Actuarial Memorandum
Blue Cross of Idaho Health Service, Inc.
Individual Qualified Health Plans
Effective January 1, 2018

I, David J. Hutchins, am Vice President of Actuarial Services and Underwriting for Blue Cross of Idaho Health Service, Inc. (BCI), HIOS Issuer ID #61589. I am a member of the American Academy of Actuaries. The purpose of this memorandum is to describe the development of Idaho rates for Blue Cross of Idaho's Individual Market Qualified Health Plans to be effective January 1, 2018 and to support an opinion whether the rates:

(a) are actuarially sound as required by Idaho Code 41-5206(4)(b);
(b) comply with the premium requirements set forth in Idaho Department of Insurance Bulletin 2013-02; and
(c) comply with the Individual Market Reform provisions of the Affordable Care Act.

This memorandum also contains information required by Idaho Department of Insurance Bulletin 2011-07 and HHS Actuarial Memorandum and Certification Instructions, and describes the calculation of the numbers used in the Unified Rate Review Template. This memorandum is intended for the use of the regulators in the Idaho Department of Insurance, the United States Department of Health and Human Services, and their contractors. It is not intended for any other purpose.

4.1 Redacted Actuarial Memorandum

This is not a redacted memorandum.

4.2 General Information Section

Company Legal Name: **Blue Cross of Idaho Health Service, Inc.**
State: **Idaho**
HIOS Issuer ID: **61589**
Market: **Individual**
Effective Date: **01/01/2018**

Primary Contact Name: **David J. Hutchins**
Primary Contact Telephone Number: **(208) 331-8871**
Primary Contact Email Address: **DHutchins@bcidaho.com**

4.3 Proposed Rate Increase(s)

The rate increases for this product apply to Individual products that are part of the individual single risk pool, as defined by 45 CFR § 156.80. The rate increases will only apply to the qualified health plans (QHP) from the single risk pool.

Reason for Rate Increase(s):

- Medical Inflation: (Cost per instance of type of service) increase due to contract and fee schedule changes.
- Increased Utilization: The usage of services is expected to be different in the effective period than in the experience period.

- Benefits have been changed in the products offered in effective period due. Changes have been made to allow products to meet metallic tier requirements of the ACA. Other changes have been made to meet expected market demands.
- Changes in Taxes and Fees.
- Anticipated changes in the risk adjustment and CSR programs.

Plans have changes that vary by plan. Benefit changes are different by plan. The level of benefit change to meet metallic tier requirements varies by plan. The rate changes in this filing do not affect rate changes for grandfathered or the transitional products that are part of the individual single risk pool in the experience period. Rates for QHP products reflect impacts of grandfathered and transitional products that migrate into QHP products.
Table 1 summarizes the effect of the rate increases.

Table 1
Anticipated Effect of the Rate Change

	Current Rate	Projected Rate	Increase
Average Rate All Plans	**$460.18**	**$576.57**	**25.3%**

4.4 Market Experience

4.4.1 Experience Period Premium and Claims

This information is based on the single risk pool in the base experience period.

Experience Period: 01/01/2016 to 12/31/2016
Date through which payments have been made on claims incurred during experience period: 4/30/2017
Premiums (net of MLR Rebate) in Experience Period: $268,914,816

The experience period used for both the rate development and the URRT was Calendar Year 2016, with claims paid through 4/30/2017. IBNR comprises less than 1% of total incurred claims so block-specific IBNR factors were not developed. IBNR factors are developed by the month a claim is incurred and the items our regression analyses have found most significant in the lag between incurral and payment, which includes coordination with Medicare, UB vs. non-UB billing form, and whether the claim was billed directly to Blue Cross of Idaho or were billed to another Blue Cross Blue Shield Association company and routed to Blue Cross through the Interplan Transfer System (ITS). Completion factors are assigned claim-by-claim based on these characteristics and applied uniformly to allowed charges, paid

amounts, and utilization counts. Prescription Drug claims complete very quickly and with two months runout the IBNR was negligible.

The rates were developed using Non-Grandfathered experience.

Premium was based on total revenues, including any expected accounting adjustments used in the Blue Cross of Idaho annual financial statements. Revenues include payments made to Blue Cross of Idaho for advance premium credits associated with 2016 QHP products.

The expected MLR rebate rules and templates for 2016 are available. The MLR rebate was estimated for the Individual Single Risk Pool as of December 31, 2016 for Blue Cross of Idaho annual financial statements. The expected rebate of $0.00 was used in the annual financial statements and is consistent with current expectations.

Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are captured in BCI claims payment system. Pharmacy claims are captured through the Pharmacy Benefit Manager (PBM) systems. Pharmacy rebates are those received by BCI for the Individual single risk pool.

The Index Rate is defined by the instructions as the EHB portion of projected allowed claims divided by all single risk pool lives. The Index Rate for the experience period was based on claim experience from 1/1/2016 through 12/31/2016 for all non-Grandfathered Blue Cross of Idaho business subject to Idaho Code 41-5206. 100% credibility was given to this experience. This follows the single risk pool definition of the instructions.

Capitation Cost Calculation:

Blue Cross of Idaho pays capitation charges for vaccinations. The state of Idaho has a childhood immunization program in which the state purchases vaccines at a low cost and provides vaccines to physicians for administration to the insured, including employees of self-funded employers, Medicaid, and uninsured populations. Insurers and groups are assessed based on the number of persons under age 19.

The experience period incurred claims are shown in Table 2. Experience period allowed claims are shown in Table 3.

Table 2
Experience Period Incurred Claims
Calendar Year 2016

Item	Amount
Projected PMPM Non-Capitated Claims	**$348.37**

Table 3 Experience Period Allowed Claims Calendar Year 2016			
	Item	**Amount**	
	PMPM Claims	**$478.90**	

Completion factors used to develop the Medical incurred but not reported (IBNR) were based on BCI's Commercial Medical and Pharmacy block of business, split by type of claim, whether Medicare was primary or not for coordination of benefit claims, and by whether the claims were submitted directly to BCI or routed through the Blue Cross Blue Shield Association Interplan Transfer System (ITS). The same completion factors were applied to paid claims on a claim-by-claim basis for both incurred and allowed claims. Using the larger block of business reduces probability of actual IBNR varying from expected. All BCI commercial claims paid by BCI's Prescription Benefit Manager were used to set the IBNR for Drug. The factors developed were applied claim-by-claim to the experience period claims.

None of the policies cover Non-Essential Health Benefits.

The Vaccine Program for Children is a mandatory program for all carriers and self-insured employers in the State of Idaho. Carriers pay into a fund maintained by the state based on the number of children under age 18 whom they cover. The state fund purchases vaccines at a favorable price from the manufacturers. It allows providers to have a single store of vaccines that can be dispensed to both Medicaid and privately insured patients. The assessment rate for carriers changes July 1 of every year.

4.4.2 Benefit Categories

Benefit Categories in Worksheet 1, Section II are calculated by Blue Cross of Idaho using a claim grouper developed by Milliman to count and classify medical claims by service category. The grouper classifies claims into many categories which were mapped to the categories described in the instructions for the URRT. Idaho's Vaccine for Children program, described in Section 4.4.1, is treated as a capitated service. Pharmacy claims submitted through our PBM are classified as Prescription Drug claims. The same completion factors were applied on a claim-by-claim basis to the utilization measures as the allowed and paid amounts.

The utilization used for capitation payments was the number of member-months for persons under age 19. Conceptually, this corresponds to how BCI is charged for participation in the program.

Allowed claims are split by type of service in table 4.

Table 4 Experience Period Allowed Claims Calendar Year 2016				
Service	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	61.50	21,309.82	109.22
Outpatient Hospital	Services	2,107.25	870.06	152.79
Professional	Services	13,608.26	114.82	130.20
Other Medical	Services	556.58	214.72	9.96
Capitation	Benefit Period	12,000.00	1.48	1.48
Prescription Drug	Prescriptions	9,543.22	94.63	75.26
Total				**$478.90**

4.4.3 Projection Factors

Changes in the Morbidity of the Population Insured:

The morbidity in the projected population is expected to be similar to the QHP population in the experience period. To adjust the Single Risk Pool morbidity to that expected in the projection period average risk factor for total pooled experience was compared to the experience period QHP population. The projected morbidity was reduced to reflect improved enforcement of the Special Election Period (SEP) requirements. Average risk factors were calculated by weighting age/gender factors by the associated distribution of membership. The change in morbidity is shown in Table 5.

Table 5 Morbidity of the Population Insured		
Item	**Amount**	
Risk QHP to Total Single Risk Pool	1.0810	

Other Adjustments:

Changes in Benefits:

Adjustment for benefit differences are shown in Table 6. The average benefit relativity (weighted by member months) is compared in the experience period and the projection period.

The QHPs include several products that feature lower-cost networks than were available for most of the experience period. The reduction in contractual payment rates is reflected in the Benefit and Network Factor of Table 6. The lower-cost network products also feature enhanced medical management and care coordination, as reflected in the Product Utilization Factor column of Table 6.

The utilization increase exceeds the benefit / network increase for three reasons. The benefit / network factor is lowered somewhat due to network discounts. In general, the medical benefits are leaner in the projected QHP market than in the current market and the drug benefits are richer. Drug benefits are more sensitive to cost sharing than medical benefits, so this shift results in an increase in utilization. Finally, the utilization factor includes the utilization and benefit impact for the Cost Sharing Reduction plans in 2018.

Table 6
Expected Benefit Change

	(a)	(b)
Benefit Level	**Projected BCI Members**	**Benefit Relativity factor**
Expected Average (Member Weighted) Factors	**435,360**	**0.6116**
Average Factors from Experience Period		**0.6226**
Factor Differential		**0.9825**

Changes in Demographics:
The age and gender mix in the 2016 QHP population is expected to be representative of the projected period mix. The age distribution was compared to the experience period using the Idaho-approved QHP age rate factors. The change in age category was further adjusted for risk differences by comparing the experience period risk factors to experience period age factors. This is to capture average cost differences not already captured by age rating curve.

Table 7 displays the total product of the "Other" category components

Table 7
Other Adjustments

Item	Amount
Total Other Adjustment Factor	1.0270

Trend Factors (cost/utilization):

Trend factors were based on observed QHP Individual trends for 2015/2014, 2016/2015 and current BCI pricing trends for commercial business.

For the purpose of Worksheet 1 of the Unified Rate Review Template, all claims paid by the Prescription Benefit Manager were classified as Pharmacy. Medical claims were classified using Milliman's Health Cost Guidelines (HCG) claim classification software.

Table 8 shows the breakdown of trend between cost and utilization. These trends apply to non-capitated claim costs only.

Table 8
Allowed Trend

Item	Medical	Drug
Cost Factor	0.981	1.118
Utilization Factor	1.070	1.054

Table 9 summarizes the projection factors used in worksheet 1 of the URRT.

Table 9
Projection Period Adjustments

Item	Pop'l risk Morbidity	Other	Cost	Util
Inpatient Hospital	1.081	1.027	1.011	1.039
Outpatient Hospital	1.081	1.027	0.964	1.096
Professional	1.081	1.027	0.973	1.064
Other Medical	1.081	1.027	1.008	1.088
Capitation	1.000	1.000	1.030	1.000
Prescription Drug	1.081	1.027	1.118	1.054

Population Risk and Morbidity factors: For non-capitated claim costs, this is the product of the Morbidity Increase rounded to three decimals. The morbidity increase represents the change in the cost for the population eligible for coverage, and the selection increase represents the additional selection compared to the experience period due to the new and anticipated market rules. Capitation for vaccines for children under 18 was assumed to be unaffected. QHP benefit design required coverage of pediatric vision for those under 18 as an Essential Health Benefit. To provide this benefit, BCI contracted with VSP for those under 18.

Other Factors: This is the demographic change based on the Idaho-approved age rate curve.

Cost Trend Factors: Includes underlying medical and prescription drug trend and changes in contracting with existing providers.

Utilization Trend Factors: This is based on Blue Cross of Idaho's Idaho medical and prescription drug coverage.

There is not a utilization trend component for capitation payments. The factor was set to 1.000.

4.4.4 Credibility Manual Rate Development

The characteristics of the Individual QHP market are significantly different than other commercial populations. Manual rates were not used.

4.4.5 Credibility of Experience

BCI Individual QHP has 655,869 member months in 2016. BCI Single Risk Pool in 2016 had 711,122 member months. Using a standard of 10,000 members (120,000 member months), both of these populations are considered to be fully credible.

4.4.6 Paid to Allowed Ratio

Average benefit relativity is for projection period is shown in Table 6.

4.4.7 Risk Adjustment and Reinsurance

The Risk Adjustment program is anticipated to result in a 4.4% receivable by Blue Cross of Idaho in 2018, in addition to the Risk Adjustment User Fee. This is based on a preliminary analysis of the 2016 payment provided by the Idaho Department of Insurance and the addition of the high claimant adjustment. The net expected risk adjustment income includes user fees which are paid.

The Temporary Reinsurance Program ended in benefit year 2016, and neither taxes nor recoveries are anticipated for benefit year 2018.

As per the directive that the Idaho Individual High Risk Pool Board has secured funding for the state's reinsurance program, a reinsurance of 1.86% of premium was included in the ratemaking assumption. This resulted in a 2% reduction to premiums as was expected by the State of Idaho Department of Insurance.

Exchange fees are based on the percentage fee charged times the expected utilization of the exchange by members. Net risk adjustment, Net Expected TRP recoveries and the exchange fee are shown in Table 10.

Table 10
Risk Adjustment and TRP Recoveries
Calendar Year 2018

	Item	Amount	

	Net Expected Risk Adjustment Income	$24.57	
	Net Expected TRP Recoveries	$0.00	
	Idaho-Specific Reinsurance	$10.61	
	Exchange Fees	$9.99	

4.4.8 Non-Benefit Expenses and Profit & Risk

Administrative Expense Load:

Overhead expenses are allocated across all departments on a monthly basis and posted to the general ledger. Depending on the type of expense, a statistical driver is chosen to determine the share of the expense account allocated to each department (cost center). The statistical drivers used are square footage, salary dollars and FTE counts.

Further allocation of expenses for line of business costing is based on the determination of the allocation of net productive hours for each department. Where possible, that allocation is determined by identifying how time is actually spent through the use of time-studies and/or inputs from management. In the case that those metrics do not provide a full allocation of resources, a secondary statistic is employed to allocate the remainder of the department. Statistics include claims counts, claims dollars, members, contracts and call volume. The statistic used is the one that best aligns with the activities within the department being allocated. The resulting data is stored in an enterprise performance management system.

Table 11
Administrative Fees

	Item	Amount	%	
	Administrative Expense Load	$45.87	8.1%	

Profit (or Contribution to Surplus) & Risk Margin:

The anticipated pre-tax margin included in the premium is 2.00%. Premium is generally received in advance of coverage being provided, ensuring that the cash flow is positive. Investment income would therefore be positive, and is ignored in the analysis. Blue Cross is a mutual insurance company and does not maintain a cost of capital model, as the source of capital is the cumulative margin provided by its insurance and administrative operations.

The Health Insurer Fee (HIF) is not deductible for Federal Income Tax purposes, so additional premium needs to be collected to pay the additional Federal Income Tax on the portion of premium collected to cover the Health Insurer Fee. This amount will show as underwriting gain on BCI's financial statements. BCI's marginal tax rate is 35%. It is also financially appropriate for an insurance company to provide for an underwriting gain in the premium. Expected profit shown in table 12 does not include HIF fee tax. The expected federal income tax includes tax on expected profit as well as the tax on HIF.

Table 12 Risk Contingency and Profit Calculation	
Item	**PMPM Amount**
Profit @2% of Premium	$11.35
Expected Federal Income Tax	$10.91

Taxes and Fees:

Market place user fees are included in taxes and fees as summarized in table 13.

Table 13 includes the components of the Tax and Fee component of the premium. Risk Adjustment Charges and Exchange fees have been classified as adjustments to claim costs, as required in the instructions. Federal Income Taxes are reported as a tax, also required by the instructions.

Table 13 Taxes and Fees	
Item	**Amount**
Total Taxes & Fees	$42.51

The estimated Health Insurer Fee percent for 2018 (to be paid in 2019) is calculated as the % fee for 2015(paid in 2016) as calculated by the IRS, times the statutory total collections in 2018 (based on 2017 premiums) divided by those in 2016 (based on 2015 premiums).

Table 14 Projected Loss Ratio	
Item	**Amount**
Medical Loss Ratio	87.5%

4.6 Application of Market Reform Rating Rules

4.6.1 Single Risk Pool

The individual single risk pool is established according to the requirements in 45 CFR § 156.80(d). The data includes all non-grandfathered individual plans including transitional plans.

4.6.2 Index Rate

BCI has no benefits in excess of the EHB. The index rate is the total allowed cost shown in Table 3. The Index Rate is to be developed following the specifications of 45 CFR § 156.80(d)(1). The Index Rate is based on the total combined claim costs for providing the EHBs for the single risk pool. The Index Rate is derived by dividing the total combined EHB allowed claims for the single risk pool by all covered lives in the single risk pool.

Table 15
Projection Period Index Rate
Calendar Year 2018

Item	Amount
Projection Period Index Rate	**$609.96**

4.6.2.1 Small Group Quarterly Rate Filings:

Not applicable to the individual single risk pool

4.6.3 Market Adjusted Index Rate

The Market Adjusted Index Rate is the Projection Period Index Rate adjusted for expected net Risk Adjustment recoveries or payments and increased for expected exchange fees. Table 16 shows the calculation of the Market Adjusted Index Rate.

Table 16
Market Adjusted Index Rate

Item	Amount
Market Adjusted Index Rate	$586.15

Note: The Marked Adjusted Index Rate does not include the Idaho-Specific Reinsurance.

4.6.4 Plan Adjusted Index Rates

Plan adjusted index rates are calculated by applying factors to the Market Adjusted Index rates. Factors:

- Expected utilization of services
- Network costs specific to a plan
- Benefit relativity factors
- Catastrophic pooling factor
- Tobacco load factor. The change in rates was calculated by applying the tobacco rating load to expected membership with tobacco use. The base rates are then reduced to offset the additional revenue from the smoker load.
- Loading factor for administrative costs

Detail of calculations are discussed in section "4.7.2 AV Pricing Values"

Table 17 (in Appendix 1) displays the Plan adjusted Index Rates both before and after adjusting for tobacco use. The rates reflect the factors above.

Table 18 displays the loading factor adjustments.

Table 18
Loading Factor Calculation

Item	Amount
Adjustment Factor	1.17813

4.6.5 Calibration

The Calibrated Plan Adjusted Index Rate is intended to approximate the premium at the average age for a Non-Smoker with a Geographic Loading factor of 1.0000. This is compliance with 45 C.F.R. §147.102. The Plan Adjusted Index Rates in Table 17 are market-wide, and represent the average age, gender, geographic, and smoker mix of the projection period, and are not calibrated. The instructions require the calibration to be performed in two separate steps, one step for age demographics and another for geographic region.

Table 19
Calibrated Plan Adjusted Index Rates

Projected Enrollment	Plan Adjusted Index Rate	Geographic Factor	Age Curve	Age 21, Region Load 1.0000 Rate
36,280	$567.48	0.9943	1.6505	$344.28

4.6.6 Consumer Adjusted Premium Rate Development

The consumer adjusted Premium rates are developed starting with the Plan adjusted index rates in Table 17. Adjustment was made for Age and Geographic factors.

4.7 Plan Product Info

4.7.1 AV Metal Values

The AV calculator could not model Blue Cross's 2018 prescription drug benefits correctly. All plan designs include a 7 tier pharmacy benefit design. The AV calculator does not differentiate cost share inputs with this benefit type. The AV was calculated using the AVC for the benefit in each of the plan design's custom drug tiers. The AVC-calculated AVs were weighted based on appropriate statistics derived from group data. Script counts or allowed amounts were used for weighting depending whether the benefit was modeled with a copay or coinsurance.
For each plan that was calculated using this alternate methodology, a separate certification is provided.

Per the instructions, the "AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate". The AV Pricing Value was calculated as the Plan Adjusted Index Rate from Table 17, divided by the Market Adjusted Index Rate, calculated in Table 16.

4.7.2 AV Pricing Values

Benefit Design Value Calculation Methodology
The model for evaluating benefit design was based on our consultant's health cost guidelines. Frequency and charge factors for this table are generally calibrated for a large employer population. Utilization factors, average charge per service numbers, and claim probability distributions were trended to the 1/1/2018 effective date, adjusted to Idaho-specific levels, and charge per service factors and claim probability distributions were reduced to reflect BCI's negotiated discounts. The utilization factors in these models are for the large group market and therefore reflect changes in behavior driven by benefit design only. These models do not reflect the impact of member selection.

Table 6 summarizes the values of the QHP benefit plans derived from these models. Each benefit plan was evaluated and two statistics were calculated.

(1) the pricing value relative to a 100% benefit plan using a PPO network, assuming the expected utilization that a 100% benefit plan would induce. This is referred to as the Benefit/Network/Utilization Factor.
(2) The percentage of allowed charges that are expected to be paid under the plan, where both the allowed charges and the paid amount are calculated using the plan design's expected utilization. This number is referred to as the Benefit-Only Factor or the Pricing AV.

Two other statistics are used as part of the pricing calculation. The Network Factor is the relativity of the allowed claim cost between the standard PPO fee schedule and lower-cost network plans. The Benefit / Network / Utilization factor has both the utilization and network factors as intrinsic portions of its derivation. A metal level adjustment factor was applied for non-catastrophic plans. This factor applies the allowed metal level differentials published by the Idaho Department of Insurance.

Catastrophic Pool Adjustment

The ACA creates a separate risk adjustment pool for young adults under age 30 and persons who can demonstrate hardship. The term "young adult" has not been precisely defined. In 2012, BCI estimated that the catastrophic pool's cost would be 12% lower than the non-catastrophic pool. The 2012 factor is not expected to differ significantly from current. The 2012 factor is used for consistency. This calculation assumed that the definition is persons age 21 through 29. Those under 21 have an age factor of .635 and would not require rate relief through a separate risk adjustment pool.

To calculate the relative cost of the two risk pools, the expected cost of each pool was calculated based on the following assumptions:

- No persons eligible for a subsidy would qualify for the catastrophic plan through hardship.
- 10% of those not eligible for a subsidy would qualify for the catastrophic plan through a hardship exemption.
- All persons over 300% of the poverty level who are ages 21 through 29 select a catastrophic plan.
- The age distribution assumed was based on BCI's individual business during 2012.

The cost profile of all members was modeled based on their age and gender according to our consultant's standard age / gender cost distribution. The risk of the entire Individual market and the risk in the catastrophic pools were modeled using these assumptions. The ratio of projected cost to allowed age / gender factors was 12% higher for the non-catastrophic population than for the catastrophic population.

4.7.3 Membership Projections

2018 Membership Projections are based on BCI Individual QHP in April 2017.

Projected 2018 BCI Enrollment	
Product	**Projected Member Months**
Catastrophic	**6,144**
Bronze	**135,048**
Silver	**267,672**
Gold	**26,496**
Total	**435,360**

4.7.4 Terminated Plans and Products

It is Blue Cross of Idaho's intent to maintain all Grandfathered and Transitional ("Grandmothered") products at least through 2018. In 2017, Blue Cross of Idaho is replaced its broad-network products with narrow network products, adding products that better meet the market requirements, and eliminating low-membership products. These new products are continuing in 2018.

4.7.5 Plan Type

Pre-QHP (Transitional) Benefit Products

This rate filing does not apply to any products in existence during 2013. The products are summarized in this memorandum because their experience forms the basis of the rates for BCI's 2018 Individual Market Qualified Health Plans.

All products are Affordable Care Act (ACA) compliant. Effective with the January 2012 renewals, essential health benefits are not subject to global annual nor lifetime dollar limits (August 2012 renewals for Farm Bureau products).

There are seven benefit families in Blue Cross of Idaho's non-grandfathered, non-group, transitional portfolio. All products except certain HSA options cover prescription drugs.

BlueCare PPO: The amount of benefit payment depends upon whether the services are in-network [provided by a preferred provider organization (PPO) contracting provider] or out-of-network [provided by a non-contracting provider]

Simply Blue: These are products with no benefits for chiropractic services, growth hormone therapy, allergy injections, allergy testing, mental health or substance abuse services

HSA Blue: These are High Deductible Health Plans that can provide coverage over tax-favored Health Savings Accounts. The amount of benefit payment depends upon whether the services are in-network [provided by a preferred provider organization (PPO) contracting provider] or out-of-network [provided by a non-contracting provider].

Farm Bureau Active and Lapsed Products: These products provide coverage to policyholders covered or formerly covered under Blue Cross of Idaho's Farm Bureau Association. Individual coverage in the lapsed products is offered only to terminating membership in the Farm Bureau Association. The product features of these products are very similar to their non-Farm Bureau counterparts.

Essential Blue: These are limited benefit products with no benefits for chiropractic services, durable medical equipment, growth hormone therapy, home intravenous therapy, mental health or substance abuse treatment, orthotic devices, outpatient diagnostic services, outpatient occupational, physical and speech therapy, or prescription drugs. The non-grandfathered products cover preventive services and immunizations.

Essential Blue Plus: These are limited benefit products with no benefits for chiropractic services, durable medical equipment, growth hormone therapy, home intravenous therapy, mental health or substance abuse treatment, orthotic devices, outpatient diagnostic services, outpatient occupational, physical and speech therapy.

Connected Care: These are coordinated care products with no benefits for chiropractic services, growth hormone therapy, allergy injections, allergy testing, mental health or substance abuse services. These products have been available since 06/01/2012. The amount of benefit payment depends upon whether the services are in-network (provided by the Saint Alphonsus Health Alliance Network) or out-of-network (provided outside of the Saint Alphonsus Health Alliance Network). There are two product options within this product family: (1) Standard and (2) Plus. Member cost sharing for Plus is less than that of Standard.

Individual QHP Products

In 2016, BCI issued three families of QHP products:

- "Choice" products use BCI's PPO network of providers. All Essential Health Benefits are covered with a variety of cost sharing parameters designed to meet the ACA's EHB and Market reform requirements.

- "Connect" products utilize lower-cost networks. "Connect East" products are available in Rating Regions 1 and 3 (Zip Codes 832xx and 834xx). "Connect Southwest" products are available in Rating Regions 5 and 6 (Zip Codes 836xx and 837xx). All Essential Health Benefits are covered with a variety of cost sharing parameters designed to meet the ACA's EHB and Market reform requirements.

- "Carepoint" products utilize a narrow network in the lower-cost networks. This product is available in regions 1, 2, 4, 5 and 6. All Essential Health Benefits are covered with a variety of cost sharing parameters designed to meet the ACA's EHB and Market reform requirements.

In 2018, there is one product family will all products based on a tailored network

Pediatric Dental coverage is provided through separate products. Rates for these products are not discussed in this memorandum.

Pediatric vision is covered as part of the medical product and is provided through an arrangement with VSP.

None of the products cover non-Essential Health Benefits.

4.7.6 Warning Alerts

Ther are no warning alerts in the submitted URRT.

4.8 Miscellaneous Instructions

4.8.1 Effective Rate Review Information (optional)

Not Applicable

4.8.2 Reliance

In forming this analysis, I used work provided by Milliman Consulting Group. I reviewed the resulting benefit factors for reasonableness and believe that they are appropriate, and such use does not constitute formal reliance.

Additional Information

A - Underwriting and Renewability Provisions:

All new issue and renewal practices comply with the Market Reform provisions of the Affordable Care Act. There is a guaranteed issue period at the beginning of each calendar year and special enrollment periods created as defined in the regulation. Policies will be issued to policyholders of any age. Persons age 65 and older may enroll if ineligible for Medicare. All premium is billed monthly, and there are no premium modalization adjustments.

A Qualified Health Plan is renewable with respect to the individual or dependents, at the option of the individual, except in any of the following cases:

a) Nonpayment of the required premiums;

b) Fraud or intentional misrepresentation of material fact by the individual Insured or his representatives.

c) In the case of Qualified Health Plans that are made available in the individual market only through one (1) or more associations, as defined in Section 41-2202, Idaho Code, the membership of an individual in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;

d) The individual carrier elects to non-renew all of its health benefit plans delivered or issued for delivery to individuals in this state. In such a case the carrier shall:
   (1) Provide advance notice of its decision under this paragraph to the director; and
   (2) Provide notice of the decision not to renew coverage to all affected individuals and to the director at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected individuals; or

e) The director finds that the continuation of the coverage would:
   (1) Not be in the best interests of the policyholders or certificate holders; or
   (2) Impair the carrier's ability to meet its contractual obligations.
   (3) In such instance, the director shall assist affected individuals in finding replacement coverage.

An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1) (d) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director. In the case of an individual carrier doing business in one (1) established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

The ACA requires that subsidized members not be terminated for non-payment of premium until 90 days after the premium due date.

B – Morbidity and Persistency Factors and Projections; Active Life Reserves:

The market reforms created by the Affordable Care Act eliminate all new business and renewal underwriting. Rates are set every year, and policyholders can select any carrier in the market during the open enrollment period. As a consequence, the block can be treated as comprised of one-year term contracts and no active life reserves are required.

The comparison of morbidity factors for the forecast period to the experience period is addressed in Section F of this memorandum.

C – Unified Rate Review Template (URRT) Construction:

This section of the memorandum discusses the creation of the numbers entered in the URRT.

Worksheet 1, Section I

Premium: Premiums represent non-Grandfathered business in the experience period. BCI charges a coupon fee for non-QHP plans for those who do not pay by electronic fund transfer. This fee meets the definition of Premium in Idaho's Individual Rate Law and is included in the calculation. Because premium was not used as part of the rate development process, this number does not reconcile to any other number in this memorandum. BCI has not paid an MLR rebate.

Incurred Claims: The incurred claims used in Table 5 are the same as those reported on the URRT.

Worksheet 1, Section II

Projection Factors are summarized in table 9.

Worksheet 1, Section III

100% credibility was assigned to the experience.
Reinsurance, risk adjustment and Reinsurance recoveries are shown in Table 10.
Administrative Expense, Profit and Risk, Taxes and Fees loads are shown in Tables 11, 12 and 13.

This method classifies the expected exchange fees as a claim cost rather than an administrative expense or a tax item. This treatment is stipulated in the instructions.

Actuarial Soundness and Company's Financial Position

The rates were prepared with data available through April 2017. The data was prepared from the records of Blue Cross of Idaho under my direction and reviewed by me for reasonableness. There are no events subsequently known to me that would alter my certification.

Idaho's individual health law is similar to small employer law enacted in Idaho and most other states. Actuarial Standard of Practice No. 26 – *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans* defines actuarial soundness as follows:

> "Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital."

The anticipated pre-tax margin included in the premium is 2.00%. Premium is generally received in advance of coverage being provided, ensuring that the cash flow is positive. Investment income would therefore be positive, and is ignored in the analysis. Blue Cross is a mutual insurance company and does not maintain a cost of capital model, as the source of capital is the cumulative margin provided by its insurance and administrative operations.
Actuarial Standard of Practice 41 – *Actuarial Communications* recommends that actuaries consider discussing uncertainty or risk in actuarial communications. This analysis is based on a forecast of premiums, claims, expenses and the reinsurance premium. There are many material sources of risk in the rate development. The first is that the forecast of claim cost used in setting the Market Adjusted Index Rate is incorrect. Past experience suggests the actual claim cost could be 5% higher or 5% lower than the forecast claim cost.

A second risk is created by the eligibility rules for QHPs. These rules allow healthy consumers to avoid paying for months of coverage during the period approaching the open enrollment period as well as during the open enrollment period. Furthermore, the changes in enforcement of the Special Enrollment Period and Catastrophic Coverage requirements can increase the risk of the QHP population covered. Premium may potentially be reduced up to 10% without a commensurate reduction in claims cost.

The current litigation by congress challenging federal funding of Cost Sharing Reduction subsidies poses a third risk. The rates in this filing have been developed assuming that CSR reimbursements are not funded.

The Idaho Department of Insurance requires that the actuarial memorandum include a statement of the company's financial position, defined as the company's surplus and risk-based capital. BCI has provided this information to the Idaho Department of Insurance under separate cover in BCI's annual financial statement and risk-based capital report.

Actuarial Certification

I, David J. Hutchins, am the Director of Actuarial Services for Blue Cross of Idaho Health Service, Inc. HIOS Issuer ID 61589. I am a member of the American Academy of Actuaries and am qualified to render this opinion. I am familiar with the laws and regulations of the State of Idaho and the requirements of federal law. I certify that, to the best of my knowledge and judgment that the rates developed for Blue Cross of Idaho's Individual Market Qualified Health Plans to be effective January 1, 2018:

(a) The rates comply with all applicable State and Federal Statutes and Regulations, with the exception of the Idaho requirement for a single risk pool for Small Employer products. Grandfathered policies are excluded from the rates being calculated. The Idaho requirement is expressly pre-empted by Federal Regulations.
(b) The rates are developed in compliance with the applicable Actuarial Standards of Practice.
(c) The rates are reasonable in relation to the benefits provided and the population anticipated to be covered.
(d) The rates are not excessive nor substantially deficient.
(e) 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.
(f) 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.
(g) 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, with modified inputs as discussed in section 4.7.1.
(h) the geographic rating factors do not reflect differences in population morbidity by geographic area

In determining actuarial soundness, I did not consider the cost of capital as recommended in Actuarial Standard of Practice 26. The rating methodology for these products is the same as BCI used to develop the 2017 Individual QHP rates.

The URRT does not demonstrate the process used by the issuer 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 Marketplaces, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers

David J. Hutchins, FSA, MAAA
Vice President, Actuarial Services and Underwriting
Phone: 208.331.8871
Email: DHutchins@BCIdaho.com
July 18, 2017

Appendix 1

Table 17 Plan Adjusted Index Rate			
Plan Name	**HIOS ID**	**Prior to Tobacco**	**Final**
MVN East Catastrophic 7350	61589ID2360017	$342.59	$342.59
MVN East Bronze HSA 6000	61589ID2360019	$396.45	$396.45
MVN East Bronze HSA 6550	61589ID2360020	$413.28	$413.28
MVN East Silver 6000	61589ID2360023	$637.18	$637.18
MVN East Silver 3500	61589ID2360096	$635.49	$635.49
MVN East Silver 4000	61589ID2360022	$639.70	$639.70
MVN East Gold 1200	61589ID2360024	$642.24	$642.24
PQA Southeast Catastrophic 7350	61589ID2360001	$353.60	$353.60
PQA Southeast Bronze HSA 6000	61589ID2360003	$409.21	$409.21
PQA Southeast Bronze HSA 6550	61589ID2360004	$426.59	$426.59
PQA Southeast Silver 6000	61589ID2360007	$657.70	$657.70
PQA Southeast Silver 3500	61589ID2360095	$655.95	$655.95
PQA Southeast Silver 4000	61589ID2360006	$660.30	$660.30
PQA Southeast Gold 1200	61589ID2360008	$662.91	$662.91
HTE Catastrophic 7350	61589ID2360025	$382.84	$382.84
HTE Bronze HSA 6000	61589ID2360027	$443.04	$443.04
HTE Bronze HSA 6550	61589ID2360028	$461.84	$461.84
HTE Silver 6000	61589ID2360031	$712.06	$712.06
HTE Silver 3500	61589ID2360097	$710.16	$710.16
HTE Silver 4000	61589ID2360030	$714.88	$714.88
HTE Gold 1200	61589ID2360032	$717.70	$717.70
CPN North Central Catastrophic 7350	61589ID2360033	$342.74	$342.74
CPN North Central Bronze HSA 6000	61589ID2360035	$396.62	$396.62
CPN North Central Bronze HSA 6550	61589ID2360036	$413.47	$413.47
CPN North Central Silver 6000	61589ID2360039	$637.46	$637.46
CPN North Central Silver 3500	61589ID2360098	$635.78	$635.78
CPN North Central Silver 4000	61589ID2360038	$639.99	$639.99
CPN North Central Gold 1200	61589ID2360040	$642.52	$642.52
KCN North Catastrophic 7350	61589ID2360049	$364.53	$364.53
KCN North Bronze HSA 6000	61589ID2360051	$421.84	$421.84

Table 17
Plan Adjusted Index Rate

Plan Name	HIOS ID	Prior to Tobacco	Final
KCN North Bronze HSA 6550	61589ID2360052	$439.76	$439.76
KCN North Silver 6000	61589ID2360055	$677.99	$677.99
KCN North Silver 3500	61589ID2360099	$676.19	$676.19
KCN North Silver 4000	61589ID2360054	$680.68	$680.68
KCN North Gold 1200	61589ID2360056	$683.36	$683.36
HTN Catastrophic 7350	61589ID2360057	$354.41	$354.41
HTN Bronze HSA 6000	61589ID2360059	$410.14	$410.14
HTN Bronze HSA 6550	61589ID2360060	$427.54	$427.54
HTN Silver 6000	61589ID2360063	$659.16	$659.16
HTN Silver 3500	61589ID2360100	$657.42	$657.42
HTN Silver 4000	61589ID2360062	$661.77	$661.77
HTN Gold 1200	61589ID2360064	$664.39	$664.39
SAHA Southwest Catastrophic 7350	61589ID2360065	$330.98	$330.98
SAHA Southwest Bronze HSA 6000	61589ID2360067	$383.04	$383.04
SAHA Southwest Bronze HSA 6550	61589ID2360068	$399.29	$399.29
SAHA Southwest Silver 6000	61589ID2360071	$615.62	$615.62
SAHA Southwest Silver 3500	61589ID2360101	$613.98	$613.98
SAHA Southwest Silver 4000	61589ID2360070	$618.06	$618.06
SAHA Southwest Gold 1200	61589ID2360072	$620.50	$620.50
IDID Southwest Catastrophic 7350	61589ID2360073	$330.98	$330.98
IDID Southwest Bronze HSA 6000	61589ID2360075	$383.04	$383.04
IDID Southwest Bronze HSA 6550	61589ID2360076	$399.29	$399.29
IDID Southwest Silver 6000	61589ID2360079	$615.62	$615.62
IDID Southwest Silver 3500	61589ID2360102	$613.98	$613.98
IDID Southwest Silver 4000	61589ID2360078	$618.06	$618.06
IDID Southwest Gold 1200	61589ID2360080	$620.50	$620.50
SLHP Southwest Catastrophic 7350	61589ID2360091	$343.26	$343.26
SLHP Southwest Bronze HSA 6000	61589ID2360092	$397.23	$397.23
SLHP Southwest Bronze HSA 6550	61589ID2360093	$414.11	$414.11
SLHP Southwest Silver 6000	61589ID2360094	$638.45	$638.45
SLHP Southwest Silver 3500	61589ID2360103	$636.76	$636.76
SLHP Southwest Silver 4000	61589ID2360081	$640.98	$640.98
SLHP Southwest Gold 1200	61589ID2360090	$643.51	$643.51
PQA Southeast Bronze Connect 7000	61589ID2360104	$392.70	$392.70
MVN East Bronze Connect 7000	61589ID2360105	$380.45	$380.45

Table 17 Plan Adjusted Index Rate			
Plan Name	**HIOS ID**	**Prior to Tobacco**	**Final**
Hometown East Bronze 7000	61589ID2360106	$425.17	$425.17
CPN North Central Bronze 7000	61589ID2360107	$380.63	$380.63
KCN North Bronze 7000	61589ID2360108	$404.83	$404.83
Hometown North Bronze 7000	61589ID2360109	$393.59	$393.59
SAHA Southwest Bronze Connect 7000	61589ID2360110	$367.58	$367.58
IDID Southwest Bronze 7000	61589ID2360111	$367.58	$367.58
SLHP Bronze CarePoint 7000	61589ID2360112	$381.21	$381.21
PQA Southeast Bronze Connect 5500	61589ID2360113	$411.82	$411.82
MVN East Bronze Connect 5500	61589ID2360114	$398.98	$398.98
Hometown East Bronze 5500	61589ID2360115	$445.86	$445.86
CPN North Central Bronze 5500	61589ID2360116	$399.16	$399.16
KCN North Bronze 5500	61589ID2360117	$424.53	$424.53
Hometown North Bronze 5500	61589ID2360118	$412.74	$412.74
SAHA Southwest Bronze Connect 5500	61589ID2360119	$385.48	$385.48
IDID Southwest Bronze 5500	61589ID2360120	$385.48	$385.48
SLHP Bronze CarePoint 5500	61589ID2360121	$399.77	$399.77