CAREFIRST BLUECROSS BLUESHIELD
PART III ACTUARIAL MEMORANDUM

Please note that the numbering below is consistent with the numbering in the 2018 Unified Rate Review Instructions.

4.1 REDACTED ACTUARIAL MEMORANDUM (AM): CareFirst (CF) is making no redactions so both AM submissions are the same.

4.2 GENERAL INFORMATION:

Company Legal Name: CareFirst BlueChoice, Inc. (CFBC) - NAIC # 96202
State: Maryland
HIOS Issuer ID: 28137
Market: Individual, Non-Medigap (On & Off Exchange)
Effective Date: 1/1/18 – 12/31/18
Company Filing Number: 2161

Primary Contact Name: Mr. Joshua R. Phelps, ASA, CERA, MAAA
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4.3 PROPOSED RATE INCREASE(S): Base rates are changing 45.6% on average. The range is 40.4% to 52.3%. Including the impact of changes to age factors for members 20 and younger, estimated renewals are 50.4% on average with a range of 45.2% to 57.1% prior to the rating effects of a change in the member's age. This filing applies to all new and renewing, in-force business in the guaranteed renewable, non-grandfathered, ACA, metaled benefit plans. The number of policyholders affected by this rate change is 96,024.

Please note that the proposed rates in this filing assume that the full amount of Cost Share Reduction subsidies will be funded and paid to affected carriers. In the event these subsidies are not funded and paid to carriers, we reserve the right to re-file and adjust the rate actions proposed in this filing.

Reason for Rate Increase(s): The main drivers supporting the rate increase are the assumed increases in allowed costs (9.2% assumed annual trend), changes in the CMS age curve for 2018, the reintroduction of the Health Insurer Tax in 2018, and the assumed projected morbidity relative to the experience morbidity. For a more complete discussion of morbidity projection, please see 4.4.3, subsection 'Changes in the Morbidity of the Population Insured' below.

4.4 MARKET EXPERIENCE:

4.4.1 - EXPERIENCE PERIOD PREMIUM AND CLAIMS: The incurred period is 1/1/16 through 12/31/16, as required.

Paid Through Date: 2/28/17
Premiums (prior to MLR rebates) in Experience Period: $593,163,203
Estimated MLR rebates in Experience Period: $0
Allowed Claims from Experience Period: $772,227,347
Paid Claims from Experience Period: $598,742,604

Estimates of Incurred but not Paid claims: These were estimated the same way for both paid and allowed claims. Estimates were derived using an internal "chain and ladder" model which is used in monthly reserving and is based on the most recent 36 months to derive the completion factor and IBNR for each incurred month.

4.4.2 - BENEFIT CATEGORIES: Inpatient (hospital), outpatient (hospital), professional, other medical (non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, vision exams, pediatric dental services and other), prescription drug & capitations.

4.4.3 - PROJECTION FACTORS:

Changes in the Morbidity of the Population Insured: In developing our 2018 rates, CareFirst has projected the expected change of the single risk pool from 2016 to 2018. Our starting point for this projection are allowed claims by member from the base period normalized for age, gender, induced demand and network as specified in the URRT instructions on page 56.

We begin our morbidity factor calculation by looking at the 2016 normalized allowed cost of persisting members as of February 2017 compared to the average for the base period. This calculation shows that the morbidity of those who persisted in 2017 is higher than the 2016 average. Assuming that new members have the same morbidity as persisting members by metal, we calculate the average morbidity for new members. Finally, we look at the normalized 2016 allowed costs for members transferring into the Individual segment in 2017 from other CareFirst segments.

Next, we look at the persisting members' first quarter 2017 costs compared to first quarter 2016 for those members with a silver plan in both years, and quantify the rate of their allowed PMPM increase above trend. This is consistent with what was observed in 2016, and we assume it will repeat in 2018. Additionally, we have assumed persistency rates in 2018 will vary by metal as the healthier members in the leaner plans terminate as rates increase.

Finally, we have assumed that the coverage mandate introduced by ACA will not be enforced in 2018 and that this will have the same impact as repeal. Based on industry and government estimates as well as actuarial judgement, we have projected that this will cause morbidity to increase by an additional 20%.

All told, the numbers described above produce the morbidity factor that is displayed in Exhibit 4.

Changes in Benefits: Exhibit 5 in the Memorandum details our support to this adjustment to account for anticipated changes in the average utilization of services due to differences in average cost- sharing requirements between the experience and projection periods.

Changes in Demographics: Exhibit 6 in the Memorandum contains support for our adjustment due to the anticipated change in the average age of this population between the experience and projection periods.

Other Adjustments: We are proposing additional other adjustments for changes to our capitation fees, drug rebates and a formulary change. See Exhibit 7 in the Memorandum for details supporting these adjustments.

Trend Factors (Cost/Utilization): Exhibit 8 in the Memorandum contains our selected annual utilization and unit cost trends by service category. We used observed rolling 12 PMPM allowed claims for the pool in total to fit a linear regression curve. Unit cost and utilization trends were set by service category based on observed trends over the experience period and to produce the overall anticipated trend indicated by our regression analysis.

4.4.1 - CREDIBILITY MANUAL RATE DEVELOPMENT: Not applicable, as experience was determined to be fully credible.

4.4.5 - CREDIBILITY OF EXPERIENCE: Exhibit 2 in the Memorandum contains a summary of our base period experience, including member months. We have assigned full credibility to this experience.

4.4.6 - PAID TO ALLOWED RATIO: See Exhibit 10A in the Memorandum for the projected ratio of paid to allowed claims.

4.4.7 - RISK ADJUSTMENT AND REINSURANCE:

Experience Period Risk Adjustment and Reinsurance Adjustment PMPM: The estimates of the experience period Risk Adjustment transfers in the URRT are based on the latest results provided by the Maryland Insurance Administration. The reinsurance estimates are based upon internal estimates of reinsured claim amounts, with experience paid through 2/28/17.

Projected Risk Adjustment PMPM: Our projected 2018 risk adjustment transfers, found in Exhibit 9, have been calculated consistent with our membership and morbidity projections found elsewhere in this filing. Further, given CareFirst's market size, we have assumed that the relationship of the state average to CareFirst in 2016 continues in 2018.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium: No longer applicable.

4.4.8 - NON-BENEFIT EXPENSES AND CONTRIBUTION TO RESERVE (CtR) & RISK: The 2018 "desired incurred claims ratio" (DICR) is 81.4%.

Administrative Expense Load: See Exhibit 10A in the Memorandum for the assumed PMPMs (including Broker Commissions & Fees).

Contribution to Reserve & Risk Margin: See Exhibit 10A in the Memorandum.

Taxes and Fees: See Exhibit 10A in the Memorandum for the assumed values of the following additional items.

1) Premium Tax/Community Health Investment
2) Federal Income Tax (FIT)
3) State Assessment Fee
4) Health Insurer Tax
5) PCORI
6) Risk Adjustment User Fee

4.5 PROJECTED LOSS RATIO: See Exhibit 10B in the Memorandum for a demonstration of our compliance with meeting the 80.0% minimum of the "Public Health Service Act" (PHSA) 218.

4.6 APPLICATION OF MARKET REFORM RATING RULES:

4.6.1 - SINGLE RISK POOL (SRP): Our SRP reflects all covered lives for every non-grandfathered product in our market per 45 CFR Part § 156.80 (d).

4.6.2 - INDEX RATE: The base period allowed PMPM, including the split between EHB & Non-EHBs can be found in Exhibit 1 in the Memorandum.

The projected index rate is also included in Exhibit 1 and projected Non-EHBs are included in Exhibit 3.

The non-EHBs in both the base and projection periods reflect coverage for abortion services and adult vision.

4.6.3 - MARKET ADJUSTED INDEX RATE: See Exhibit 1 in the Memorandum for the application of these factors. Exhibit 9 contains more detail behind the Risk Adjustment Program Market Level Adjustment.

4.6.4 - PLAN ADJUSTED INDEX RATES: There is a "cost-share" factor derived from our internal pricing AV model. An induced utilization factor is also applied and includes metal level induced demand. There is 1 type of network factor: Open Access. Cost-Share factors, induced utilization factors, and Non-EHBs vary by plan. The catastrophic factor has been developed from the experience of the catastrophic population, and is applied only to the catastrophic plan as required. All other factors applied to the Market Adjusted Index Rate are the same across all plans.

4.6.5 - CALIBRATION: Calibration has been completed for age, but we have elected not to rate for tobacco usage or geographic rating.

Age Curve Calibration – We have calibrated to the rounded weighted average age which was determined as the age for the factor nearest our projected average factor.

4.6.6 - CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT: Rate charts are provided for all of the consumer adjusted premiums.

4.7 PLAN PRODUCT INFORMATION:

4.7.1 - HHS ACTUARIAL METAL VALUES (AV): The majority of our 2018 plans include varying cost share levels for some services that depend on the setting in which care is delivered. The HHS AV calculator was used to compute two separate AVs for each impacted plan – one which applied the higher level of cost-share, and one which applied the lower. The results were blended assuming 81% of the designated services are rendered in higher cost-share setting and the remaining 19% at the lower, consistent with 2016 experience for our small group and Individual markets. Plans without these features used the AV calculator without modification.

Printouts for each plan are provided in the “Actuarial Memorandum and Certifications” section of the Supporting Documentation tab of the SERFF filing, and also as part of the QHP binder submission under separate cover.

4.7.2 - AV PRICING VALUES: The breakdown of the AV Pricing values is shown in Exhibit 11 of the Memorandum.

4.7.3 - MEMBERSHIP PROJECTIONS: The distribution of projected enrollment is based on actual enrollment by plan as of 2/28/17. Total projected enrollment is consistent with our corporate plan.

4.7.4 - TERMINATED PLANS AND PRODUCTS: See the Exhibit Appendix – HIOS ID Mappings in the Memorandum.

4.7.5 - PLAN TYPE: HMO

4.7.6 - WARNING ALERTS: There are no warning alerts in our URRT template.

4.8 MISCELLANEOUS INSTRUCTIONS:

4.8.1 – EFFECTIVE RATE REVIEW INFORMATION (OPTIONAL): We have no additional exhibits.

4.8.2 – RELIANCE: Not applicable.

4.8.3 – ACTUARIAL CERTIFICATION: Included in the Memorandum.