BLUE SHIELD OF CALIFORNIA COMPANY
2016 INDIVIDUAL PRODUCTS RATE FILING
ACTUARIAL MEMORANDUM

I. General Information

a. Company Identifying Information:

- Company Legal Name: California Physician's Service, dba Blue Shield of California
- State: California
- HIOS Issuer Id: 70285
- Market: Individual
- Effective Date: January 1, 2016

b. Company Contact Information:

- Primary Contact Name: John Chong
- Primary Contact Telephone Number: 310-744-2923
- Primary Contact Email Address: john.chong@blueshieldca.com

II. Proposed Rate Increases

This filing covers the rate increase on the non-grandfathered individual plans. The average increase is **4.6%** and varies from -9.7% to 44.9% depending on benefit plan and geographic rating region. These rate changes do not include the impact of age band increases. Please see below for the major components of the average increase.

Table 1: Rate Increase Drivers

Updated Experience	0.7%
Core Trend	6.0%
Health Status	0.4%
Reinsurance	4.1%
Changes in Benefits	0.4%
Risk Adjustment	-5.2%
Other	0.0%
Administrative Expenses	-1.6%
Margin (before taxes)	0.0%
2016 Rate Increase	**4.6%**

The individual rate increase applicable to each member will vary from the average rate increase of 4.6% due to changes in region and plan relativities. The region relativities have been updated with actual experience to reflect more accurate cost relativities and include anticipated network contracting changes. The plan relativities have also been updated with actual experience to reflect more accurate induced utilization and proposed benefit changes.

III. Experience Period Premium and Claims

a. Paid Through Date:

The experience period is from January 1, 2014 through December 31, 2014 and paid through February 28, 2015

b. Premiums (net of MLR Rebate) in the Experience Period:

- Premiums gross of MLR rebates come from Blue Shield's data warehouse. These amounts are then reconciled to internal financials.

- The MLR rebates have been projected based on experience thru February 2015 and assumes the reinsurance coinsurance recovery is 100% and risk adjustment transfers are consistent with a statewide study conducted by an external consulting firm.
- A risk corridor payment has also been estimated based on the same reinsurance recovery and risk adjustment transfers assumptions.

Table 2: Net Premiums

Experience Period Premium	$1,965,513,707
Projected Risk Corridor	($93,300,063)
Projected MLR Rebates	($53,518,791)
Net Premiums (URRT cell F14)	**$1,818,694,853**

c. Allowed and Incurred Claims During the Experience Period:

- Allowed claims and paid on incurred claims come from Blue Shield's data warehouses. Capitation makes up a small percentage of claims in the experience period and shows up in the allowed amount on a paid basis, with no adjustments for cost sharing. Completion factors are then applied to both allowed and paid for each incurred month to arrive at an estimated incurred claims number. This estimate is then reconciled to internal, restated financials to account for claims processed outside of Blue Shield's claims system.
- The table below shows how the amounts reported in cells F15 and F16 of the URRT break out into paid on incurred, claim processed outside of Blue Shield's claims system, claims incurred but not paid (IBNP), reinsurance recoveries, and risk adjustment transfer payments:

Table 3: Experience Period Claims

	Paid Claims	Allowed Claims
Paid and Incurred	$1,573,319,105	$2,752,315,213
Incurred But Not Paid	$141,919,403	$248,269,363
Outside System	$0	$0
Estimated Net Reinsurance Recovery	($347,498,223)	
Estimated Net Risk Adjustment Transfer	($113,364,005)	
Total (URRT cells F15 and F16)	**$1,254,376,280**	**$2,194,366,614**

d. Estimate of Incurred But Not Paid Claims

- For determination of incurred but not paid, our individual business is grouped as follows: HMO, PPO regulated by the Department of Managed Healthcare (DMHC), and PPO regulated by the California Department of Insurance (CDI)
- For each grouping, three sets of month to month completion factors are derived by averaging the prior 6, 9, and 12 months of data within that grouping. The median of the three estimates is used to complete the claims (typically the 9 month average).
- Smoothing of Outliers: For any incurred month/paid lag combination in which the percentage of total paid is greater than 1.96 standard deviations from the average percentage for that paid lag, the percent of total paid is replaced with the average.
- For incurred months with zero to two months of paid runout, the IBNP estimate derived from the completion factors is blended with an estimate based on a projection of the incurred claims for that month.

IV. Benefit Categories

a. **Inpatient Hospital**: Represents claims billed by a hospital facility for members receiving care on an inpatient basis. These amounts do not include inpatient services that are billed by the physician directly.

b. **Outpatient Hospital**: Represents claims billed by a hospital facility for members receiving care on an outpatient basis. These amounts do not include outpatient services that are billed by the physician directly.

c. **Professional:** Represents claims billed directly by the physician. Includes office visits, preventive care, physical medicine, injectables administered in the office, and physician services rendered at on inpatient or outpatient facility.

d. **Other Medical**: Includes radiology, radiation therapy, lab tests, ambulance, durable medical equipment, orthotics, and prosthetics.

e. **Capitation**: Represents costs in which the provider is reimbursed on a per member per month basis, as opposed to fee for service. For our HMO products, the majority of professional costs and a small minority of inpatient and outpatient costs are paid through capitation. For both HMO and PPO, this line also includes a fixed per member per month payment we pay to an outside vendor for the coverage of some mental health services.

f. **Prescription Drug**: Represents prescriptions obtained through retail and mail order pharmacies.

V. Projection Factors

a. Changes in Population Risk Morbidity

The trend for changes in the population risk morbidity was determined using the same manual rate development as described in Section V of the 2015 Actuarial Memorandum. The economic decision making model was updated to reflect 2014 enrollment as the starting point for 2015. After the initial surge in enrollment in 2014, we expect two main dynamics to impact the population risk morbidity in 2015 and 2016.

- **Individual Mandate**: The ACA imposes a financial penalty (with exceptions) for those that do not maintain qualified health insurance coverage for the entire year. In 2015, the penalty is increased to the greater of $325 per adult/$162.50 per child or 2% of annual household income. In 2016, the penalty is increased to the greater of $695 per adult/$347.50 per child or 2.5% of annual household income. The mandate is expected to decrease the overall morbidity of the insured population, as it provides incentive for health enrollees to purchase coverage.
- **Employer Migration**: The ACA also imposes changes to the employer market with similar rating rule and market changes to the Small Group market and minimum essential coverage requirements for the Large Group market. The migration from group coverage to the Individual market is expected to increase the overall morbidity of the insured population, as we have compared the relative health of our own members who have migrated from group coverage.

Table 4: Population Risk Morbidity

	2015	2016
Employer Migration	1.7%	1.2%
Cobra Migration	0.2%	0.1%
Full 2015 Mandate	-2.5%	-1.0%
Population Risk Morbidity	**-0.6%**	**0.4%**

b. Changes due to Demographics

Significant changes in the demographic profile of the population are not expected in 2015 and 2016. We expect the majority of the changes to have already occurred in 2014. The demographic profile at the beginning of the year was younger than at the end of the year when the membership eventually stabilized. We've assumed the demographic profile to be consistent with the most recent view as of February 2015 for future periods which results in a **0.6%** demographic trend. This trend is reflected under "Util Adj 1" of the SRRT.

c. Changes due to Seasonality

The allowed seasonality generally reflects the monthly changes in costs due to the effective days (the number of weekdays, holiday and weekends). We have also observed a slight increase in allowed costs in the latter half of the year as members utilize services before their deductible and out of pocket accumulations reset. In 2014, a significant portion of our members joined after the first quarter which inflates the total allowed PMPM for the year. We do not expect this to be the case in 2016 due to an earlier open enrollment period, more market awareness of key dates and higher overall retention. The difference in the distribution of members from 2014 to 2016 is expected to result in a **-0.7%** seasonality trend. This trend is reflected under "Util Adj 2" of the SRRT.

d. Changes due to Duration

Similar to the seasonality trend, we have observed a gradual increase in allowed costs in members in their initial four months of coverage. This dynamic is only associated with new members. The high volume of new members in 2014 results in a lower allowed PMPM than expected going forward into 2015 and 2016. The lower portion of sales to members in 2016 relative to 2014 is expected to result in a **1.4%** duration trend. This trend is reflected under "Util Adj 2" of the SRRT.

e. Change due to Plan Mix

The distribution of members across plans is expected to gravitate towards the silver metal plan. The shift in the membership will result in a **1.2%** plan mix trend. This trend is reflected under "Util Adj 3" of the SRRT. Please see below for a distribution of members across plans.

Table 5: Plan Mix

	2014	2015	2016
Platinum	9.9%	9.9%	9.9%
Gold	10.4%	11.1%	11.6%
Silver	19.2%	21.4%	22.4%
Bronze	22.3%	20.9%	21.1%
Catastrophic	2.8%	1.6%	1.3%
CSR Variant	35.4%	35.1%	33.7%
Total	**100.0%**	**100.0%**	**100.0%**

f. Other Changes

In addition to the trends listed above, the following adjustments are reflected under the "Cost Adj 1" of the SRRT to reflect one-time adjustments relative to our 2014 experience.

- **Network Changes**: Additional providers are being included to our network which will allow for converting four EPO regions into PPO regions so we have a full PPO network across the state. Additional providers are also being included in existing PPO regions to increase the breadth of the network. This is expected to increase costs by 0.6%.
- **Rx Utilization:** Pharmacy utilization ramped up throughout 2014 and has remained high into 2015. This increase in pharmacy utilization has not been incorporated into the 2015 and 2016 core trends and results in a 1.2% increase in costs.
- **Payment Errors:** A variety of payment issues including adjudication errors, incorrect identification of out of network providers, and payment for lapsed members inflated cost in

2014. We have made the appropriate revisions to mitigate these types of errors and do not expect these costs in our 2014 experience to continue and will result in a 2.6% decrease in costs.

g. Pediatric Benefits

Of the required benefits covered under the Essential Health Benefits package, we only expect pediatric dental and pediatric vision to have a significant impact on costs. Please note that experience for pediatric vision and dental are not reflected in the experience period because they were not embedded benefits, but the projected costs include pediatric dental and vision. The impact of pediatric vision and dental is included in the URRT as a trend component and results in a **0.9%** increase in trend. This trend is reflected under "Cost Adj 2" of the SRRT.

h. Trend Factors (cost/utilization)

Trend factors are derived from historical Blue Shield experience. The key components of the trend factor buildup are as follows:

- effective days trend which is largely a leap year effect,
- CoHC strategies and initiatives that are expected to produce incremental cost savings,
- provider contracting changes,
- and residual trends that reflect the unexplained variance from actual trend after accounting for demographics, underwriting wear-off, benefits, and seasonality changes.

We have historically seen higher trends in the Individual market, as compared to the Group market (reflected in the residual trend measurements). We believe that these higher trends were due to plan migration effects that no longer apply in a post-ACA guaranteed issue market. We have thus chosen to use the lower residual trends derived from our large group experience for setting the 2015 and 2016 trends. The table below summarizes the trend assumptions separately for 2015 and 2016 (this reconciles to the overall trends shown in columns L and M of the URRT.

Table 6: Trend Assumptions by Year (Cost/Utilization combined)

Benefit Category	2015	2016
Inpatient Hospital	3.0%	4.0%
Outpatient Hospital	5.0%	6.1%
Professional	4.8%	5.2%
Other Medical	5.3%	6.1%
Capitation	18.8%	5.9%
Prescription Drug	12.1%	11.2%
Total	**6.2%**	**6.5%**

VI. Paid to Allowed Ratio

The Paid to Allowed Average Factor in the Projection Period is developed from the total projected paid costs divided by the projected allowed costs. The following table shows the paid to allowed ratio for each plan and in total.

Table 7: Paid to Allowed by Plan Design

Plan	Enrollment	Allowed	Paid to Allowed
Standard Platinum	9.9%	$1,097.60	91.6%
Standard Gold	11.6%	$528.77	84.3%
Standard Silver	56.1%	$418.85	75.7%
Standard Bronze	13.3%	$218.26	65.2%
Standard Bronze HSA	7.8%	$235.38	60.9%

Catastrophic	1.3%	$165.97	59.6%
Silver Seven 3750	0.0%	$0.00	76.0%
Silver 1850	0.0%	$0.00	75.8%
Bronze 5550	0.0%	$0.00	65.3%
Total	100.0%	$454.71	79.3%

VII. Risk Adjustment and Reinsurance

a. Projected Risk Adjustments PMPM

The risk adjustment transfer has been one of the most challenging components to project as it reflects the risk relative to the market. Our risk adjustment projections are based on the results from a statewide study conducted by an external consulting firm. They collected diagnosis data from all of the major insurance companies in California and simulated the risk adjustment transfer. Based on these results and the changes to the risk score factors announced in the final 2016 NBPP, we have determined the following risk adjustment transfer PMPMs.

Table 8: Risk Adjustment PMPM by Plan Design

Plan	Enrollment	Risk Adjustment
Standard Platinum	9.9%	$379.18
Standard Gold	11.6%	$51.77
Standard Silver	56.1%	$2.37
Standard Bronze	13.3%	-$110.56
Standard Bronze HSA	7.8%	-$110.56
Catastrophic	1.3%	$26.56
Silver Seven 3750	0.0%	$2.37
Silver 1850	0.0%	$2.37
Bronze 5550	0.0%	-$110.56
Total	100.0%	$21.92

b. Projected ACA Reinsurance Recoveries

We estimated the percentage of claims that would be covered by the temporary reinsurance program based on 2014 experience. The reinsurance program reimburses carriers for 50% of a member's claims between the amounts of $90,000 and $250,000. We expect to receive a gross reinsurance payment of $22.10 or a net reinsurance payment of $19.86 PMPM after the reinsurance fee of $2.25.

Per the URRT instructions, the reinsurance PMPM shown in cell V37 of the first tab is net of the $2.25 PMPM contribution fee.

VIII. Non-Benefit Expense and Profit & Risk

a. Administrative Expense Load

Administrative expense load assumptions were developed from Blue Shield historical expense costs, with appropriate trend adjustments to 2016. The table below splits out the administrative expense load into medical and pediatric components.

Table 9: PMPM Administrative Expense Load

Medical Admin PMPM	$36.13
Medical Broker Commission	$7.71
Medical Management	$2.56
Pediatric Admin	$1.08

Total Admin	**$47.48**

b. Contribution to Surplus and Risk Margin

The proposed rate increase reflects an expected contribution to surplus of 2.09% or $8.37 PMPM. Please note that this represents an increase of 0.1% from 2015.

c. Taxes and Fees

The following taxes and fees are built into the proposed pricing:

- **Insurer Tax:** This is the percent of premium fee imposed by Section 9010 of the ACA. Per 9010(e), the federal government will collect $8 billion from the industry for 2014 and $11.3 billion in 2015 and 2016. We estimate the fee to be assessed at 1.7% of revenue for 2016.
- **Exchange Participation Fee:** Per guidance issued by Covered California, we assumed a Participation Fee of $13.95 PMPM for all business sold through the Covered California exchange. As required by the Market Rules, the anticipated total fees are spread equally across our entire non-grandfathered book of business in 2016. With these assumptions, the projected PMPM Participation fee used for pricing is $8.87.
- **Income Taxes:** Income taxes are anticipated to be 40.75% of pre-tax earnings. Note that the insurer tax mentioned above cannot be deducted from earnings.

Table 10: Taxes and Fees

Insurer Tax	$6.82
Exchange Participation Fee	$8.87
PCORI Fee	$0.18
Income Taxes	$10.43
Taxes & Fees	**$26.31**

IX. Projected Loss Ratio

The projected 2016 Federal Loss Ratio for our non-grandfathered Individual business is 85.7%. Please note that this determination is an estimate as it does not include all the applicable adjustments and experience that the actual federal MLR rebate calculation is based on. The actual 2016 federal MLR determination is based on a three year aggregate.

X. Index Rate

The index rate is the total allowed costs for providing essential health benefits within the single risk pool of the non-grandfathered Individual plans in California. The index rate is expected to increase from $393 in 2014 to $454 in 2016. The annualized trend in the index rate is 7.5%.

XI. Market Adjusted Index Rate

The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The following market-wide adjustments to the Index Rate have been made:

- Federal reinsurance program adjustment
- Risk adjustment transfer
- Marketplace user fee adjustment

The buildup of the Market Adjusted Index Rate has been provided in the SRRT.

XII. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all the allowable plan level modifiers defined in the market rating rules:

- Actuarial value and cost-sharing adjustment
- Provider network, delivery system and utilization management adjustment
- Adjustment for benefits in addition to essential health benefits
- Impact of specific eligibility categories for the catastrophic plan
- Adjustment for distribution and administrative costs

The buildup of the Plan Adjusted Index Rate has been provided in the SRRT. The AV and cost-sharing adjustment takes into account benefit and utilization differences. There is no adjustment for provider network since all plans are on the same network. The impact of specific eligibility categories for the catastrophic plan is consistent with the 2015 filing.

XIII. Calibration

a. Age Curve Calibration

The approximate weighted average age during the experience period was 39 years. Please note this average includes all members and not just billable members and this average was note used to determine the age curve calibration.

The age curve calibration is equal to the age curve factor for age 21 divided by the weighted average age curve factor of our 2014 membership. We have also included a 0.009 adjustment to the calibration due to membership data discrepancies that would artificially lower the proposed rates. The resulting age curve calibration factor is 0.649.

b. Geographic Factor Calibration

The geographic factor calibration is equal to 1 divided by the weighted average 2016 region factors across our 2014 membership. The resulting geographic factor calibration is 1.000.

XIV. AV Metal Values

Worksheet 2 of the URRT contains the following standard plan designs in addition to the alternative plan designs that will be offered strictly off the Exchange:

Table 11: Metal Level Actuarial Values by Plan

Plan	Metal AV
Standard Platinum	0.885
Standard Gold	0.802
Standard Silver	0.705
Standard Bronze	0.619
Standard Bronze HSA	0.611
Catastrophic	0.616
Silver Seven 3750	0.707
Silver 1850	0.705
Bronze 5550	0.620

Please note that we are relying on Covered California's determination of the Federal Actuarial Values for the standard plan designs.

XV. AV Pricing Values

The permitted plan-level adjustments to the index rate are:

- The actuarial value and cost sharing design of the plan
- The plan's provider network delivery system and utilization management practices
- The benefits provided under the plan that are in addition to the essential health benefits
- Administrative costs, excluding Exchange user fees
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans

The table below shows, for each filed plan, the impact of cost sharing and induced utilization separately.

Table 12: Cost Sharing and Induced Utilization Pricing Factors

Plan	Cost Share	Induced	Total
Standard Platinum	0.915	1.292	1.182
Standard Gold	0.855	1.084	0.927
Standard Silver	0.801	0.915	0.733
Standard Bronze	0.663	0.946	0.628
Standard Bronze HSA	0.669	0.946	0.633
Catastrophic	0.647	0.946	0.613
Silver Seven 3750	0.772	0.915	0.707
Silver 1850	0.744	0.915	0.680
Bronze 5550	0.647	0.946	0.613

The impact of cost sharing was derived from an internally developed actuarial value calculator, based on 2014 experience of this block. The development of the induced utilization assumption was also based on 2014 experience of this block. Allowed costs were normalized by health status and bucketed into metal levels to estimate the amount of induced utilization in each metal level.

XVI. Membership Projections

Membership projections by plan are based on a variety of sources and factors. The total market growth is estimated by looking at internal and external sources and then we apply an assumption on our expected market share based on a combination of historical information and competitive positioning across regions. This determines our growth by plan and we allocate the growth between sales and lapses using historical lapse rate and sales trends.

The same methodology is used to project the proportion of enrollment that will elect the cost share reduction variants of the Silver plans. The table below shows Silver plan enrollment split by cost share subsidy level.

Table 13: Projected Member Months in Silver Cost Share Subsidized Plans

Silver Variant	Act Value	Member Months
138-150%	94%	21.5%
150-200%	87%	31.8%
200-250%	73%	11.5%
250%+	70%	35.2%
Total		**100.0%**

XVII. Terminated Products

The only non-grandfathered products to be terminated prior to January 1, 2016 are the non-grandfathered products that implemented in EPO regions. As previously stated, we have increased the breadth of the network to extend our PPO plans into these regions. Our members who were previously on EPO plans

will be migrated to PPO plans effective January 1, 2016. The plans associated with our EPO region will be terminated December 31, 2015:
70285CA126, 70285CA128, 70285CA130, 70285CA133, 70285CA134, and 70285CA136.

XVIII. Plan Type

All of the plans included in the URRT are PPO plans.

XIX. Warning Alerts

There are no warnings indicated in Worksheet 2.

XX. Actuarial Certifications

a. Certifying actuary: I, John Chong, Senior Manager, am an employee of Blue Shield of California, a Fellow of the Society of Actuaries, and a member of the American Academy of Actuaries.

b. Index rate:

1. In my opinion the projected index rate:
   - is in compliance with applicable State and Federal statutes, in particular it complies with 45 CFR 156.80(d)(1);
   - was developed in compliance with the applicable Actuarial Standards of Practice

2. In my opinion the plan level adjusted index rates:
   - were developed in compliance with the applicable Actuarial Standards of Practice
   - are reasonable in relation to the benefits to be provided
   - are neither excessive or unfairly discriminatory
   - were developed using only the permitted plan level adjustments

c. Plan Level Rates: In my opinion, the plan level rates used to develop the plan rates were generated using only the index rate and allowable adjustments as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2).

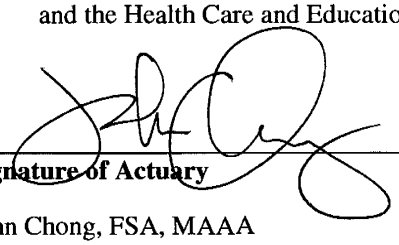
d. Percent of Total Premium for Essential Health Benefits: In my opinion, the percent of total premium that represents essential health benefits shown in Sections III and IV of the URRT were calculated in accordance with actuarial standards of practice.

e. AV Metal Values: I have relied on Covered California's determination of AV Metal value for their standardized plans. To my knowledge, the Federal AV calculator was used for this purpose and no alternate methodologies were used in the calculation of the AV Metal Values.

f. Qualification of opinion: The Part I Unified Rate Review Template does not demonstrate the process that was used to determine rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases. We have completed the template to the best of our ability and believe our responses to be accurate and in accordance with the instructions provided.

g. I, (John Chong, FSA, MAAA), certify that I am knowledgeable as to the California laws and regulations that apply to this filing and that, to the best of my knowledge and belief, this filing is in compliance with such laws and regulations and provides all required benefits.

h. I, (John Chong, FSA, MAAA), am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations concerning the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.



Signature of Actuary

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