all non-HSA plans. Further, given two plans, an HSA plan with all services subject to a deductible and an otherwise identical plan with the exception of office visits being subject only to a copayment, they will have actuarial values that are not significantly different. However, the manner in which CareFirst is applying the HSA adjustment will lead to rates for the HSA plan having premium rates that are roughly 10% different than the non-HSA plan, despite almost no difference in average cost sharing.

Notwithstanding the issue of whether the presence of an HSA represents a difference in cost sharing, the instructions clearly state that the differences due to health status may not be included in a utilization adjustment. However, CareFirst has calculated the roughly 10% differential by comparing the observed utilization, without adjustment for differences in health status, of small group members enrolled in an HSA plan with that of members enrolled in an HRA plan. By comparing unadjusted utilization data, the difference does not reflect solely the difference in utilization between populations that do and do not have an HSA. The difference in utilization also reflects underlying differences in benefits, demographics, and morbidity.

Opinion: The decision as to whether CareFirst may make an additional adjustment to rates for HSA plans relative to non-HSA plans beyond those listed in 45 CFR 156.80(d)(2) is a policy decision that may require a legal interpretation of the Market Rules. We are not qualified to provide legal advice and therefore we offer no opinion on this issue. However, if it is determined that such an adjustment is allowed, HHS has made it clear that the adjustment cannot account for differences in morbidity. In our opinion the factors calculated by CareFirst are not appropriate as they reflect underlying differences in benefits, demographics and morbidity.

Provider Network and Deliver System Characteristics of the Plan

CareFirst uses multiple networks for its BlueChoice products. Under 45 CFR 156.80(d)(2), carriers are allowed to vary the costs by plan based on the provider network, delivery system characteristics, and utilization management practices. Differences due to the morbidity of members who select one network plan over another are prohibited from inclusion in the rates.

While the methodology used to develop the network differentials appears reasonable, the application of the factor in the initial BlueChoice filings resulted in an overstatement of rates for the individual market and an understatement of rates for the small group market. CareFirst separately scaled the network factors within each market such that they aggregated to 1.00. However, given the requirement in the District to develop an index rate based on the combined experience of the individual and small group markets, the index rate to which the network factors were applied represents a blend of networks across both individual and small group markets. Therefore, they should instead be scaled such that they aggregate to 1.00 across the individual and small group markets combined. CareFirst made a correction in their revised submission. This correction had the effect of reducing rates by roughly 0.8% in the individual market and increasing rates by roughly 0.4% in the small group market.

Opinion: The methodology used by CareFirst to develop the BlueChoice network differential appears reasonable. However CareFirst incorrectly scaled the network factors to 1.00 within each market when they should have been scaled to 1.00 across the individual and small group markets in total. CareFirst corrected for this error in their revised submission which had the impact of reducing rates by roughly 0.8% in the individual market and increasing rates by roughly 0.4% in the small group market.

Benefits in Addition to EHB

CareFirst provides an adult vision benefit in the individual market which is a non-EHB benefit. However, CareFirst developed and applied the cost for this benefit ($0.10 PMPM for BlueChoice and $0.11 PMPM for GHMSI) by spreading it across both the individual and small group markets. Given the benefit only applies to the individual market, and further the requirement that plan level modifiers be applied to the index rate separately for each market, CareFirst should have included the full cost of the adult vision benefit in the individual rates and no cost associated with the adult vision benefit in the small group rates. This resulted in rates in the individual market being understated by $1.31 PMPM for BlueChoice and $1.27 PMPM for GHMSI. Likewise, the rates in the small group market were overstated by $0.13 PMPM for BlueChoice and $0.11 for GHMSI.

Opinion: In our opinion the cost for the adult vision benefit should not have been spread over both the individual and small group markets when the benefit only applies in the individual market. This error resulted in rates in the individual market being understated by $1.31 PMPM for BlueChoice and $1.27 PMPM for GHMSI. Likewise, the rates in the small group market were overstated by $0.13 PMPM for BlueChoice and $0.11 for GHMSI.

Catastrophic Adjustment

CareFirst offers a Catastrophic plan through its BlueChoice legal entity. CFR 156.80(d)(2)(v) allows carriers to make an adjustment to the rates for the Catastrophic plan to reflect "the expected impact of the specific eligibility categories for those plans." The primary category of individuals eligible for the Catastrophic plan is those who have not yet turned 30 by the start of the plan year. Therefore, the average age of individuals enrolled in the Catastrophic plan is expected to be less than the average age of individuals enrolled in the metal plans. Carriers are allowed to reflect this lower average age in their development of rates for the Catastrophic plan.

We reviewed CareFirst's development of the Catastrophic adjustment factor and in our opinion it conforms to the requirements stated above. However, we note that when developing their 2014 rates CareFirst mistakenly did not consider the fact that after applying the Catastrophic adjustment to the index rate, the assumed average age underlying the resulting Gross Premium PMPM for the Catastrophic plan has been correspondingly reduced. Therefore, CareFirst's 2014 rates for their Catastrophic plan were significantly underpriced.

In developing their 2015 rates, CareFirst did not fully correct for this error. In the Actuarial Memorandum CareFirst states "We calculated a needed renewal for the Catastrophic of 68% but have chosen to grade in the correction. Hence the proposed renewal is 24.1%." In our opinion, the proposed 2015 rates for the Catastrophic plan continue to be significantly underpriced. However, from a policy perspective it may be desirable to allow CareFirst to grade in the correction as proposed, as long as the underpricing does not pose a significant financial risk to the company. We note that CareFirst projects that only 8% of its BlueChoice individual business to be enrolled in the Catastrophic plan in 2015, which represents 3% of its combined individual and small group business.

Opinion: In our opinion CareFirst has calculated a Catastrophic plan level adjustment which is consistent with 45 CFR 156.80(d)(2)(v). However, due to a significant error in pricing this plan in 2014 they have elected to phase in the correction. Evaluating the impact that this policy could have on the financial health of CareFirst is outside the scope of our analysis.

Administrative Costs Excluding Exchange User Fees

We compared the administrative expenses and commissions included in the rate development with expenses shown in the 2013 Supplemental Health Care Exhibit (SHCE) of the financial statements.

2013 Financial Statements

	BlueChoice Individual	BlueChoice Small Group	GHMSI Individual	GHMSI Small Group
General Admin Expense	$37.12	$25.57	$35.65	$22.37
Claims Adjustment Expense	$19.46	$10.40	$16.07	$14.31
Commissions	$11.89	$23.67	$8.12	$22.65
Total Excluding Taxes and Fees	**$68.48**	**$59.64**	**$59.84**	**$59.33**

2015 Rate Filings

	BlueChoice Individual	BlueChoice Small Group	GHMSI Individual	GHMSI Small Group
Total Excluding Taxes and Fees*	$57.54	$73.12	$80.66	$87.12
Annualized Increase Over 2013	-8.3%	+10.7%	+16.1%	+21.2%

* From URRT

The tables above appear to show a significant increase in the administrative expenses and commissions projected for 2015 relative to those observed in 2013. We note that for BlueChoice, the PMPM decrease in the individual market is roughly equal to the PMPM increase in the small group market.

Opinion: CareFirst projects significant increases in their administrative expenses between 2013 and 2015 for both legal entities in all markets except the BlueChoice individual market. While we did not perform an in-depth administrative expense analysis, the support provided for the projected increases appears reasonable.

ACA Fees

CareFirst included an addition to premium for the ACA insurer fee, Patient Centered Outcome and Research Institute fee, and the risk adjustment user fees. The amount included for the ACA insurer fee was 3.2% of premium for BlueChoice and 2.6% of premium for GHMSI. Oliver Wyman conducted a study of the estimated impact of this new fee and the amounts CareFirst has included are consistent with our research. The amounts included for the other fees are consistent with the assessments prescribed in Federal regulation.

Opinion: In our opinion the amounts CareFirst has loaded for the various ACA fees are reasonable.

Contribution to Surplus

The following contributions to surplus were included in each of the filings.

Contribution to Surplus as a Percent of Premium

	BlueChoice Individual	BlueChoice Small Group	GHMSI Individual	GHMSI Small Group
Initial Filings	0.0%	2.0%	0.0%	2.0%
Final Filings	0.0%	2.0%	-0.2%	1.5%

A complete review of CareFirst's financial position was outside the scope of our work. However, we did gather information on each entity's risk based capital (RBC) history and provide the results in the following table.

RBC Ratios

	BlueChoice	GHMSI
2013	1069%	932%
2012	1035%	921%
2011	1133%	998%
2010	1199%	1098%
2009	838%	902%

The table above shows that CareFirst has enjoyed healthy RBC ratios on both its BlueChoice and GHMSI entities over the past five years.

Opinion: A complete review of CareFirst's financial position is outside of the scope of our work and therefore we offer no opinion as to a recommended contribution to surplus.

Calibration to 1.0 on District Age Curve

In adjusting the calculated 2015 plan adjusted index rates to consumer level premiums, one of the adjustments applied was to normalize the projected claim cost to reflect that of an individual at a 1.00 factor on the District age curve. The adjustments applied are shown in the table below.

Age Calibration Factors

	BlueChoice Individual	BlueChoice Small Group	GHMSI Individual	GHMSI Small Group
Factor	0.950	0.950	0.914	0.950

The amounts in the table above are equal to the reciprocal of the weighted average District age factor, with the weighting based on projected enrollment by age.

Opinion: In our opinion, CareFirst appropriately applied an age calibration factor in developing the consumer level premiums.

Projected Loss Ratios

In its revised filings CareFirst projected that if claims and expenses unfold as projected, the following loss ratios will develop for each legal entity and market. The traditional loss ratio is calculated as incurred claims divided by earned premium. The MLR loss ratio reflects adjustments to the numerator and denominator of the traditional loss ratio as allowed under Federal MLR regulations.

Projected Loss Ratios

	BlueChoice Individual	BlueChoice Small Group	GHMSI Individual	GHMSI Small Group
Traditional Loss Ratio	73.0%	70.0%	75.2%	78.4%
MLR	80.1%	84.6%	80.0%	81.9%

Opinion: In our opinion the projected loss ratios are reasonable and the projected MLRs are all at least 80%, the minimum requirement in the individual and small group markets. However, we have noted several issues and inconsistencies in previous sections of this analysis which, if adjusted for, would result in the projected MLRs falling below Federal minimum levels.

Actuarial Certification

The final step in our review was to perform a compliance check to ensure that the individuals certifying the rates were members of the American Academy of Actuaries, current on continuing education requirements. The two initial individual filings were certified by Mr. Todd Switzer, ASA, MAAA and the two initial small group filings were certified by Mr. Dwayne Lucado, FSA, MAAA. Screen shots from the Society of Actuaries on-line directory are included in Appendix D and show that Mr. Switzer is not reflected as being compliant with 2012-2013 continuing education requirements necessary to be eligible to certify rates in 2014. However, we note this information is self-reported and may not indicate that the continuing education requirements have not been met. Further, all four of the final filings were certified by Mr. Kenny Kan, FSA, MAAA, CPA, CFA. Mr. Kan is reflected in the Society of Actuaries on-line directory as being compliant with continuing education requirements.

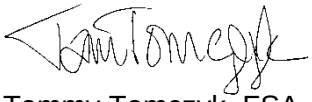
Conclusion

As previously noted, our review was limited to the information included in the filing provided by CareFirst, and responses which in some cases did not provide the level of support requested. Had additional information been provided our opinions noted herein may have differed. Also, please note that since the proposed rates are an estimate of future contingent events, the actual results may vary.

I am a member of the American Academy of Actuaries and meet all of its requirements to render the opinions provided in the letter. I have utilized generally accepted actuarial methodology in reaching these opinions.

Please do not hesitate to contact me if you have any questions.

Sincerely,



Tammy Tomczyk, FSA, MAAA, FCA

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Appendix A
Effective Rate Review

Effective Rate Review Requirements of 45 CFR 154.301

1. Medical trend changes by major service category;
2. Utilization changes by major service category;
3. The impact of cost sharing changes by major service categories, including actuarial values;
4. The impact of benefit changes, including essential health benefits and non-essential health benefits;
5. The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under Section 2701 of the PHSA;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative expenses;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical loss ratio;
12. Capital and surplus;
13. The impact of geographic factors and variations;
14. The impact of changes within a single risk pool to all products or plans within the risk pool; and
15. The impact of reinsurance and risk adjustment payments and charges under Sections 1341 and 1343 of the Affordable Care Act.

Additional District Specific Considerations:

1. Carriers operating in both the individual and small group markets must utilize the pooled experience from both markets in calculating their index rate;
2. Carriers must use the District specific standardized age curve;
3. Carriers may not rate by geography; and
4. Carriers may not rate by tobacco use status.

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Appendix B
Summary Of Proposed and Alternate Assumptions

	Blue Choice Individual			Blue Choice Small Group			GHMSI Individual			GHMSI Small Group		
	Filing	Oliver Wyman Estimate	Potential Rate Impact	Filing	Oliver Wyman Estimate	Potential Rate Impact	Filing	Oliver Wyman Estimate	Potential Rate Impact	Filing	Oliver Wyman Estimate	Potential Rate Impact
IMPACT ON ALL PLANS												
Trend	7.0%	6.0%	-1.5%	7.0%	6.0%	-1.5%	7.0%	6.0%	-1.5%	7.0%	6.0%	-1.5%
Risk Adjustment	-4.3%	-4.3%	0.0%	0.0%	N/A	0.0%	4.5%	4.5%	0.0%	0.0%	N/A	0.0%
Population Change (Demographics)	1.1%	1.1%	0.0%	1.1%	1.1%	0.0%	0.3%	0.3%	0.0%	0.3%	0.3%	0.0%
Population Change (Morbidity/Early Renewals)	1.5%	0.8%	-0.6%	1.5%	0.8%	-0.6%	1.7%	0.9%	-0.7%	1.7%	0.9%	-0.7%
Transitional Reinsurance Recoveries (% Claims)	-3.8%	-3.8%	0.0%	N/A	N/A	N/A	-4.3%	-4.3%	0.0%	N/A	N/A	N/A
Induced Utilization - Base Period vs. Projection Period	0.0%	-4.6%	-3.7%	0.0%	-4.6%	-3.8%	0.0%	-3.0%	-2.4%	0.0%	-3.0%	-2.4%
Induced Utilization - Index Rate vs. Market Level	0.0%	-3.6%	-2.9%	0.0%	2.6%	2.1%	0.0%	-2.6%	-2.1%	0.0%	0.3%	0.3%
Exchange Fee	2.0%	1.0%	-1.0%	2.0%	1.0%	-1.0%	2.0%	1.0%	-1.0%	2.0%	1.0%	-1.0%
Contribution to Surplus	0.0%	N/A	N/A	2.0%	N/A	N/A	-0.2%	N/A	N/A	1.5%	N/A	N/A
Admimistrative Expenses	$57.54	$57.54	N/A	$59.64	$59.64	N/A	$59.84	$59.84	N/A	$59.33	$59.33	N/A
Network Differentials	0.0%	-1.0%	-0.8%	0.0%	0.5%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA Insurer Fee	3.2%	3.2%	0.0%	3.2%	3.2%	0.0%	2.6%	2.6%	0.0%	2.6%	2.6%	0.0%
Pediatric Dental	$3.89	$3.89	0.0%	$3.89	$3.89	0.0%	$3.89	$3.89	0.0%	$3.89	$3.89	0.0%
Adult Vision - Index Rate Adj.	$0.10	$0.00	0.0%	$0.10	$0.00	0.0%	$0.11	$0.00	0.0%	$0.11	$0.00	0.0%
Adult Vision - Plan Level Adj.	$0.10	$1.07	0.2%	$0.10	$0.00	0.0%	$0.11	$1.07	0.2%	$0.11	$0.00	0.0%
IMPACT ON SPECIFIC PLANS												
HSA Factors	45 CFR 156.80 allows for five plan level adjustments. An additional plan level adjustment was applied based on whether the plan is designed to be used with an HSA account and results in widening the premium differentials by 9-10% in the individual market and 5% in the small group market.											
Catastrophic Plan Level Adjustment	0.42	0.54	28.7%	N/A		N/A	N/A		N/A	N/A		N/A
Paid-to-Allowed Ratios for Small Group Platinum Plans	N/A		N/A	Paid-to-Allowed ratios for Platinum plans are 15-20% higher than Gold plans			N/A		N/A	N/A		N/A

MARSH & McLENNAN COMPANIES

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Appendix C
Independent Trend Analysis

BlueChoice

Trend Metric	Months of Trend Data	Trend Basis		Allowed Claims: Non-Capitated Medical Services: Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Total Medical	Total Allowed Rx Claims	Total Trend - Medical and Rx Combined
Average	**24**	**Monthly**	**Exponential**	**-0.92%**	**8.17%**	**4.53%**	**1.06%**	**4.25%**	**3.37%**	**4.07%**
Low Range of CI	24	Monthly	Exponential	-6.12%	5.24%	2.46%	-2.31%	3.01%	1.05%	3.03%
High Range of CI	24	Monthly	Exponential	4.57%	11.17%	6.64%	4.55%	5.49%	5.75%	5.13%
Average	**24**	**Rolling**	**Exponential**	**4.78%**	**8.28%**	**2.03%**	**-2.08%**	**3.93%**	**7.60%**	**4.87%**
Low Range of CI	24	Rolling	Exponential	N/A	N/A	N/A	N/A	N/A	N/A	N/A
High Range of CI	24	Rolling	Exponential	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average	**36**	**Monthly**	**Exponential**	**-4.00%**	**8.26%**	**4.86%**	**3.56%**	**3.37%**	**3.41%**	**3.41%**
Low Range of CI	36	Monthly	Exponential	-8.08%	6.21%	3.42%	1.34%	2.08%	1.91%	2.32%
High Range of CI	36	Monthly	Exponential	0.26%	10.34%	6.33%	5.82%	4.68%	4.92%	4.50%
Average	**36**	**Rolling**	**Exponential**	**-1.18%**	**8.23%**	**3.41%**	**5.05%**	**3.45%**	**4.21%**	**3.64%**
Low Range of CI	36	Rolling	Exponential	-2.12%	7.85%	3.15%	4.21%	3.22%	3.77%	3.39%
High Range of CI	36	Rolling	Exponential	-0.23%	8.62%	3.66%	5.90%	3.68%	4.65%	3.90%

GHMSI

Trend Metric	Months of Trend Data	Trend Basis		Allowed Claims: Non-Capitated Medical Services: Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Total Medical	Total Allowed Rx Claims	Total Trend - Medical and Rx Combined
Average	**24**	**Monthly**	**Exponential**	**5.88%**	**5.51%**	**6.72%**	**26.93%**	**7.81%**	**5.60%**	**7.30%**
Low Range of CI	24	Monthly	Exponential	2.08%	3.37%	4.78%	22.65%	6.59%	3.42%	6.13%
High Range of CI	24	Monthly	Exponential	9.82%	7.70%	8.70%	31.35%	9.04%	7.83%	8.48%
Average	**24**	**Rolling**	**Exponential**	**10.08%**	**9.77%**	**8.12%**	**26.41%**	**10.13%**	**11.41%**	**10.45%**
Low Range of CI	24	Rolling	Exponential	N/A	N/A	N/A	N/A	N/A	N/A	N/A
High Range of CI	24	Rolling	Exponential	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average	**36**	**Monthly**	**Exponential**	**0.79%**	**6.28%**	**5.04%**	**11.76%**	**4.96%**	**3.30%**	**4.57%**
Low Range of CI	36	Monthly	Exponential	-2.00%	4.78%	3.80%	8.59%	3.96%	1.93%	3.64%
High Range of CI	36	Monthly	Exponential	3.67%	7.81%	6.29%	15.02%	5.97%	4.69%	5.50%
Average	**36**	**Rolling**	**Exponential**	**2.38%**	**8.27%**	**4.01%**	**11.42%**	**5.22%**	**4.79%**	**5.12%**
Low Range of CI	36	Rolling	Exponential	1.62%	8.01%	3.60%	9.66%	4.74%	4.11%	4.59%
High Range of CI	36	Rolling	Exponential	3.15%	8.53%	4.41%	13.22%	5.71%	5.48%	5.64%

Note: The filing did not contain prescription drug data by brand vs. generic

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Appendix D
Certifying Actuaries

Todd S Switzer

Personal Information
Todd S Switzer
Senior Director, Actuarial Pricing
CareFirst BlueCross BlueShield
OM1, 7th Floor, 01-780
10455 Mill Run Circle
Owings Mills, MD 21117
United States

Tel: (410) 998-7107
Fax: (410) 998-7717
Email: Todd.Switzer@CareFirst.com

Designations
ASA 1993
MAAA 1994

SOA Continuing Professional Development Requirement
Non-compliant(2012-2013)

Academic Degrees
B.A.
B.Math

Other Professional Designations

Industry
Healthcare: Health Insurance

Primary Area of Practice
Health

Specializations

Society of Actuaries Sections

MARSH & McLENNAN COMPANIES

Dwayne L Lucado

Personal Information
Dwayne L Lucado
Director, Actuarial Pricing
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117
United States

Tel: (410) 998-7519
Fax: (410) 998-7717
Email: dwayne.lucado@carefirst.com

Designations
MAAA 2002
FSA 2004

SOA Continuing Professional Development Requirement
Compliant(2012-2013)

Academic Degrees
B.S.

Other Professional Designations

Industry
Healthcare: Health Insurance

Primary Area of Practice
Health

Specializations
Investments
Marketing

Society of Actuaries Sections
Health

Kenny W Kan

Personal Information
Kenny W Kan
Senior VP and Chief Actuary
CareFirst BlueCross BlueShield
OM1-720
10455 Mill Run Circle
Owings Mills, MD 21117
United States

Tel: (410) 998-4588
Fax: NA
Email: kwtkan@hotmail.com

Designations
MAAA 1995
FSA 2000

SOA Continuing Professional Development Requirement
Compliant(2012-2013)

Academic Degrees
M.B.A.

Other Professional Designations
CFA
CPA

Industry
Healthcare: Health Insurance

Primary Area of Practice
Health

Specializations
Capital Management
Product Pricing/Development

Society of Actuaries Sections
Health
International
Investment
Management & Personal Development
Social Insurance & Public Finance