Actuarial Memorandum – Individual Market

General Information

Company Identifying Information

- Company Legal Name: Blue Cross & Blue Shield of Rhode Island ("BCBSRI")
- State: Rhode Island
- HIOS Issuer ID: 15287
- Market: Individual
- Effective Date: January 1, 2018

Company Contact Information

- Primary Contact Name: Catherine Mitchell
- Primary Contact Telephone Number: 401-459-5476
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Proposed Rate Increase(s)

This filing is being made to establish new rates to be used effective January 1, 2018 for BCBSRI's portfolio of plans in the Individual market. The RI Essential Health Benefit ("EHB") rate increase we are submitting is 12.3%, and the weighted average premium increase for the Individual market is 13.9%. The actual rate impact on any given individual currently enrolled in an individual plan, however, will depend on the subscriber's age (and the age of each dependent), the plan selected, and whether the individual is eligible for federal subsidies.

The overall average increase is driven by a number of significant factors that are outlined below. Further details on each of these factors are given later in this memorandum.

This filing assumes that the Cost Sharing-Reduction (CSR) program will continue to reimburse insurance carriers for the full amount associated with reduced cost sharing subsidies for qualified low income subscribers enrolled in On Exchange silver plans. For BCBSRI this is estimated to be approximately $9 million for 2018. This filing will need to be amended if the federal government stops directly funding the CSR program.

Claims Trend and Base Experience – Claims trends (both utilization and price) are projected to increase for 2018 when compared to 2016 claims. Some of this increase, however, will be offset by larger prescription drug rebates projected for 2018.

Administrative Expense – This filing includes administrative expenses which were projected based on a combination of actual year-to-date February 2017 spend and other known adjustments.

Base Modifications – There are no modifications made to the base.

ACA Related Taxes and Fees – Rates must reflect an Exchange User Fee, the Patient-Centered Outcomes Research Trust Fund Fee, and the fee for administration of the Risk Adjustment Program. The Health Insurance Providers Fee is also reinstated for 2018.

Uncollected Premium
This filing includes an adjustment for unpaid premium. See the section entitled "Adjustment for Uncollected Premium" for additional details.

Premium Stabilizers
BCBSRI is estimating a $15.59 PMPM payment from the Risk Adjustment Program in this filing. This estimate assumes a payment commensurate with BCBSRI's 2016 benefit year risk adjustment transfer amount, as published by CMS on June 16, 2017, and adjusted for known changes finalized in the Notice of Benefit and Payment Parameters for 2018, including a 14% reduction in transfer payments due to the removal of administrative expenses from the calculation. The estimate does not include proposed or discussed changes which have not been finalized through regulation.

Experience Period Premium and Claims

Paid Through Date
The experience period for this filing is incurred January – December 2016, paid through February 2017.

Premiums (net of MLR Rebate) in Experience Period
The earned premium prior to MLR rebates for the calendar year 2016 experience period is $130,057,742. For the Individual market, earned premium prior to MLR rebates is the sum of premium of each member, excluding members who are charged $0 premium because they are dependents of a family with more than three children under the age of 21. Earned premium also reflects bad debt allowance expense, uncollected balances written off, and retroactive adjustments to enrollment or rates from prior periods.

There is no MLR rebate anticipated for the Individual market.

The information shown in Tab I, Data & Rate Increase differs from the information that was included in the MLR rebate calculations. This is due, in part, to differences in the definitions of each market under the ACA, which requires BCBSRI to move certain premium and claims experience between markets for MLR purposes.

Allowed and Incurred Claims during the Experience Period

Paid and allowed claims processed through our claims system are summarized by benefit category and incurred date. (Allowed claims are developed by summing paid amount and coinsurance, co-pay and deductible amounts.) These claims are then completed using incurred but not reported (IBNR) factors which are based on claim reserve estimates developed monthly for financial reporting.

In order to estimate claims incurred but not paid, lag triangles are created for each line of business (Inpatient, Outpatient, Medical/Surgical and Prescription Drugs) for the various market segments within commercial business. Three and six month averages based on paid claims experience for the last three years are used to calculate monthly multiplicative completion factors. Adjustments may be made to lag data to remove the impact of unusual payment patterns that are not expected to reoccur, or to include any known outstanding large claims. Completion factors for the total commercial book of business are applied to base claims.

Please refer to the attached appendix titled “Appendix A: Base Claims Development” for further details.

Benefit Categories

OHIC Rate Review Template

Inpatient services are those received during a patient's hospital stay, and these claims fall into the Inpatient Hospital category. Outpatient services are those that a member receives without being admitted to a hospital (e.g., X-rays, lab tests, and some surgical procedures), and these claims fall into the Outpatient Hospital category. Primary care claims are routine healthcare services, including preventive care. The Other Medical/Surgical category represents all other claims for professional services that are not primary care. All retail/mail order pharmacy claims are included in the Prescription Drug category. The benefit category “Other Not Categorized” represents state assessments, which encompass adult immunizations, childhood immunizations and a children’s health account (used to fund various programs for children).

Unified Rate Review Template

The benefit category “Professional” includes primary care claims and other claims for professional services, except for ambulance, home health care, durable medical equipment, prosthetics, supplies, vision exams, and dental services. The benefit category “Other Medical” includes these excluded services as well as state assessments.

For the projection period the benefit category “Prescription Drugs” is adjusted to be net of rebates from drug manufacturers.

Projection Factors

Changes in the Morbidity of the Insured Population
No morbidity changes to the population are assumed.

Changes in Benefits
The "Adjustment to bring to Index Rate for Projection Period" represents additional benefits which are not reflected in base period claims on a comparable basis to the projected period because changes were made to the benefit after the base period. These include:

- Addition of coverage for services related to autism;
- Addition of coverage for electric breast pump to members' preventive services benefit;
- Expansion of recommended use of statins by the U.S. Preventive Services Task Force; and
- Introduction of new drugs to treat cancer, spinal muscular atrophy, multiple sclerosis, and tardive dyskinesia.

Changes in Demographics
No adjustments were made to the demographics of the experience period claims.

Utilization Trends
Utilization projection factors were developed to project base period expenses to the rating period for expected changes in the number of services utilized by covered members (utilization) and changes in the types of services used (mix). Utilization/mix trend factors were developed separately for inpatient, outpatient, medical/surgical, and prescription drug services. The utilization/mix trend analysis used allowed claims PMPMs for outpatient, medical/surgical, and prescription drug lines of business. For inpatient services, admissions per 1,000 members were analyzed to develop the projected utilization trend.

The utilization/mix trend analysis used allowed claims PMPMs that were normalized for changes in claims costs that were due to influences other than utilization or mix. The data for outpatient and medical/surgical services were de-priced to a common price level, namely January 2014. The trend data for all types of services was also normalized for the utilization effects due to cost sharing provisions of the benefit plans inherent in the data. This adjustment was made to remove the distortion caused by a change in the mix of plans over time. The projected impact due to these factors was developed and applied separately in the rate development. The data used for the prescription drug trend was normalized to remove the impact of changes in contractual terms with our Pharmacy Benefit Manager. The prescription drug trend data was also normalized to remove the anticipated effect of new brand name drugs being introduced to the market, and the anticipated availability of new generic drugs as well as pricing changes associated with certain high impact drugs.

The data points used in this analysis were 12-month moving values, beginning with the period ending December 2014. Twenty-five data points, equating to three years of experience, were analyzed. Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, a statistical technique for quantifying trend levels. BCBSRI's standard procedure is to determine the line that best fits the data points using the most recent 13 or more data points, generally with a minimum r-squared value of 0.70 to help assure a reasonable fit to the data points. The principle of least squares states that the line of best fit to a series of observed values is the line where the sum of the squares of the deviations (the differences between the line and the actual values) are minimal, or the least possible.

Given that the underlying data is credible, the annual trend indicated by the least squares line producing the best fit under this procedure is then selected as the basis for the trend assumption, provided the result is actuarially acceptable. Adjustment or modification to this result, or substitution of an alternative assumption, may occur if the original result is not credible, reasonable, or appropriate in our actuarial judgment.

We reviewed the results of the regression analysis both by market segment and by all insured commercial markets. In order to increase credibility and decrease the volatility associated with market segment-specific trend data, the trends selected are based on insured commercial market (Large Group, Small Group, and Individual) in total.

For inpatient admissions per 1,000 members, the total commercial data produces a best fit line at -0.8%. At only .589, however, the r-squared value is deemed to be unreliable. Over the past several years, inpatient utilization has fluctuated between slight positive and slight negative trends, so a 0% trend for inpatient was selected as a reasonable assumption.

For outpatient services, the comparable regression analysis produces a best fit trend indication of 5.9% with a high r-squared value of .986, so a utilization/mix trend of 5.9% was selected.

For medical/surgical services, the regression analysis produces a best fit trend of 3.5% with a high r-squared value of .972, so a utilization/mix trend of 3.5% was selected.

Finally, for prescription drug services, the regression analysis produces a best fit trend of 9.7%. (Note: The impact of Individual market members who were enrolled only in 2014 was removed from the trend analysis in order to remove the unfavorable distortion in the results and to more accurately represent the projected enrollment for this market. The prescription drug trend still would have shown a best fit at 9.7% without this modification, but the other points in the regression would have been higher.) This line of business always yields high reliability with its very high r-squared values, so the indicated combined price and utilization trend of 9.7% was selected.

Price/Unit Cost Trends
Price projection factors were developed for inpatient, outpatient, primary care services, and other professional services. These factors represent anticipated unit price increases during the 24 months from the experience period to the rating period. The price projection factors are based on actual unit cost increases, estimates of price increases based on negotiations, and any planned or estimated increases and adjustments to provider contracts. This information was provided by BCBSRI's medical economics area. I have reviewed the information for reasonableness, but have not independently audited or otherwise verified the information provided.

Other Adjustments
An adjustment is applied to the projection of prescription drugs to account for the impact of drug rebates. The estimated rebate amount for CY 2018 is $23.40 PMPM. An adjustment is also applied to reflect the anticipated impact of changes to PBM pricing, the impact of pipeline Specialty drugs used for treatment of Amyotrophic Lateral Sclerosis (ALS), Atopic Dermatitis, Cystic Fibrosis, Cholesterol, Liver Disease, and Duchenne Muscular Dystrophy, as well as the impact of any new generic drugs expected to enter the market during the rating period. Hepatitis C costs were adjusted to be constant at levels based on June to December 2016, which reflect the anticipated ongoing expense of Hepatitis C drug utilization. All of these adjustments make up the "Other" factor in the prescription drug benefit category.

Credibility Manual Rate Development

No manual rate was used.

Credibility of Experience

Due to the size of the block in the experience period, no credibility adjustments were used.

Paid to Allowed Ratio

The Paid-to-Allowed Ratio for 2018 is calculated to be the ratio between expected paid claims and expected allowed claims under 2018 benefit plans. Projected allowed claims (line 1) without state-mandated assessments are converted to an expected paid basis by utilizing the actual 2016 paid-to-allowed factor adjusted for the effects of trend.

For the calculation of the 2016 paid-to-allowed factor, the experience paid claims are decreased by the estimated federal cost-sharing reduction settlement of $9,044,092.

Please refer to the attached appendix titled “Appendix D: Calculation of Paid to Allowed Average Factor and 70% Utilization Factor in Projection Period” for further details.

Percentage Adjustments Required in Tab II, Rate Development (Sections II and III)

The percentage adjustments in Tab II, Rate Development are applied to the projected allowed claims PMPM and to the average required EHB PMPM. Note that the percentage values have been calculated so that they will produce the correct revenue when they are used in the development of projected rates.

To determine the appropriate percentages, a projected medical premium PMPM was developed based on the expected plan distribution. The starting point was to convert projected allowed claims to an expected paid claims PMPM. (See the Paid to Allowed Ratio section.) The fixed and variable retention components were then added onto the projected paid claims PMPM to determine the projected average medical premium PMPM.

Please refer to the attached appendix titled “Appendix E: Calculation of Expected Medical Premium” for further details.

Adjustment for Uncollected Premium

In total for 2016, BCBSRI had 1.18% in uncollected premium in the Individual market. This is the percentage of unpaid premium compared to the total earned premium. Individual market members have a one-month grace period for premium non-payment during which BCBSRI continues to pay claims incurred during this month. Assuming similar levels of non-payment in 2018, the overall required premium will need to increase by 1.18%. This adjustment is applied to the projected medical premium PMPM.

Please refer to the attached appendix titled “Appendix B: Population Risk/Other Adjustment” for further details.

Risk Adjustment

Projected Risk Adjustments PMPM

Several key changes to the Risk Adjustment Program are described in the Notice of Benefit and Payment Parameters for 2018, as finalized in December 2016. These include the following changes:

- Removal of administrative expense from the risk adjustment transfer formula.

  For the 2018 benefit year, CMS will reduce the statewide average premium in the risk adjustment transfer formula by 14% to account for administrative costs that do not vary with claims. This results in a reduction of the expected transfer payment and must be reflected in the filing.

- Accounting for high-cost claimants in the risk adjustment calculation.

  The risk adjustment calculation will be revised to account for costs associated with high-cost enrollees. High-cost enrollee claims will be funded at 60% of costs over $1 million. For the purpose of this filing, we are assuming that the charge for this will be equal to the reimbursement; therefore, we are not making any adjustments to reflect this change in the calculation.

- Incorporating prescription drug data for select drug classes to improve the predictive ability of the risk adjustment model.

  HHS has yet to release the updated model that would allow issuers to approximate the impact of this change, and there is also no information that would allow us to predict its impact across our market. Therefore, we do not have the information necessary to make any adjustments for this change at this time.

- Adding enrollment duration factors to account for partial year enrollment.

  Without a way of predicting how these factors may impact issuers across our market, we do not have the information necessary to make any adjustments for this change at this time.

In this filing, then, BCBSRI is assuming a risk adjustment PMPM commensurate with BCBSRI's 2016 benefit year risk adjustment transfer amount, as published by CMS on June 16, 2017, adjusted for the 14% reduction anticipated in 2018 as outlined above.

A PMPM of $0.14 was included to reflect the fee for administration of the Risk Adjustment Program.

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

BCBSRI creates its expense budget using current market segment allocation ratios and applying those allocations to the anticipated 2018 corporate budget. The corporate budget is based on projected expenses as determined by senior management. Adjustments are then made to reflect known changes, such as corporate project spend, enrollment shifts, etc.

Market segments can either be charged directly (e.g., 100% of expense is charged to the segment) or through an allocation where the expense is benefiting more than one

segment. Each corporate area is allocated based on the function that is being performed (e.g., the Claims area would be allocated based on paid claims, Sales would be allocated based on contracts, etc.). These ratios are then used to distribute the particular area's expenses to the market segment. Expenses exclude premium tax and expenses associated with the new core claim processing system because these components are reflected in separate rating factors.

An investment credit of 0.01% is included in this filing.

Formulas in Tab IV, Retention Charge were revised to reflect the average proposed retention charges.

Profit (or Contribution to Surplus) & Risk Margin
This filing includes a 3.00% contribution to corporate reserves, which includes the amortized costs of the core claim processing system.

Taxes and Fees
The State of Rhode Island levies taxes of 2% on fully insured premium, including individual plans, pursuant to section 44-17-1 of the Rhode Island General Laws.

As part of the ACA, the federal government imposes fees for the Patient-Centered Outcomes Research Trust Fund (section 6301 of the ACA), the Risk Adjustment Program (section 1343 of the ACA), as well as the Health Insurance Providers Fee (section 9010 of the ACA).

The aggregate Health Insurance Providers fee for 2018 is estimated to be 2.15% of premium for 2018. The Patient-Centered Outcomes Research Trust Fund annual per capita fee is estimated to be $2.49 ($0.21 PMPM). The 2018 annual per capita Risk Adjustment fee is $1.68 ($0.14 PMPM).

The Exchange User Fee rate of 1.80% was calculated by applying the federal assessment rate of 3.5% to the projected proportion of BCBSRI members who purchase coverage through the Rhode Island health insurance exchange, HealthSource RI, and then spreading it across all members. If the Rhode Island legislature were to change the fee amount or the method for its collection, we would expect to be allowed to resubmit our rate filing to reflect the change.

Prior Period Adjustment
The prior period adjustment shown in Tab I, Data & Rate Increase reflects the remaining component once claims trend, population risk, administrative expense, contribution to reserve, premium tax, ACA taxes and fees, and any other ACA program recoveries have been accounted for. For the Individual market the prior period adjustment percentage shown for 2018 will reflect a more accurate representation when it is offset by the risk adjustment percentage, thereby factoring in BCBSRI's risk population, which is worse than market average.

Recovery of Assessments

Documentation of Payments

	1Q2016	2Q2016	3Q2016	4Q2016	Total
Care Transformation Collaborative of RI	$1,533,728	$1,596,368	$1,780,314	$1,065,089	**$5,975,499**
Current Care	$770,436	0	$770,400	$0	**$1,540,836**
Total	$2,304,164	$1,596,368	$2,550,714	$1,065,089	**$7,516,335**

See attached invoices for further documentation of payments.

Recovery of Assessments in 2018 Rates

Payments to support the Care Transformation Collaborative of RI ("CTC", formerly known as the Chronic Care Sustainability Initiative) and Current Care are included in the Out of System ("OOS") factor for PCP and Other Professional. The OOS factor is applied to the experience period professional claims to account for these two programs along with provider risk sharing payments and Patient Centered Medical Home (PCMH) expenses that are not captured in the experience period claims. The calculations for the CTC and Current Care components of the OOS factors are displayed below. To bring the payments (Line 1) to the same base as the allowed dollars (line 6), we included an adjustment to add payments that would have been made for Rhode Island self-insured members (Line 3). OOS factors are included in Appendix A: Base Claims Development in Section C. Out-of-System Liability Factor (Multiplicative) in the factors for PCP and Other Professional.

The dollars shown in the Current Care Adjustment for R.I. Self Insured (line 2) are not actual charges paid by BCBSRI; they are an adjustment to the actual CY2016 payments (line 1) to keep the payments and claims expenses on the same base. This is necessary because the Total CY 2016 allowed dollars (line 6) include self-insured claims, while the Total CY 2016 payments do not include self-insured payments for Current Care.

	CTC	Current Care
1. Total CY 2016 Payout	$5,975,499	$1,519,128
2. Adjustment for R.I. Self Insured		$793,425
3. Total Adjusted for Self Insured	$5,975,499	$2,312,553
4. % Allocated to Commercial	69.5%	100%
5. Total Commercial Dollars (L3 * L4)	$4,152,972	$2,312,553
6. Total CY 2016 Commercial Allowed (Contracted Providers Only)	$349,957,075	$349,957,075
7. Estimated BlueCard Spend (%)	32%	32%
8. Allowed Including BlueCard (L6/(1 - L7))	$514,642,757	$514,642,757
9. Net to Allowed (Based on Commercial)	0.80	0.80
10. Paid Dollars (L8 * L9)	$409,910,592	$409,910,592
11. Final Factor (1 + L5/L10)	1.010	1.006

Recovery of Assessments in 2017 Rates

Payments to support the Care Transformation Collaborative of RI ("CTC", formerly known as the Chronic Care Sustainability Initiative) and Current Care are included in the Out of System ("OOS") factor for PCP and Other Professional. The OOS factor is applied to the experience period professional claims to account for these two programs along with provider risk sharing payments and Patient Centered Medical Home (PCMH) expenses that are not captured in the experience period claims. The calculations for the CTC and Current Care components of the OOS factors are displayed below. To bring the payments (Line 1) to the same base as the allowed dollars (line 6), we included an adjustment to add payments that would have been made for Rhode Island self-insured members (Line 3). OOS factors are included in Appendix A: Base Claims Development in Section C. Out-of-System Liability Factor (Multiplicative) in the factors for PCP and Other Professional.

The dollars shown in the Current Care Adjustment for R.I. Self Insured (line 2) are not actual charges paid by BCBSRI; they are an adjustment to the actual CY2015 payments (line 1) to keep the payments and claims expenses on the same base. This is necessary because the Total CY 2015 allowed dollars (line 6) include self-insured claims, while the Total CY 2015 payments do not include self-insured payments for Current Care.

	CTC	Current Care
1. Total CY 2015 Payout	$5,770,061	$1,704,588
2. Adjustment for R.I. Self Insured		$1,113,148
3. Total Adjusted for R.I. Self Insured	$5,770,061	$2,817,736
4. % Allocated to Commercial	72.4%	100%
5. Total Commercial Dollars (L3*L4)	$4,178,156	$2,817,736
6. Total CY 2015 Commercial Allowed (Contracted Providers Only)	$389,012,129	$389,012,129
7. Estimated BlueCard Spend (%)	20%	20%
8. Allowed Including BlueCard (L6/(1-L7))	$486,265,161	$486,265,161
9. Net to Allowed (Based on Commercial)	0.81	0.81
10. Paid Dollars (L8*L9)	$393,552,598	$393,552,598
11. Final Factor (1+L5/L10)	1.011	1.007

Recovery of State Mandated Assessments in 2018 Rates

Childhood immunization, Adult immunization, and Children's Health Account payments are included in the proposed rates as State Mandated Assessments (SMA). Effective January 1, 2016, the State of Rhode Island changed the funding formula from a percentage of fully insured premium for domestic carriers to a PMPM per Rhode Island (RI) resident covered under a fully insured or self-insured arrangement with a domestic or foreign carrier, with the exception of self-insured Municipalities.

The PMPM amounts applicable to each assessment are updated annually on a fiscal year basis beginning July 1st and ending June 30th. To develop the estimated future values for each assessment we simply trended forward the 2016 fiscal year PMPMs provided by the State based on the annual increase in BCBSRI's aggregate commercial SMA PMPM payments between 2014 and 2015. These years were used because they are the most recent two years utilizing a consistent assessment methodology. We then produced calendar year PMPM estimates for each assessment based on the expected charges within each year. Next, the distribution of the Rhode Island adults and children was obtained from the CY 2016 base and used to produce a weighted average total SMA PMPM value for the RI members. Finally, the percentage share of RI membership, again obtained from the CY 2016 base, was used to create the final PMPM projection for all BCBSRI Individual market members.

As this filing is being prepared, the General Assembly is considering the budget for Fiscal Year 2018. The budget as introduced includes Article 13, section 4, which would increase the Children's Health Account from $7,500 per child per service, to $12,500 per child per service, which the Governor estimates will increase the total assessment by approximately $3.5 Million. In the event the budget as enacted includes this or a similar budget article, we request leave to amend this factor to recoup the full amount of the assessment.

Calculations are displayed here:

Fiscal Year SMA PMPM's per RI Resident

Assessment	**FY 2017**	**FY 2018[1]**	**FY 2019[1]**	**FY 2020[1]**
Adult Immunization	$1.66	$1.89	$2.15	$2.45
Child Immunization	$15.84	$18.04	$20.54	$23.38
Child Health Account	$9.29	$10.58	$12.04	$13.71

[1] Trended by CY2015 over CY 2014 total SMA payments from previous PMPM

Calendar Year SMA PMPM's per RI Resident

Assessment	**CY 2017**	**CY 2018**	**CY 2019**
Adult Immunization	$1.78	$2.02	$2.30
Child Immunization	$16.94	$19.29	$21.96
Child Health Account	$9.93	$11.31	$12.88

Direct Pay Segment Specific PMPM 2018

	2018 PMPM	**Percent of Membership [1]**
Adult immunization	$2.02	88%
Child immunization	$19.29	12%
Child Health Account	$11.31	12%
RI member PMPM [2]	*$5.37*	
% RI Members	99%	
DP PMPM [3]	**$5.32**	

[1]- Based on BCBSRI's RI Membership.

[2]- Membership weighted PMPM applicable to all BCBSRI RI members.

[3]- PMPM applicable to all BCBSRI Direct Pay members.

Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology is 85.3%.

Single Risk Pool

The Single Risk Pool reflected in this rate filing includes all covered lives for every product/plan combination issued by BCBSRI in the Individual market.

Index Rate

The Index Rate represents the average allowed claims PMPM for Essential Health Benefits, excluding any adjustments for Exchange User Fees and the Risk Adjustment impact. The difference between the Index Rate and the 2018 projected allowed claims expense is accounted for by the removal of abortion claims and the addition of new benefits (see the subsection titled Changes in Benefits for more details). A description of our methodology is included elsewhere in the Actuarial Memorandum.

Market Adjusted Index Rates

The Market Adjusted Index Rate represents the Index Rate adjusted for the Risk Adjustment impact and the Exchange User Fee.

Plan Adjusted Index Rates

The Plan Adjusted Index Rate represents the Market Adjusted Index Rate further adjusted to include administrative costs and plan-specific factors such as utilization, cost sharing, provider network adjustments, adjustments for additional benefits, and the adjustment for uncollected premium. Plan Adjusted Index Rates reported in Tab III, Plan Rates reflect recoupment for the child dependent limit (a maximum of three dependents under the age of 21 are included in rates), whereas those reported in the Unified Rate Review Template do not.

Please refer to the Unified Rate Review Template for further details.

Calibration - Age Curve

A projected weighted average age was calculated using the actual age distribution for CY 2016.

The weighted average ACA age factor is 1.7072.

This age calibration includes an adjustment for the child dependent limit (a maximum of three dependents under the age of 21 are included in rates).

Please refer to the attached appendix titled “Appendix C: Age Normalization” for further details.

Consumer Adjusted Premium Rate

Consumer adjusted premium rates are calculated using the following equation:

*Plan Adjusted Index Rate /Weighted Average ACA Age Factor (Age Curve Calibration) * ACA Age Factor*

AV Metal Values

BCBSRI Acceptable Alternative Methodology for Valuing Plan Designs using the Actuarial Value Calculator

Due to specific plan features and differences between underlying assumptions in the AV calculator and our plan designs, an acceptable alternative methodology was used to generate the AV metal values for some plans. The AV calculator was used to generate all AV values and metal levels; however, we had to adjust the inputs to the calculator to appropriately reflect the benefit designs of certain plans. The methodology used to develop inputs for the AV calculator is documented below.

1) 5-tier Drug Benefit
The AV calculator is set up for 4 tiers of drugs. For most of our plans, however, there are 5 tiers of drugs. In order to fit 5 tiers into the 4-tier AV calculator, we took the first two tiers and accounted for them in Tier 1. We calculated the average copay for the first two tiers and entered that as the copay for Tier 1 drugs. All copays entered were rounded to the nearest dollar.

	Tier 1 - Low Cost	Tier 1 - High Cost	Value Entered in AV Calculator for Tier 1
Weight	36%	64%	
Copays	$0	$15	$10
Copays	$5	$15	$11
Copays	$7	$15	$12
Copays	$7	$20	$15
Copays	$7	$35	$25
Copays	$8	$20	$16
Copays	$10	$25	$20
Copays	$10	$30	$23
Copays	$10	$35	$26
Copays	$10	$40	$29
Copays	$10	$50	$36

2) Tiered PCP Copays (VantageBlue, BasicBlue)

For the VantageBlue and BasicBlue plans, there are two tiers of PCP copays. In order to value these plans using the AV calculator, we calculated the average copay and entered that as the PCP copay. All copays entered were rounded to the nearest dollar.

	Weight	Copay							
Tier 1	50%	$10	$15	$15	$20	$25	$30	$30	$40
Tier 2	50%	$20	$25	$35	$30	$45	$40	$50	$60
Value Entered in AV Calculator:		$15	$20	$25	$25	$35	$35	$40	$50

AV Pricing Values

BCBSRI develops plan relativity values used in rating through the use of a cost model. That model simulates the payment of medical and drug claims for a standard population for different plan cost sharing provisions. The model estimates plan payments by applying each plan's deductibles, coinsurance, copays, and out of pocket maximums to the claims experience of the model's standard population.

Our cost model is built from the actual allowed claims incurred across our total commercial business (Individual, Small Group, and total Large Group) over a twelve-month period, updated each year. This data is used to develop a claim probability distribution split by type of service, utilization and cost per service. Since it is well

established that member cost-sharing has an impact on the utilization of medical services, our methodology adjusts the utilization factor to the appropriate level based on the particular plan to be rated. We then re-adjudicate the claims for that plan design.

We make use of multiple data sources to develop and to keep up-to-date the assumptions built into our cost model. The foundation of our model was a rating manual purchased from a nationally known actuarial consulting firm. While we have largely retained that manual's overall structure, the underlying claim costs and utilization assumptions are updated and re-calibrated on an ongoing basis.

We calibrate the utilization effects of different cost sharing levels by comparing our actual claim experience on different plan designs adjusted to remove the effects of health status selection. The process begins by examining our actual loss ratio experience by plan design for our Small Group block. We start there because we sell a broad range of standard plans to groups that are all community rated. The utilization differences we measure here are impacted not only by plan design features but also by health status differences among groups purchasing plans of different benefit richness.

We remove the effects of these health status differences by adjusting the overall slope of our initially determined utilization differences in order to be synchronized with the utilization slope developed by performing the same exercise for our Large Group block of business for groups with a single benefit option. We assume that these cases are immune, or largely immune, to health status differences by plan design. We cannot base our utilization factor determination wholly on our Large Group experience because many of these groups have customized benefit designs. This makes it difficult for us to develop credible experience for any particular benefit plan. However, by aggregating the experience of groups with similar plan designs we are able to determine a broad relationship between utilization rates and cost sharing levels which we believe allows us to remove selection effects from the more detailed analysis we are able to perform on our Small Group business. Final adjustments to the utilization assumptions in our pricing model are made based on actuarial judgment and comparisons with the pricing practices of other carriers.

RI Base Essential Health Benefit (EHB) Rate

The RI Base EHB Rate is defined as the rate for a 21-year old (age factor of 1.000) for 100% allowed dollars for EHB with a utilization assumption consistent with a plan with a 70% actuarial value. The calculation of the Base EHB rate starts with the Single Risk Pool Gross Premium Average Rate PMPM from Tab II, Rate Development. This is the average rate applicable to the benefits to be offered in the Individual market in CY 2018. Three adjustments are made to this rate to convert it to the Base EHB Rate.

First, an Average Benefit Factor is applied to convert the Gross Premium Average Rate to an allowed dollar basis. This factor also incorporates a utilization adjustment to bring the costs in line with a plan consistent with a 70% actuarial value. Second, a normalization factor is applied to convert the rate to be applicable to a 21-year old (age factor of 1.000). This normalization factor reflects the current age distribution of the Individual market portfolio and the federal default uniform age rating curve factors. Finally, the rate is adjusted to reflect the rating rules related to family composition. The premium for family coverage will be computed by adding the premiums for each member of a family, with the exception that only the three oldest children under age 21 shall be counted in developing a family premium. An adjustment must therefore be made to the Base EHB rate so that overall, the revenue collected from the proposed rates equates to the required revenue. This adjustment factor is calculated as the ratio of the revenue expected to be collected from the projected membership to the revenue that would be collected if premium were attributed to every family member.

Membership Projections

Method of Analysis

Projected membership by product for 2018 is assumed to be the same as actual enrollment as of March 2017, adjusted to reflect the assumption that some members will move from existing products into the new, lower priced products being introduced in 2018. This assumption is appropriate and consistent with experience in recent years with the introduction of new plans. Specifically, with the introduction of a new low cost silver plan, a significant portion of CSR members have historically migrated to the lowest price option.

Terminated Products

Following is a list of the products which will be discontinued for 2018.

VantageBlue with Dental Direct 1200/2400 WPD
VantageBlue with Dental Direct 1200/2400 WOPD

Mapping of these products to 2018 products is shown in Tab III, Plan Rates.

Plan Type

Not applicable to the OHIC Rate Review Template.

Warning Alerts

Wksh 2 - Plan Product Info - Cell L15 - (Section I - AV Metal Value) value is not valid. For Gold metal plans the AV Metal Value must be between 0.82 And 0.78

Wksh 2 - Plan Product Info - Cell R15 - (Section I - AV Metal Value) value is not valid. For Gold metal plans the AV Metal Value must be between 0.82 And 0.78

Wksh 2 - Plan Product Info - Cell AA15 - (Section I - AV Metal Value) value is not valid. For Gold metal plans the AV Metal Value must be between 0.82 And 0.78

Wksh 2 - Plan Product Info - Cell AC15 - (Section I - AV Metal Value) value is not valid. For Gold metal plans the AV Metal Value must be between 0.82 And 0.78

These warning alerts are occurring because the Unified Rate Review Template has not been updated to reflect the changes to the allowable variation in the AV to -4/+2 percentage points. All plans listed on the warning alerts fall within the expanded metal AV range.

The metal AVs for all terminated plans were set to the base AV for their respective tier. This was done because there is not an appropriate 2018 AV for a plan that will not be offered in 2018.

Reliance

In developing this rate filing I relied on information drawn from various areas within BCBSRI, including Medical Economics, Legal, Strategic Marketing, Financial Forecasting and Budgets. Such information included projections of provider price increases, enrollment, and operating expenses. All this information was collected and conveyed to me in accordance with our established methods and reviewed for reasonableness by me. While I did not audit this data, I consider this information to be reliable. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

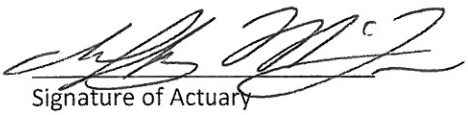
Actuarial Certification

I, Jeffrey McLane, am a member in good standing, of the American Academy of Actuaries and meet the Academy qualification standards for rendering this opinion. To the best of my knowledge and judgment, the projected Index Rate in the OHIC Rate Review Template was developed in compliance with all applicable State and Federal statutes and regulations, in particular 45 CFR 156.80(d)(1) and in compliance with applicable Actuarial Standards of Practice. It is my opinion that the Index Rate is reasonable in relation to the benefits proposed to be offered and the population anticipated to be covered, and is neither excessive nor deficient. Plan level rates were developed using only the Index Rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2).

The percent of total premium that represents Essential Health Benefits included in Tab II, Rate Development, Sections II and III of the OHIC Template were calculated in accordance with actuarial standards of practice.

The Federal AV calculator was used to generate all AV values and metal levels. As documented in this memorandum, certain inputs to the calculator were adjusted to appropriately reflect the plan designs.

The Part I Unified Rate Review Template does not demonstrate the exact process used to develop rates. Rather it represents information required by federal regulation to be provided in support of the review of rate increases and for certification that the Index Rate is developed in accordance with federal regulation and used consistently and that it is only adjusted by the allowable modifiers.



Signature of Actuary

6/30/17

Date

Blue Cross & Blue Shield of Rhode Island

Appendix A: Base Claims Development

for 2018 Individual Market Rate Filing

	A. On-system Claims											
	Paid						Allowed					
Incurred	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims
1/1/2016	$2,021,899	$2,082,827	$370,748	$1,484,156	$1,735,544	$0	$2,216,919	$3,124,344	$500,176	$2,934,392	$2,543,215	$0
2/1/2016	$2,597,816	$2,399,570	$454,463	$1,664,087	$2,043,170	$0	$2,791,084	$3,212,111	$580,663	$2,996,060	$2,724,250	$0
3/1/2016	$2,169,286	$2,792,211	$523,757	$2,105,884	$2,529,059	$0	$2,354,919	$3,625,236	$667,577	$3,526,938	$3,173,641	$0
4/1/2016	$2,981,413	$2,901,719	$483,758	$2,159,609	$2,660,389	$0	$3,153,651	$3,602,243	$612,815	$3,407,909	$3,210,435	$0
5/1/2016	$2,655,183	$3,181,555	$497,784	$2,277,262	$2,688,331	$0	$2,805,743	$3,910,628	$616,391	$3,518,059	$3,229,244	$0
6/1/2016	$2,840,667	$2,838,733	$494,686	$2,372,357	$2,926,465	$0	$3,000,930	$3,546,809	$607,187	$3,595,288	$3,448,774	$0
7/1/2016	$2,305,390	$3,038,560	$423,581	$2,098,974	$2,617,522	$0	$2,406,316	$3,624,193	$527,109	$3,091,794	$3,105,011	$0
8/1/2016	$2,939,725	$2,925,487	$513,704	$2,295,062	$2,926,920	$0	$3,056,983	$3,541,188	$623,269	$3,367,225	$3,378,394	$0
9/1/2016	$2,888,056	$2,883,744	$481,870	$2,486,570	$2,799,022	$0	$2,999,666	$3,435,363	$590,457	$3,525,655	$3,246,799	$0
10/1/2016	$2,516,492	$2,981,969	$482,675	$2,469,131	$2,986,058	$0	$2,655,702	$3,568,170	$587,075	$3,509,911	$3,418,809	$0
11/1/2016	$2,410,559	$2,883,686	$479,087	$2,407,611	$3,091,450	$0	$2,511,873	$3,410,009	$579,059	$3,377,069	$3,519,868	$0
12/1/2016	$2,758,658	$3,070,112	$466,424	$2,473,860	$3,344,064	$0	$2,855,140	$3,592,568	$572,267	$3,393,398	$3,803,095	$0

	B. IBNR Adjustment (Divisional)											
	Paid						Allowed					
Incurred	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims
1/1/2016	1.0001	0.9968	0.9980	0.9980	1.0000	1.0000	1.0001	0.9968	0.9980	0.9980	1.0000	1.0000
2/1/2016	1.0023	0.9958	0.9987	0.9987	1.0000	1.0000	1.0023	0.9958	0.9987	0.9987	1.0000	1.0000
3/1/2016	0.9910	0.9963	0.9973	0.9973	1.0000	1.0000	0.9910	0.9963	0.9973	0.9973	1.0000	1.0000
4/1/2016	1.0073	0.9948	0.9970	0.9970	1.0000	1.0000	1.0073	0.9948	0.9970	0.9970	1.0000	1.0000
5/1/2016	0.9963	0.9954	0.9960	0.9960	1.0000	1.0000	0.9963	0.9954	0.9960	0.9960	1.0000	1.0000
6/1/2016	0.9919	0.9935	0.9947	0.9947	1.0000	1.0000	0.9919	0.9935	0.9947	0.9947	1.0000	1.0000
7/1/2016	0.9604	0.9934	0.9923	0.9923	1.0000	1.0000	0.9604	0.9934	0.9923	0.9923	1.0000	1.0000
8/1/2016	0.9784	0.9904	0.9907	0.9907	0.9999	1.0000	0.9784	0.9904	0.9907	0.9907	0.9999	1.0000
9/1/2016	0.9937	0.9906	0.9878	0.9878	0.9999	1.0000	0.9937	0.9906	0.9878	0.9878	0.9999	1.0000
10/1/2016	0.9855	0.9802	0.9806	0.9806	0.9999	1.0000	0.9855	0.9802	0.9806	0.9806	0.9999	1.0000
11/1/2016	0.9686	0.9730	0.9721	0.9721	0.9998	1.0000	0.9686	0.9730	0.9721	0.9721	0.9998	1.0000
12/1/2016	0.8903	0.9530	0.9522	0.9522	0.9997	1.0000	0.8903	0.9530	0.9522	0.9522	0.9997	1.0000

	C. Out-of-System Liability Factor (Mulitplicative)											
Incurred	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims
CY 2016	0.9995	1.0008	1.0854	1.0854	1.0000	1.0000	0.9995	1.0008	1.0854	1.0854	1.0000	1.0000

	D. Total CY 2016 Claims Liability [(A/B)*C]											
	Paid						Allowed					
Incurred	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims	Inpatient	Outpatient	PCP	Other Professional	Rx	Other Claims
1/1/2016	$2,020,686	$2,091,185	$403,217	$1,614,131	$1,735,544	$0	$2,215,589	$3,136,881	$543,979	$3,191,372	$2,543,215	$0
2/1/2016	$2,590,559	$2,411,618	$493,916	$1,808,551	$2,043,170	$0	$2,783,287	$3,228,239	$631,072	$3,256,156	$2,724,250	$0
3/1/2016	$2,187,893	$2,804,823	$570,025	$2,291,915	$2,529,059	$0	$2,375,117	$3,641,610	$726,549	$3,838,502	$3,173,641	$0
4/1/2016	$2,958,326	$2,919,221	$526,651	$2,351,093	$2,660,389	$0	$3,129,231	$3,623,969	$667,151	$3,710,074	$3,210,435	$0
5/1/2016	$2,663,711	$3,198,815	$542,464	$2,481,667	$2,688,331	$0	$2,814,755	$3,931,843	$671,717	$3,833,836	$3,229,244	$0
6/1/2016	$2,862,432	$2,859,591	$539,793	$2,588,676	$2,926,465	$0	$3,023,923	$3,572,870	$662,552	$3,923,118	$3,448,774	$0
7/1/2016	$2,399,247	$3,061,195	$463,322	$2,295,904	$2,617,522	$0	$2,504,282	$3,651,190	$576,564	$3,381,874	$3,105,011	$0
8/1/2016	$3,003,122	$2,956,207	$562,809	$2,514,445	$2,927,212	$0	$3,122,909	$3,578,373	$682,847	$3,689,094	$3,378,732	$0
9/1/2016	$2,904,913	$2,913,437	$529,481	$2,732,257	$2,799,302	$0	$3,017,174	$3,470,736	$648,797	$3,874,009	$3,247,124	$0
10/1/2016	$2,552,241	$3,044,638	$534,260	$2,733,016	$2,986,356	$0	$2,693,429	$3,643,159	$649,818	$3,885,027	$3,419,151	$0
11/1/2016	$2,487,459	$2,966,077	$534,926	$2,688,222	$3,092,069	$0	$2,592,006	$3,507,437	$646,549	$3,770,673	$3,520,572	$0
12/1/2016	$3,097,022	$3,224,101	$531,670	$2,819,920	$3,345,067	$0	$3,205,338	$3,772,762	$652,320	$3,868,088	$3,804,236	$0

Blue Cross & Blue Shield of Rhode Island

Appendix B: Population Risk/Other Adjustments

for 2018 Individual Market Rate Filing

Uncollected Premium Adjustment	
Bad Debt 2016	$1,626,698
Total Premium Individual Market 2016	$138,438,001
Uncollected Premium Adjustment	**1.0118**

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Appendix C: Age Normalization

for 2018 Individual Market Rate Filing

Age	ACA Age Factor	Member Months
0 - 14	0.765	28,917
15	0.833	2,443
16	0.859	2,873
17	0.885	2,935
18	0.913	2,734
19	0.941	4,687
20	0.970	4,373
21	1.000	4,166
22	1.000	4,098
23	1.000	3,686
24	1.000	3,369
25	1.004	3,226
26	1.024	8,121
27	1.048	6,100
28	1.087	5,673
29	1.119	5,723
30	1.135	4,615
31	1.159	4,810
32	1.183	4,637
33	1.198	5,085
34	1.214	4,517
35	1.222	4,328
36	1.230	4,290
37	1.238	4,106
38	1.246	4,355
39	1.262	4,044
40	1.278	4,140
41	1.302	4,553
42	1.325	4,194
43	1.357	4,885
44	1.397	5,128
45	1.444	5,490
46	1.500	6,001
47	1.563	5,789
48	1.635	6,289
49	1.706	6,853
50	1.786	7,450
51	1.865	7,726
52	1.952	8,065
53	2.040	7,933
54	2.135	8,479
55	2.230	8,072
56	2.333	9,039
57	2.437	9,748
58	2.548	9,737
59	2.603	9,617
60	2.714	10,109
61	2.810	11,398
62	2.873	11,520
63	2.952	12,618
64	3.000	7,177
65+	3.000	2,528

	Member Months	ACA Age Factor	Weighting
Total	332,449	1.7089	568,135
Over 3 children under 21 years old	713	0.8245	588
All Other	331,736		
ACA Age Normalization Factor		1.7089	
>3 children under 21 adjustment		0.9990	

Blue Cross & Blue Shield of Rhode Island

Appendix D: Calculation of Paid to Allowed Average Factor and 70% Utilization Factor in Projection Period

for 2018 Individual Market Rate Filing

1.	Allowed Claims PMPM	**$**	**541.25**
2.	State-Mandated Assessments	**$**	**5.32**
3.	2018 Projected Allowed PMPM	**$**	**546.57**
4.	2016 Actual Net to Allowed		0.7462
5.	2-Year Paid Leveraging Factor		1.0241
6.	2018 Expected Net to Allowed		0.7642
7.	2018 Expected Paid Under Current Benefit Design		$413.65
8.	Average 2016 EHB Benefit Factor Relative to 70% Silver		0.7023
9.	Average 2018 EHB Benefit Factor Relative to 70% Silver		0.6699
10.	Benefit Adjustment		0.9540
11.	2018 Expected Paid under EHB Benefit Design		$399.93
12.	**2018 Paid-to-Allowed Factor (line 11 divided by line 3)**		**0.7317**
13.	**70% Silver Plan Utilization Adjustment**		**0.0922**

Blue Cross & Blue Shield of Rhode Island

Appendix E: Calculation of Expected Medical Premium

for 2018 Individual Market Rate Filing

Projected Claims	**PMPM**
Projected Allowed Claims	$543.79
Mandated/Additional Benefits	$2.81
Abortion Claims	-$0.04
Allowed Adjustment	$2.77
Total Allowed Claims	$546.57
Paid to Allowed Factor	0.7317
Paid Claims Before Risk Adjustment/Reinsurance	$399.93
Reinsurance Recovery	$0.00
Risk Adjuster	-$15.45
Paid Claims	$384.48

Projected Retention	**PMPM**	**% Premium**	
Admin	$56.57	11.67%	*PMPM*
Broker Commissions	$0.00	0.00%	*PMPM*
PCORI	$0.21	0.04%	*PMPM*
Premium Tax	$9.69	2.00%	*%*
Health Insurer Tax	$10.42	2.15%	*%*
Investment Income	-$0.05	-0.01%	*%*
Contribution to Reserves	$14.54	3.00%	*%*
Exchange User Fees	$8.73	1.80%	*%*
Other Taxes	$0.00	0.00%	*%*
Total After Claims	$100.11	20.66%	
EHB Projected Premium	**$484.59**	100.00%	
EHB Projected Premium Adjusted for Uncollected Premium	**$490.28**		

Rate Template Part I
Data and Explanation of Rate Increase

A1 Incurred and Paid

Calendar Year Experience	Paid Through Date	Inpatient Days/1000		Total	Inpatient Hospital	Outpatient Hospital	Primary Care	Other Med/Surg	Prescription Drugs	Capitation	Claims not Otherwise categorized (explain)
CY 2014	2/28/2015	331.51		$ 140,866,309	$ 37,317,798	$ 37,473,899	$ 6,237,340	$ 30,952,107	$ 25,581,077	$ -	$ 3,304,089
CY 2015	2/29/2016	358.67		$ 120,623,875	$ 29,221,331	$ 29,521,608	$ 4,771,164	$ 25,083,203	$ 29,253,258	$ -	$ 2,773,312
CY 2016	2/28/2017	303.71		$ 131,152,686	$ 31,085,143	$ 33,980,173	$ 5,672,538	$ 26,294,563	$ 32,347,993	$ -	$ 1,772,276

A2 Completed and Incurred

Calendar Year Experience	Member Months	Earned Premium	Total	Inpatient Hospital	Outpatient Hospital	Primary Care	Other Med/Surg	Prescription Drugs	Capitation	Claims not Otherwise categorized (explain)	Loss Ratio	Investment Income Credit	Contribution to Reserves	Taxes & Fees	Fraud & Abuse	Advanced Pmt CSR	Reinsurance Receivables	Risk Adjustment net payments expected (charges
CY 2014	400,631	$ 142,982,746	$ 142,608,949	$ 36,769,226	$ 37,518,867	$ 6,614,075	$ 32,821,614	$ 25,581,077	$ -	$ 3,304,089	99.7%	$ -	$ 11,280,235	$ 11,395,353	$ 34,879	$ 12,500,000	$ 19,368,632	$ -
CY 2015	295,544	$ 112,309,035	$ 122,552,794	$ 29,186,265	$ 29,559,986	$ 5,078,904	$ 26,701,069	$ 29,253,258	$ -	$ 2,773,312	109.1%	$ -	$ 9,700,612	$ 5,027,100	$ 48,677	$ 8,000,000	$ 16,585,067	$ 8,470,730
CY 2016	332,449	$ 130,057,742	$ 135,453,614	$ 31,727,612	$ 34,450,908	$ 6,232,535	$ 28,919,786	$ 32,350,487	$ -	$ 1,772,276	104.1%	$ -	$ (9,814,006)	$ 6,862,463	$ 41,943	$ 6,729,319	$ 3,201,246	$ 8,380,259

A3 Allowed

Calendar Year Experience	Total	Inpatient Hospital	Outpatient Hospital	Primary Care	Other Med/Surg	Prescription Drugs	Capitation	Claims not Otherwise categorized
CY 2014	$ 172,777,839	$ 38,734,413	$ 45,618,358	$ 8,493,051	$ 46,140,074	$ 30,487,854	$ -	$ 3,304,089
CY 2015	$ 149,057,282	$ 30,927,768	$ 36,135,617	$ 6,466,020	$ 38,379,801	$ 34,374,765	$ -	$ 2,773,312
CY 2016	$ 168,794,511	$ 33,477,040	$ 42,759,070	$ 7,759,914	$ 44,221,826	$ 38,804,386	$ -	$ 1,772,276

B Average Rate Increase Components

Should reconcile with rate increase for 21 year old EHB rate, 0% cost sharing, silver utilization

Claims Category Part I	Assumed Weight	Cost	Utilization,Other	Total
Inpatient Hospital	16.2%	0.5%	0.0%	0.5%
Outpatient Hospital	23.0%	0.6%	1.4%	1.9%
Primary Care	4.1%	0.1%	0.1%	0.3%
Other Medical/Surgical	22.3%	0.4%	0.8%	1.1%
Prescription Drug	16.1%	0.0%	1.6%	1.6%
Capitation	0.0%	0.0%	0.0%	0.0%
Other Not Categorized	0.8%	0.0%	0.0%	0.0%
Total Projected Claims	82.5%			5.5%

Calculation of Weights

Claims Category	Index Rate PMPM	% Distribution
Inpatient Hospital	$107.54	16.2%
Outpatient Hospital	$152.38	23.0%
Primary Care	$26.99	4.1%
Other Medical/Surgical	$147.84	22.3%
Prescription Drug	$106.47	16.1%
Capitation	$0.00	0.0%
Other Not Categorized	$5.35	0.8%
Total Projected Claims	$546.56	82.5%

Adjustments & Retention Part II	Assumed Weight	CY 2017 Adjustment	CY 2018 Adjustment	Total
Population Risk Adjustment	82.5%	0.0%	0.0%	0.0%
Other Adjustment	82.5%	-2.0%	-3.3%	-1.2%
Risk Adjustment		-7.3%	-3.2%	4.4%
Exchange User Fee		2.1%	1.8%	-0.3%
Admin Expense Load		9.9%	11.7%	1.6%
ACA Taxes & Fees		0.0%	2.2%	2.2%
Broker Commission		0.0%	0.0%	0.0%
Premium Tax		2.0%	2.0%	0.0%
Other Retention Charge		0.0%	0.0%	0.0%
Contribution to Reserve		2.8%	3.0%	0.2%
Investment Income Credit		0.0%	0.0%	0.0%
Prior Period Adjustment (+/-)				-0.6%
Total				12.3%

1/1/2018 EHB 21 year old rate increase	12.3%

Adjustments & Retention Part II	PMPM	% Distribution
Risk Adjustment	-$21.12	-3.2%
Exchange User Fee	$11.93	1.8%
Administrative Expense Load	$77.31	11.7%
ACA Fees and Taxes	$14.53	2.2%
Broker Commissions	$0.00	0.0%
Premium Tax	$13.25	2.0%
Other Retention Charge	$0.00	0.0%
Contribution to Reserve	$19.87	3.0%
Investment Income Credit	-$0.07	0.0%
Retention	*$124.88*	*18.9%*
Total Theoretical Rate	$662.25	

C Enrollment Statistics

Age Category	Membership Enrollment 31-Dec-15	31-Dec-16	31-Mar-17
<18	2,691	3,077	3,089
18-24	1,856	2,215	2,213
25-29	1,777	2,172	2,097
30-34	1,589	1,917	1,892
35-39	1,473	1,742	1,759
40-44	1,557	1,787	1,801
45-49	2,082	2,424	2,426
50-54	2,784	3,228	3,099
55-59	3,285	3,834	3,812
60-64	4,117	4,786	4,718
65+	168	268	249
Total	23,379	27,450	27,155

Policy Type	31-Dec-16 Number of Subscribers/ Policyholders	31-Dec-16 Number of Members	31-Mar-17 Number of Subscribers/ Policyholders	31-Mar-17 Number of Members
Single Policy	13,162	13,163	13,028	13,028
Dual Policy	2,441	4,882	2,271	1,873
EC Policy	695	1,695	775	7,712
Family Policy	2,035	7,710	2,039	4,542
Total	18,333	27,450	18,113	27,155

D Distribution of Rate Increases

Rate Change Distribution	% Distribution	Avg Rate Change
Reduction of 10% or more	0.0%	0.0%
Reduction between 5.01% and 9.99%	0.0%	0.0%
Reduction of 5% or less	0.0%	0.0%
Increase of less than 5%	14.2%	2.6%
Increase between 5.01% and 9.99%	23.7%	8.9%
Increase between 10.0% and 14.99%	19.1%	13.0%
Increase of 15% or more	42.9%	24.0%
Total	100.0%	11.9%

Rate Template Part II
Rate Development

Company Legal Name: **Blue Cross & Blue Shield of Rhode I** State: **RI**
HIOS Issuer ID: Market: **Individual**
Effective Date: **1/1/2018**

Experience Period: 1/1/2016 to 12/31/2016

Section I: Index Rate for Projection Period

Experience Period — **Projection Period:** 1/1/2018 to 12/31/2018 — Mid-point to Mid-point, Experience to Projection: 24 months

		on Actual Experience Allowed			Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual			
Benefit Category	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM	Pop'l risk Morbidity	Other	Cost	Util & Other	Utilization per 1,000	Average Cost/Service	PMPM	Utilization per 1,000	Average Cost/Service	PMPM	
Inpatient Hospital	admit/days	303.71	$ 3,978.77	$ 100.70	1.000	1.000	1.031	1.000	303.71	4,227.64	$ 107.00			$ -	
Outpatient Hospital	services	2,151.23	$ 717.46	$ 128.62	1.000	1.000	1.025	1.059	2,412.56	754.08	151.60			-	
Primary Care	services	1,537.21	$ 182.21	$ 23.34	1.000	1.000	1.036	1.035	1,646.70	195.68	26.85			-	
Other Medical/Surgical	services	9,824.96	$ 162.47	$ 133.02	1.000	1.000	1.016	1.035	10,524.75	167.71	147.09			-	
Prescription Drug	scripts	15,563.27	$ 90.00	$ 116.72	1.000	0.754	1.000	1.097	18,728.97	$ 67.87	$ 105.93			-	
Capitation	-	-		-	1.000	1.000	1.000	1.000	-	-	-	-	-	-	
Other Not Categorized	-	1.00	$ 165.14	$ 5.33	1.000	0.998	1.000	1.000	1.00	164.81	5.32			-	
Total				$ 507.73							$ 543.79	-		$ -	

				PMPM	% Adjustment
(1)	Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100%	0%	$543.79	
(2)	Adjustment to bring to Index Rate for Projection Period			$2.77	0.5%
(3)	Index Rate for the Projection Period			$546.56	

Section II: Market Adjusted Index Rate

(4)	Risk Adjustment Impact	-$21.12	-3.9%
(5)	Exchange User Fees	$11.93	2.2%
(6)	Market Adjusted Index Rate	$537.37	-1.7%

Section III: Calculation of EHB Rate for 21 Year Old, 0% Cost Sharing, Silver Utilization Level

Section III A: Market Adjusted Index Rate Silver Utilization Level

(7)	Experience Period Paid to Allowed Ratio	80%
(8)	Paid to Allowed Ratio in Projection Period	73%
(9)	Projected Federal Actuarial Value	0%
(10)	Adjustment to Silver Level utilization	1.09
(11)	Market Adjusted Index Rate Silver Utilization Level	$586.92

Section III B: Retention Charge

		PMPM	% Charge
(12)	Administrative Expense Load	$84.44	11.7%
(13)	ACA Fees and Taxes	$15.86	2.2%
(14)	Broker Commission	$0.00	0.0%
(15)	Premium Tax	$14.47	2.0%
(16)	Other Retention Charge	$0.00	0.0%
(17)	Contribution to Reserve	$21.70	3.0%
(18)	Investment Income Credit	-$0.07	0.0%
(19)	Total Retention Charge	$136.40	18.9%
(20)	**1/1/2018 EHB Revenue Requirement for 0% cost sharing, silver utilization level (70%)**	$723.32	

Section III C: Age Normalization/Calibration

(21)	Age Normalization to 21 year old	1.7072
***	Uncollected Premium Adjustment	1.0118
(22)	**1/1/2018 EHB Rate for 21 year old, 0% cost sharing, silver utilization level (70%)**	$428.67
(23)	**1/1/2017 Approved EHB Rate for 21 year old, 0% cost sharing, silver utilization level (70%)**	$381.56
(24)	**RATE INCREASE**	12.3%
(25)	**1/1/2016 Approved EHB Rate for 21 year old, 0% cost sharing, silver utilization level (70%)**	$364.44
(26)	**1/1/2018 Weighted Average Increase for All Plan Offerings**	13.9%

Section IV: Annual Trend Assumption

	Cost	Utilization	Projected PMPM
Inpatient Hospital	3.1%	0.0%	$103.80
Outpatient Hospital	2.5%	5.9%	$139.64
Primary Care	3.6%	3.5%	$25.04
Other Medical/Surgical	1.6%	3.5%	$139.88
Prescription Drug	0.0%	9.7%	$128.04
Capitation	0.0%	0.0%	$0.00
Other Not Categorized	0.0%	0.0%	$5.33
			$541.73
Annual Trend			**8.7%**

Rate Template Part III
Plan Rates

Carrier Name:	Blue Cross & Blue Shield of Rhode Island
Plan Type(s):	
Market Segment:	Individual
Rate Effective Date:	1/1/2018
Market Adjusted Index Rate	$537.37

													45 CFR Part 156.8 (d) (2) Allowable Factors							
Plan Number	2017 & 2018 HIOS Plan ID (Standard Component)	Plan Type (HMO, POS, PPO, Indemnity, Other)	1/1/17 & 1/1/18 Carrier Plan Code or Name	Discontinued, New, Modified, Existing (D, N,M, E) for 2018	2018 HIOS Plan ID (Standard Component	1/1/18 Carrier Plan Code or Name	2018 Metallic Tier	Metallic Tier Actuarial Value	Standard AV, Approach (1), Approach (2)	Exchange On/Off or Off	Pedi-Dental Y or N	Abortion Benefit Y or N	Provider Network	Utilization Management	Benefits in addition to EHB	AV and Cost Sharing	Distribution and Admin Costs less Exchange Fees	Cat Plan Adjustment	Proposed 1/1/18 Plan Adjustment	Other Adjustments (Calibration, 3 child cap etc.)
Totals																				
Plan 1A	15287RI0270003	PPO	VantageBlue Direct 1000/2000 WPD	M	15287RI0270003	VantageBlue Direct 1325/2650 WPD	Gold	0.8198	Standard AV	On/Off	Y	Y	1.00	1.1599	1.00	0.8150	1.23	1.00	1.165	0.59
Plan 1B	15287RI0360001	PPO	VantageBlue Direct 1000/2000 WOPD	M	15287RI0360001	VantageBlue Direct 1325/2650 WOPD	Gold	0.8198	Standard AV	On/Off	N	Y	1.00	1.1599	1.00	0.8134	1.23	1.00	1.163	0.59
Plan 2A	15287RI0270004	PPO	VantageBlue Direct 3050/6100 WPD	M	15287RI0270004	VantageBlue Direct 4850/9700 WPD	Silver	0.7194	Standard AV	On/Off	Y	Y	1.00	1.0490	1.00	0.7083	1.23	1.00	0.916	0.59
Plan 2B	15287RI0360002	PPO	VantageBlue Direct 3050/6100 WOPD	M	15287RI0360002	VantageBlue Direct 4850/9700 WOPD	Silver	0.7194	Standard AV	On/Off	N	Y	1.00	1.0490	1.00	0.7069	1.23	1.00	0.914	0.59
Plan 4A	15287RI0020005	PPO	BlueSolutions for HSA Direct 1400/2800 WPD	M	15287RI0020005	BlueSolutions for HSA Direct 1400/2800 WPD	Gold	0.7820	Standard AV	On/Off	Y	N	1.00	1.1115	1.00	0.8236	1.23	1.00	1.128	0.59
Plan 4B	15287RI0350001	PPO	BlueSolutions for HSA Direct 1400/2800 WOPD	M	15287RI0350001	BlueSolutions for HSA Direct 1400/2800 WOPD	Gold	0.7820	Standard AV	On/Off	N	N	1.00	1.1115	1.00	0.8219	1.23	1.00	1.126	0.59
Plan 5A	15287RI0020006	PPO	BlueSolutions for HSA Direct 3900/7800 WPD	M	15287RI0020006	BlueSolutions for HSA Direct 4100/8200 WPD	Silver	0.6801	Standard AV	On/Off	Y	N	1.00	0.9576	1.00	0.6886	1.23	1.00	0.813	0.59
Plan 5B	15287RI0350002	PPO	BlueSolutions for HSA Direct 3900/7800 WOPD	M	15287RI0350002	BlueSolutions for HSA Direct 4100/8200 WOPD	Silver	0.6801	Standard AV	On/Off	N	N	1.00	0.9576	1.00	0.6872	1.23	1.00	0.811	0.59
Plan 6A	15287RI0020008	PPO	BlueSolutions for HSA Direct 6000/12000 WPD	M	15287RI0020008	BlueSolutions for HSA Direct 6000/12000 WPD	Bronze	0.6092	Standard AV	On/Off	Y	Y	1.00	0.9022	1.00	0.6249	1.23	1.00	0.695	0.59
Plan 6B	15287RI0350003	PPO	BlueSolutions for HSA Direct 6000/12000 WOPD	M	15287RI0350003	BlueSolutions for HSA Direct 6000/12000 WOPD	Bronze	0.6092	Standard AV	On/Off	N	Y	1.00	0.9022	1.00	0.6237	1.23	1.00	0.693	0.59
Plan 11A	15287RI0800002	POS	BlueCHiP Direct 1800/3600 WPD	M	15287RI0800002	BlueCHiP Direct 2300/4600 WPD	Gold	0.7698	Standard AV	On/Off	Y	Y	0.95	1.0959	1.00	0.7964	1.23	1.00	1.022	0.59
Plan 11B	15287RI0810002	POS	BlueCHiP Direct 1800/3600 WOPD	M	15287RI0810002	BlueCHiP Direct 2300/4600 WOPD	Gold	0.7698	Standard AV	On/Off	N	Y	0.95	1.0959	1.00	0.7948	1.23	1.00	1.020	0.59
Plan 10A	15287RI0800001	POS	BlueCHiP Direct 4800/9600 WPD	M	15287RI0800001	BlueCHiP Direct 4800/9600 WPD	Silver	0.6806	Standard AV	On/Off	Y	Y	0.95	1.0013	1.00	0.7180	1.23	1.00	0.842	0.59
Plan 10B	15287RI0810001	POS	BlueCHiP Direct 4800/9600 WOPD	M	15287RI0810001	BlueCHiP Direct 4800/9600 WOPD	Silver	0.6806	Standard AV	On/Off	N	Y	0.95	1.0013	1.00	0.7166	1.23	1.00	0.840	0.59
Plan 7A	15287RI0700001	PPO	BasicBlue Direct 2750/5500 WPD	E	15287RI0700001	BasicBlue Direct 2750/5500 WPD	Gold	0.7920	Standard AV	On/Off	Y	Y	1.00	1.0881	1.00	0.8262	1.23	1.00	1.108	0.59
Plan 7B	15287RI0710001	PPO	BasicBlue Direct 2750/5500 WOPD	E	15287RI0710001	BasicBlue Direct 2750/5500 WOPD	Gold	0.7920	Standard AV	On/Off	N	Y	1.00	1.0881	1.00	0.8245	1.23	1.00	1.106	0.59
Plan 8A	15287RI0700002	PPO	BasicBlue Direct 4900/9800 WPD	E	15287RI0700002	BasicBlue Direct 4900/9800 WPD	Silver	0.6944	Standard AV	On/Off	Y	Y	1.00	1.0008	1.00	0.7359	1.23	1.00	0.908	0.59
Plan 8B	15287RI0710002	PPO	BasicBlue Direct 4900/9800 WOPD	E	15287RI0710002	BasicBlue Direct 4900/9800 WOPD	Silver	0.6944	Standard AV	On/Off	N	Y	1.00	1.0008	1.00	0.7345	1.23	1.00	0.906	0.59
Plan 9A	15287RI0700003	PPO	BasicBlue Direct 7150/14300 WPD	M	15287RI0700003	BasicBlue Direct 6850/13700 WPD	Bronze	0.6395	Standard AV	On/Off	Y	Y	1.00	0.9345	1.00	0.6947	1.23	1.00	0.800	0.59
Plan 9B	15287RI0710003	PPO	BasicBlue Direct 7150/14300 WOPD	M	15287RI0710003	BasicBlue Direct 6850/13700 WOPD	Bronze	0.6395	Standard AV	On/Off	N	Y	1.00	0.9345	1.00	0.6933	1.23	1.00	0.798	0.59
Plan 3A		PPO		N	15287RI0270009	VantageBlue Direct 3250/6500 WPD	Gold	0.7604	Standard AV	Off	Y	N	1.00	1.0995	1.00	0.7508	1.23	1.00	1.017	0.59
Plan 3B		PPO		N	15287RI0360004	VantageBlue Direct 3250/6500 WOPD	Gold	0.7604	Standard AV	Off	N	N	1.00	1.0995	1.00	0.7493	1.23	1.00	1.015	0.59
Plan 12A		POS		N	15287RI1130001	BlueCHiP Direct Advance 4650/9300 WPD	Silver	0.6850	Standard AV	On	Y	Y	0.84	1.0056	1.00	0.7223	1.23	1.00	0.748	0.59
Plan 12B		POS		N	15287RI1140001	BlueCHiP Direct Advance 4650/9300 WOPD	Silver	0.6850	Standard AV	On	N	Y	0.84	1.0056	1.00	0.7208	1.23	1.00	0.747	0.59
	15287RI0720001	PPO	VantageBlue with Dental Direct 1200/2400 WPD	D	15287RI0270003	VantageBlue Direct 1325/2650 WPD	Gold	0.8198	Standard AV	On/Off	Y	Y	1.00	1.1599	1.00	0.8150	1.23	1.00	1.165	0.59
	15287RI0840001	PPO	VantageBlue with Dental Direct 1200/2400 WOPD	D	15287RI0360001	VantageBlue Direct 1325/2650 WOPD	Gold	0.8198	Standard AV	On/Off	N	Y	1.00	1.1599	1.00	0.8134	1.23	1.00	1.163	0.59

Plan Number	Total Number of Members/Enrolled Policyholders + Covered Dependents	Total Number of Subscribers/Enrolled Policyholders	1/1/18 Number of Members/Enrolled Policyholders + Covered Dependents	1/1/18 Number of Subscribers/Enrolled Policyholders	1/1/17 Normalized Plan Adjusted Rate PMPM	1/1/18 Normalized Plan Adjusted Rate	1/1/18 Normalized PMPM Value of Benefits Other Than EHB	1/1/18 Normalized Plan Adjusted Rate PMPM Excluding Non-EHB	Proposed Rate Change Compared to Prior 12 months	1/1/18 Rate Increase Due to Plan Design Changes	% of Total Members/Enrolled Policyholders + Covered Dependents	% of 1/1/18 Members/Enrolled Policyholders + Covered Dependents
Totals	**27,005**	**18,034**	**27,005**	**18,034**	**$257.97**	**$293.84**			**13.9%**	**-1.68%**		
Plan 1A	4,118	2,347	4,118	2,347	$ 337.25	$367.11	$0.04	$367.07	8.9%	-2.7%	15.2%	15.2%
Plan 1B	1,469	938	1,469	938	$ 336.46	$366.38	$0.04	$366.34	8.9%	-2.7%	5.4%	5.4%
Plan 2A	2,564	1,546	2,564	1,546	$ 281.35	$288.56	$0.04	$288.52	2.6%	-10.2%	9.5%	9.5%
Plan 2B	777	566	777	566	$ 280.69	$287.98	$0.04	$287.94	2.6%	-10.2%	2.9%	2.9%
Plan 4A	1,111	613	1,111	613	$ 309.53	$355.50		$355.50	14.9%	-0.1%	4.1%	4.1%
Plan 4B	150	89	150	89	$ 308.80	$354.79		$354.79	14.9%	-0.1%	0.6%	0.6%
Plan 5A	2,885	2,156	2,885	2,156	$ 229.04	$256.05		$256.05	11.8%	-4.0%	10.7%	10.7%
Plan 5B	165	107	165	107	$ 228.50	$255.54		$255.54	11.8%	-4.0%	0.6%	0.6%
Plan 6A	2,494	1,588	2,494	1,588	$ 186.14	$218.92	$0.04	$218.88	17.6%	-0.2%	9.2%	9.2%
Plan 6B	619	432	619	432	$ 185.70	$218.49	$0.04	$218.45	17.7%	-0.2%	2.3%	2.3%
Plan 11A	157	97	157	97	$ 281.74	$321.99	$0.04	$321.95	14.3%	-4.8%	0.6%	0.6%
Plan 11B	40	30	40	30	$ 281.08	$321.34	$0.04	$321.30	14.3%	-4.8%	0.1%	0.1%
Plan 10A	779	721	779	721	$ 207.10	$265.23	$0.04	$265.19	28.1%	0.8%	2.9%	2.9%
Plan 10B	39	37	39	37	$ 206.61	$264.70	$0.04	$264.66	28.1%	0.8%	0.1%	0.1%
Plan 7A	707	441	707	441	$ 295.27	$349.07	$0.04	$349.03	18.2%	0.0%	2.6%	2.6%
Plan 7B	151	100	151	100	$ 294.58	$348.38	$0.04	$348.34	18.3%	0.0%	0.6%	0.6%
Plan 8A	1,901	1,302	1,901	1,302	$ 234.35	$286.00	$0.04	$285.96	22.0%	0.0%	7.0%	7.0%
Plan 8B	287	209	287	209	$ 233.80	$285.43	$0.04	$285.39	22.1%	0.0%	1.1%	1.1%
Plan 9A	2,470	1,660	2,470	1,660	$ 189.38	$252.11	$0.04	$252.07	33.1%	5.3%	9.1%	9.1%
Plan 9B	662	535	662	535	$ 188.93	$251.60	$0.04	$251.56	33.2%	5.3%	2.5%	2.5%
Plan 3A	200	100	200	100		$320.58		$320.58		NA	0.7%	0.7%
Plan 3B	50	50	50	50		$319.94		$319.94		NA	0.2%	0.2%
Plan 12A	3,000	2,200	3,000	2,200		$235.81	$0.04	$235.77		NA	11.1%	11.1%
Plan 12B	210	170	210	170		$235.33	$0.04	$235.29		NA	0.8%	0.8%
					$ 356.21	$367.11	$0.04	$367.07	3.1%	-2.4%	0.0%	0.0%
					$ 355.37	$366.38	$0.04	$366.34	3.1%	-2.4%	0.0%	0.0%

Rate Template Part IV
Administrative Charges

Section I. EHB 0% cost sharing, silver utilization level (70%)

		Individual Market 1/1/18		Individual Market 1/1/17	
		PMPM	Percentage	PMPM	Percentage
(1)	Retention Charge	$136.40	18.9%	$93.66	14.8%
(2)	ACA Fees and Taxes	$15.86	2.2%	$0.26	0.0%
(3)	Premium Tax	$14.47	2.0%	$12.65	2.0%
(4)	Other Retention Charge	$0.00	0.0%	$0.00	0.0%
(5)	Contribution to Reserve	$21.70	3.0%	$17.96	2.8%
(6)	Investment Income Credit	-$0.07	0.0%	-$0.06	0.0%
(7)	Administrative Expense Load	$84.44	11.7%	$62.86	9.9%
	7a. Payroll and benefits	$33.50	4.6%	$22.80	3.6%
	7b. Outsourced Services (EDP, claims etc.)	$20.63	2.9%	$17.56	2.8%
	7c. Auditing and consulting	$2.23	0.3%	$2.19	0.3%
	7d. Commissions	$0.00	0.0%	$0.00	0.0%
	7e. Marketing and Advertising	$0.93	0.1%	$1.68	0.3%
	7f. Legal Expenses	$0.33	0.0%	$0.96	0.2%
	7g. Taxes, Licenses and Fees not included in (2) and (3)	$0.00	0.0%	$0.00	0.0%
	7h. Reimbursements by Uninsured Plans	$0.00	0.0%	$0.00	0.0%
	7i. Other Admin Expenses	$26.82	3.7%	$17.68	2.8%
		$84.44	11.7%	$62.86	9.9%

Section II. Market Segment

		Individual Market 1/1/18		Small Group Market 1/1/18	
		PMPM	Percentage	PMPM	Percentage
(1)	Retention Charge	$91.38	18.9%	$120.34	21.6%
(2)	ACA Fees and Taxes	$10.63	2.2%	$12.43	2.2%
(3)	Premium Tax	$9.69	2.0%	$11.14	2.0%
(4)	Other Retention Charge	$0.00	0.0%	$0.00	0.0%
(5)	Contribution to Reserve	$14.54	3.0%	$19.49	3.5%
(6)	Investment Income Credit	-$0.05	0.0%	-$0.51	-0.1%
(7)	Administrative Expense Load	$56.57	11.7%	$77.79	14.0%
	7a. Payroll and benefits	$22.45	4.6%	$33.80	6.1%
	7b. Outsourced Services (EDP, claims etc.)	$13.82	2.9%	$20.32	3.6%
	7c. Auditing and consulting	$1.49	0.3%	$2.23	0.4%
	7d. Commissions	$0.00	0.0%	$12.95	2.3%
	7e. Marketing and Advertising	$0.63	0.1%	$0.90	0.2%
	7f. Legal Expenses	$0.22	0.0%	$0.46	0.1%
	7g. Taxes, Licenses and Fees not included in (2) and (3)	$0.00	0.0%	$0.00	0.0%
	7h. Reimbursements by Uninsured Plans	$0.00	0.0%	-$22.97	-4.1%
	7i. Other Admin Expenses	$17.97	3.7%	$30.11	5.4%