

SERFF Tracking #:

CELT-131502642

State Tracking #:

ACA ON/OFF EXCHANGE

Company Tracking #:

AR PY 2019 RATE

State: Arkansas

Filing Company: Celtic Insurance Company

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: Ambetter from AR Health & Wellness

Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: SERFF
 Rate Change Type: Increase
 Overall Percentage of Last Rate Revision: 21.400%
 Effective Date of Last Rate Revision: 01/01/2018
 Filing Method of Last Filing: SERFF
 SERFF Tracking Number of Last Filing: CELT-131164164

Company Rate Information

| Company Name: | Company Rate Change: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | Number of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|--------------------------|----------------------|-----------------------------|------------------------|------------------------------------------|-----------------------------------------------------|-----------------------------------|---------------------------------|---------------------------------|
| Celtic Insurance Company | Increase | 4.600% | 4.600% | \$20,468,523 | 78,977 | \$446,459,498 | 38.000% | -1.700% |

State: Arkansas **Filing Company:** Celtic Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Ambetter from AR Health & Wellness
Project Name/Number: /

Rate Review Detail

COMPANY:

Company Name: Celtic Insurance Company
 HHS Issuer Id: 62141

PRODUCTS:

| Product Name | HIOS Product ID | HIOS Submission ID | Number of Covered Lives |
|----------------------------------|-----------------|---------------------------|-------------------------|
| Ambetter | 62141AR008 | 62141-1270944124815600646 | 83036 |
| Ambetter + Vision + Adult Dental | 62141AR010 | 62141-1270944124815600646 | 2337 |

Trend Factors: The overall annual trend is 4.5%. This trend comprises utilization and unit cost trends across all service categories, consistent with Worksheet 1 of the URRT (Part I). Section 5 of the actuarial memorandum (Part III) provides additional support.

FORMS:

New Policy Forms:
 Affected Forms:
 Other Affected Forms: 62141AR008, 62141AR010

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
 Member Months: 993,852
 Benefit Change: Increase
 Percent Change Requested: Min: -1.7 Max: 38.0 Avg: 4.6

PRIOR RATE:

Total Earned Premium: 586,202,805.00
 Total Incurred Claims: 425,776,183.00
 Annual \$: Min: 166.00 Max: 1,221.00 Avg: 433.00

REQUESTED RATE:

Projected Earned Premium: 440,667,965.00
 Projected Incurred Claims: 316,633,557.00
 Annual \$: Min: 194.00 Max: 1,375.00 Avg: 443.00

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AR PY 2019 RATE

State: Arkansas

Filing Company:

Celtic Insurance Company

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: Ambetter from AR Health & Wellness

Project Name/Number: /

Supporting Document Schedules

| | |
|--------------------------|-----------------------------------------------------------|
| Satisfied - Item: | Redacted Actuarial Memorandum for Public Disclosure |
| Comments: | |
| Attachment(s): | 2019_Celtic_AR_Actuarial_Memorandum_Redacted_20180731.pdf |
| Item Status: | |
| Status Date: | |

| | |
|--------------------------|-------------------------------------------------|
| Satisfied - Item: | Arkansas Plain Language Summary |
| Comments: | |
| Attachment(s): | AR-Specific Plain Language Summary_20180801.pdf |
| Item Status: | |
| Status Date: | |

Part III: Actuarial Memorandum
[Redacted]
Celtic Insurance Company
Annual Individual Health Rate Filing
Arkansas
Effective January 1, 2019
Forms: 62141AR008, 62141AR010

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1. General Information

Scope and Purpose:

This document contains the Part III Actuarial Memorandum for Celtic Insurance Company (Celtic)'s individual health block of business annual rate filing in the state of Arkansas, effective January 1, 2019. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT) and Part II Written Justification. This is a renewal rate filing.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rates. This information may not be appropriate for other purposes.

Consistent with the October 12, 2017 payment memo from the U.S. Department of Health and Human Services (HHS)¹, the premium rates developed and supported by this Actuarial Memorandum assume that cost-sharing reduction (CSR) subsidies will not be funded (for members above 100% of the federal poverty level). Subsidies will be funded for Arkansas Works members below 100% of the federal poverty level.

For Arkansas Works members on the 94% AV plan, Celtic has been guided by the state to assume that such members will be removed from the program, potentially entering the exchange where CSRs will not be funded. The premium rates developed here assume that migration. Future modifications to this intended migration -- or any other change to legislation, appropriations, regulation at the state or federal level, such as the current Section 1115 Waiver Expansion Program (Arkansas Works) or the Affordable Care Act (ACA), and/or court decisions regarding the funding of CSR payments -- may affect the extent to which the premium rates are neither excessive nor deficient.

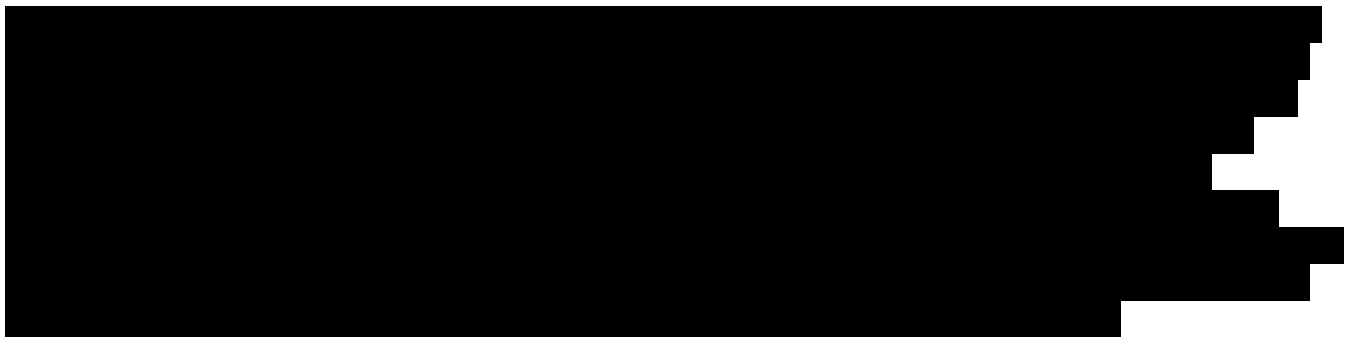
As instructed by Celtic, the premium rates developed and supported by this Actuarial Memorandum are based on legislative and regulatory provisions in effect at the time of submission, including the continued operation of the risk adjustment program as described in current regulations and guidance. Changes to the administration of the program that impact 2019 may affect the extent to which the premium rates are sufficient and neither excessive nor deficient. Furthermore, delays in resolving the impacts to 2018 and prior years, based on the recent suspension of the risk adjustment program for those years, may lead to emerging disruption in the market, which may also affect the extent to which the premium rates are sufficient and neither excessive nor deficient. Celtic reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed to ensure rates are appropriate. In addition to CSR payments and risk adjustment program

¹ <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>

payments/disruption, material rating impacts could arise from changes to various factors, including but not limited to:

- Advanced Premium Tax Credits
- Limit on age rating factors
- Open enrollment duration and grace period modifications
- Status and implementation of the Medicaid Expansion
- Enrollment of other populations (Medicare, Medicaid, high risk pool)
- Non-QHP coverage options (e.g. association health plans, short-term limited-duration insurance)
- Rules for Health Savings Accounts and Health Reimbursement Arrangements
- 1332 Waivers (e.g. state-based reinsurance programs)
- Taxes and fees
- Changes in the funding or enforcement of the current Sec. 1115 Waiver Expansion Program (Arkansas Works)
- Non-participation of other carriers in the Arkansas Works program

If there are material deviations in the state-wide average premium (SWAP) for 2019 – for example, based on changes in the number of carriers in the market or carriers’ pricing assumptions for 2019 - we would like to work with the Arkansas Insurance Department after the initial submission to update our estimated risk adjustment transfer. Market disruption, resulting from changes or carriers’ perceived changes in the risk adjustment program, could also necessitate working with the Department to update other critical pricing assumptions such as market morbidity and/or relative risk.



This information is intended for use by the Arkansas Insurance Department, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of Celtic’s individual rate filing. However, we recognize that this certification may become a public document. Milliman makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place

reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Milliman or its employees under any theory of law.

The results are actuarial projections. Actual results will vary from those projected in the filing for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Company Identifying Information:

- Company Legal Name: Celtic Insurance Company
- State: The State of Arkansas has regulatory authority over these policies.
- HIOS Issuer ID: 62141
- Market: Individual
- Effective Date: January 1, 2019

Company Contact Information:

- Primary Contact Name [REDACTED]
- Primary Contact Telephone Number [REDACTED]
- Primary Contact Email Address [REDACTED]

Description of Benefits:

These products are issued by Celtic as PPO health policies.

The major provisions of this form for each plan design and product can be found in Appendix 1.1.

Rate Guarantees:

Rates are guaranteed not to change through December 31, 2019.

Renewability:

Each policy is renewable by paying the applicable renewal premiums unless the policy holder no longer meets the eligibility requirements of the policy or the company decides not to renew all the policies in the state.

Applicability:

The rates will apply to new and renewing business.

General Marketing Method:

This product will be sold through agents, direct mailings, the internet, and the State Based Exchange.

Estimated Average Annual Premium:

The estimated average annual premium per policy in calendar year 2019 is [REDACTED]

Distribution of Business:

See Appendix 1.2 for the expected age and geographic distributions for these products.

Rate Tables:

See Appendix 1.3 for allowable rating factors. Appendix 1.4 also includes an example of how rating factors will be applied. For family coverage, rates for children are charged to no more than the three oldest covered children under age 21 consistent with the Patient Protection and Affordable Care Act (ACA).

2. Proposed Rate Increases

The rate increases for each product offered in the single risk pool by Celtic in the State of Arkansas are reflected in Worksheet 2, Section I of the Part I URRT.

Reasons for Rate Increase(s):

The rate projections for 2019 have been updated from the previous year's projections to reflect the most recent information available. The components of the premium increase are shown in Worksheet 2, Section II of the URRT.

The following provides a narrative description of the significant factors driving the proposed rate change for 2019:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. Experience Period Premium and Claims

The following information supports the best estimate of premium and claims for the single risk pool during the experience period, as reported in Worksheet 1, Section I of the URRT. The experience period for this rate filing is calendar year 2017.

Premiums (net of MLR Rebate) in Experience Period:

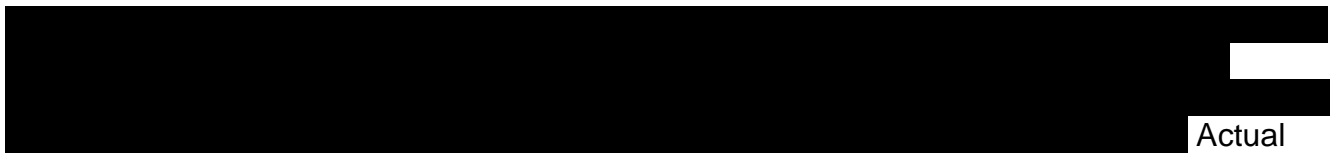
Earned premium in the experience period, both prior to and net of MLR rebates, as well as the estimated amount of MLR rebates refunded [REDACTED] are provided in Appendix 3.1.

A large rectangular area of the document is completely redacted with black ink, obscuring the data presented in Appendix 3.1.

Earned premium in the experience period is not adjusted for taxes, assessments, or risk adjustment receivables or payables.

Allowed and Incurred Claims Incurred During the Experience Period:

A breakout of the claims shown in Worksheet 1, Section I is provided in the appendices as Appendix 3.2.

A large rectangular area of the document is completely redacted with black ink, obscuring the data presented in Appendix 3.2. The word "Actual" is visible at the bottom right of the redacted area.

claims run-out may reflect some variability from expectations.

Incurred claims are defined as allowed claims less member cost-sharing and cost-sharing paid by the U.S. Department of Health and Human Services (HHS) on behalf of low-income members.



4. Benefit Categories



The algorithm used to assign the experience and manual data utilization and cost information is summarized as follows:

Inpatient Hospital

Inpatient hospital includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Outpatient hospital includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Professional includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services other than hospital based professionals whose payments are included in facility fees.

Other Medical

Other medical includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services. The measurement units for utilization used in this category are a mix of visits, cases, procedures, etc.

Capitation

Capitation includes all services provided under one or more capitated arrangements.

Prescription Drug

Prescription drug includes drugs dispensed by a pharmacy and is net of rebates.

5. Projection Factors

This section describes and supports the factors used to project the 2017 experience period allowed claims to the 2019 projection period as shown in Worksheet 1, Section II of the URRT.

Changes in the Morbidity of the Population Insured:

[REDACTED]

[REDACTED]

[REDACTED]

Changes in Benefits

[REDACTED]

Changes in Demographics (URRT Other Projection Factor):

[REDACTED]

[REDACTED]

Trend Factors (URRT Cost Trend and URRT Utilization Trend Projection Factors):

[REDACTED]

[Redacted]

[Redacted]

- [Redacted]

[Redacted]

[Redacted]

[Redacted]

- [Redacted]

Other Changes (URRT Other Projection Factor):

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]



6. Credibility Manual Rate Development

This filing is 100% experience rated. No credibility manual rate is being filed for 2019. This section describes the manual calculations used to supplement and support review of the experience projections described in the prior section.

Source and Appropriateness of Experience Data Used:

Manual Experience Basis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Manual Morbidity Basis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Adjustments Made to the Data:

The following adjustments were made to calibrate the pricing model to the expected population:

[REDACTED]

The adjustments, which are discussed above, are appropriate and necessary to reflect the anticipated population, region, provider network, and benefits anticipated for the 2019 single risk pool.

Inclusion of Capitation Payments:

[REDACTED]

7. Credibility of Experience

Description of the Credibility Methodology Used:

Credibility is calculated using the following formula:

| | |
|------------|------------|
| [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] |
| [REDACTED] | [REDACTED] |

[REDACTED]

[REDACTED]

Total 2017 Member Months: [REDACTED]

Credibility Level Assigned to Base Period Experience: [REDACTED]

Note that credibility is calculated based on 2017 experience data that is suitable for pricing and may not exactly match the total 2017 member months shown above.

Actuarial Standard of Practice #25 "Credibility Procedures" was considered when determining the credibility level.

8. Paid to Allowed Ratio

Paid to allowed ratios for each plan were calculated using the Milliman Managed Care Rating Model (MCRM), calibrated to the expected population as described in Section 6, "Credibility Manual Rate Development."

The Paid to Allowed Average Factor in the Projection Period for the market is shown on Worksheet 1, Section III of the URRT.



9. Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

The risk adjustment for the experience period is shown on Worksheet 2, Section III of the URRT. The final amount for risk adjustment was not known at the time of rate development. This amount was estimated using data available through 3/31/2018. The Federal Transitional Reinsurance Program ended with the 2016 benefit year.

Projected Risk Adjustments PMPM:

The Projected Risk Adjustment Transfer PMPM is shown on Worksheet 1, Section III.

The risk adjustment transfer calculations are based on the risk adjustment transfer formula, as provided in the Federal Register Volume 78 Number 47, and displayed below.

$$T_i = \left[\frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)} \right] \bar{P}_s$$

Where:

\bar{P}_s = state average premium;

$PLRS_i$ = plan i 's plan liability risk score;

AV_i = plan i 's metal level AV;

ARF_i = plan i 's allowable rating factor;

IDF_i = plan i 's induced demand factor;

GCF_i = plan i 's geographic cost factor;

s_i = plan i 's share of state enrollment as measured in member months;

and the denominator is summed across all plans in the risk pool in the market in the state.

We project the portfolio average for each factor in the risk adjustment transfer formula using a combination of (i) the state's actual historical risk adjustment factors adjusted to the projected

population and (ii) adjustments for market and risk adjustment program changes. The resulting aggregate payment or receivable is then proportionally allocated to all plans in the portfolio.

For the purpose of our modeling, each of these factors was approximated as follows.

\bar{P} : The state average premium was assumed to be [REDACTED]

PLRS: The statewide average risk score is [REDACTED]

[REDACTED]

HHS's proposed HCC model and coefficient changes for 2018 and 2019 (including prescription drug condition categories and model recalibration) were considered in the development of the projected risk adjustment transfer. The demographic, plan mix, and morbidity assumptions supporting the projected statewide and Celtic risk score projections are consistent with the demographic, plan mix, and morbidity assumptions used to project claims costs.

IDF: The statewide average IDF is projected based on the average IDF of the single risk pool in 2016, as reported by HHS.

The average IDF for Celtic is projected by applying the induced demand factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 11 to Celtic's projected population. The formula recognizes the following IDF factors by metallic tier: Bronze 1.00, Silver 1.03, Gold 1.08 and Platinum 1.15.

AV: The statewide average actuarial value (AV) is projected based on the average metal level AV of the single risk pool in 2016, as reported by HHS.

The average AV for Celtic is projected by applying the metal level AV factors from the market reform rule published in the March 11, 2013 Federal Register, page 15433, Table 9 to Celtic's projected population. The formula recognizes the following AV values by metallic tier: Bronze 0.60, Silver 0.70, Gold 0.80, and Platinum 0.90.

ARF: As stated in the March 11, 2013 Federal Register, page 15433, the allowable rating factor (ARF) adjustment accounts only for age rating.

The statewide average ARF is projected based on the average ARF of the single risk pool in 2016, as reported by HHS, adjusted for projected changes in the demographics of the single risk pool from 2016 to 2019.

The average ARF for Celtic is projected by applying the proposed 2019 HHS age rating factors to Celtic's projected population. An equal distribution across ages within each age band was assumed.

GCF: The average GCF for Celtic relative to the statewide average was modeled based on historical GCFs by rating area, any anticipated changes in these GCFs over time, and Celtic's projected enrollment by rating area.

Based on the 2019 Notice of Benefit and Payment Parameters (NBPP), we have also modeled a net risk adjustment transfer for 2019 attributable to the high cost risk pooling program. We modeled this as the combination of a receivable, based on the attachment point and coinsurance (as outlined in the 2019 NBPP), and an assessment, based as a percentage of premium.

Outliers were reflected in our calculations to the extent that outliers are reflected in historical risk scores used as the starting point of the 2019 risk transfer projection and via the calculation of the net High Risk Pool receivable or payment. Otherwise, there were no "potential outlier assumptions" that would have an impact on transfers.

The risk adjustment transfer amounts shown on Worksheet 1 of the URRT are the actual PMPM amounts expected in the projection period. The risk adjustment transfer amount applied to the Index Rate in the development of the Market Adjusted Index Rate is on an allowed claims basis, as the Index Rate is on an allowed claims basis.

The demographic, plan mix, and morbidity assumptions supporting the risk transfer projection are consistent with the demographic, plan mix, and morbidity assumptions used to project claims costs.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

The Federal Transitional Reinsurance Program ended with the 2016 benefit year. This field has been populated with "0" in the URRT for the 2019 plan year.

10. Non-Benefit Expenses and Profit & Risk

The non-benefit expense values can be found in Appendix 10.1.

Administrative Expense Load:



There is an additional amount to cover approved quality improvement expenses and provider incentive payments.

The administrative expenses are allocated proportionally by plan on a constant percentage of premium basis.

Profit (or Contribution to Surplus) & Risk Margin:

This load was applied proportionally to all products and plans and can be found in Appendix 10.1.

Taxes and Fees:

The taxes and fees which may be subtracted from premiums for purposes of calculating the MLR are listed in Appendix 10.1.

The Risk Adjustment User Fee is netted out of the risk adjustment transfer amount. This value is not included as part of Taxes and Fees on Worksheet 1, Section III of the URRT.

See Section 14, "Market Adjusted Index Rate", for discussion on how the Exchange user fee is calculated and applied to the Market Adjusted Index Rate.

11. Projected Loss Ratio

The projected medical loss ratio (MLR) as prescribed by 45 CFR 158 is [REDACTED]. The projected MLR reflects the projection year single risk pool experience, rather than the three-year combined period that is used for determining MLR rebates. There was no credibility adjustment applied to the projected MLR. Including a credibility adjustment would only increase the projected MLR, which already satisfies the MLR requirement. See Appendix 11.1 for the calculation for the projected federal medical loss ratio.

The traditional ratio of incurred claims to earned premium (without reference to MLR payments, risk adjustment, reinsurance, or risk corridor programs) is [REDACTED].

12. Single Risk Pool

The Index Rate is based on the single risk pool set by the State of Arkansas, which was established according to the requirements in 45 CFR Part 156.80. The single risk pool is defined as the non-grandfathered individual business in Arkansas, including the Arkansas Works membership.

Neither the single risk pool for the experience period nor the projection period include members who are eligible to remain enrolled in transitional plans.

13. Index Rate

The Index Rate for the Experience Period (calendar year 2017) is a measurement of the average allowed claims PMPM for EHB benefits. This value is located on Worksheet 1, Section I of the URRT. The Index Rate for the Experience Period reflects the actual mixture of smoker/non-smoker population, area factors, plan enrollment, and the actual mixture of risk morbidity in the single risk pool during the experience period. The Index Rate for the Experience Period has not been adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. We have adjusted the Index Rate for the Experience Period to remove any non-EHBs. The claim system does not currently distinguish between EHB and non-EHB claims, so this adjustment was made based on the expected percentage of non-EHB claims for the experience period. The experience period did not contain non-single risk pool claims, so no adjustment was made for this.

The Index Rate for the Projection Period (calendar year 2019) is reflected in Worksheet 1, Section III of the URRT. It was developed following the specifications of 45 CFR part 156.80(d)(1). The Index Rate for the Projection Period represents the estimated total combined projected allowed claims PMPM for Essential Health Benefits (EHB) for calendar year 2019 and has not been adjusted for payments and charges under the risk adjustment program or for Exchange user fees. The total allowed claims include benefits in excess of EHBs (coverage for adult vision and adult dental). Pediatric dental is not included in the benefit package since this will be offered through a stand-alone plan on the Exchange. [REDACTED]

[REDACTED] The Index Rate for the Projection Period will remain unchanged until a renewal filing effective January 1, 2020.

The development of the Index Rate for the Projection Period is shown in Worksheet 1, Section II. This reflects:

- The 12-month projection period shown in Worksheet 1, Section II
- The anticipated claim level of the projection period with respect to trend, benefits, and demographics
- The experience of all policies expected to be in the single risk pool (with necessary adjustments)

Appendix 13.1 demonstrates the calculation of the Projected Index Rate by blending the Experience Period Index Rate with the Credibility Manual Index Rate, as applicable. The next three sections further describe the steps taken to develop the Market Adjusted Index Rate and Plan Adjusted Index Rate.

14. Market Adjusted Index Rate

The Index Rate for the Projection Period is adjusted to arrive at the Market Adjusted Index Rate based on the following, as outlined in 45 CFR 156.80(d):

- Adjustment for the Risk Adjustment Program
- Exchange user fee adjustment

The risk adjustment estimation process is described in Section 9, “Risk Adjustment and Reinsurance”. Since the Index Rate is on an allowed claims basis, the market-level adjustments are done on an allowed basis.

[REDACTED]

[REDACTED]

[REDACTED]

Appendix 14.1 shows the development of the Market Adjusted Index Rate.

15. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is included in Worksheet 2, Section IV of the URRT. The Plan Adjusted Index Rate is the Market Adjusted Index Rate adjusted for only the following allowable adjustments, where applicable, as outlined in 45 CFR 156.80(d):

- The actuarial value and cost-sharing design of the plan

[REDACTED]

[REDACTED]

[REDACTED]

- The plan's provider network, delivery system characteristics, and utilization management adjustment practices.

[REDACTED]

- Benefits provided under the plan that are in addition to the EHBs.

[REDACTED]

- Administrative costs, excluding the Exchange user fees (which are already accounted for in the Market Adjusted Index Rate).

[REDACTED]

There are no catastrophic plans being offered, so there is no eligibility adjustment made for catastrophic plan enrollment.

Administrative costs and other benefits (non-EHB) common to all plans are added to the Market Adjusted Index Rate. Then, factors for actuarial value and cost-sharing and non-EHBs by plan are applied to reach the Plan Adjusted Index Rate for each plan.

The development and values of the Plan Adjusted Index Rates are shown in Appendix 15.1.

The Plan Adjusted Index Rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

On Worksheet 2, Section III, the Plan Adjusted Index Rate of the Experience Period is reported.

16. Calibration

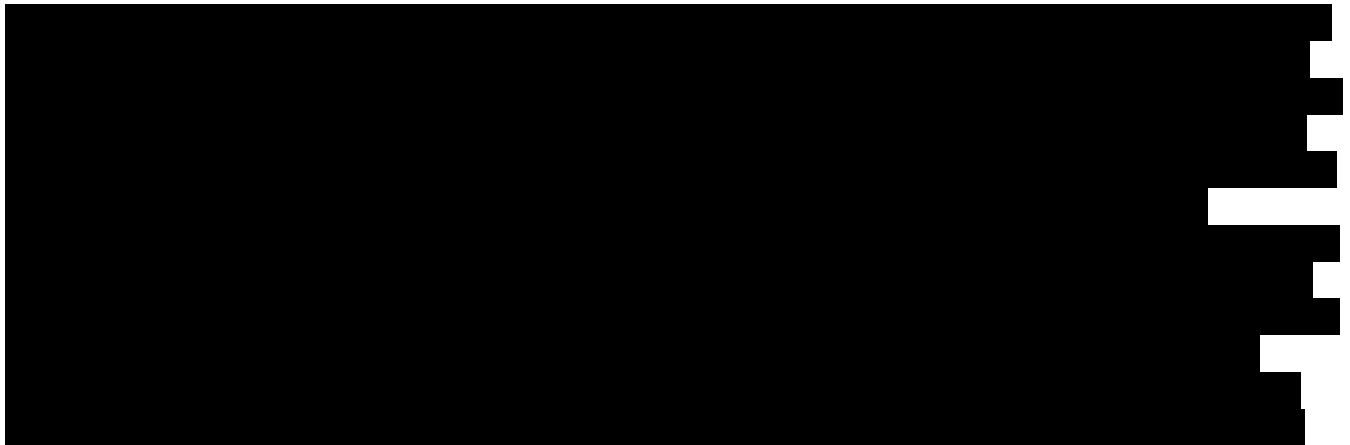
The Plan Adjusted Index Rate is calibrated for plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0. The intent of the calibration factors is to reset the Plan Adjusted Index Rate so that applying the age factor, geographic rating area factor, and tobacco use factor will result in the appropriate consumer adjusted premium rate. The calibration factors for each of the age, geographic, and tobacco use factors are shown in Appendix 16.1. Note that each of the calibration factors has one value that is applied uniformly and does not vary by plan.

Age Curve Calibration:



Appendix 16.1 of the Actuarial Memorandum demonstrates the calibration of the Plan Adjusted Index Rate for age. The distribution of members by age is in Appendix 1.2 and the age factors are in Appendix 1.3.

Geographic Factor Calibration:



[REDACTED]

Tobacco Use Rating Factor Calibration:

[REDACTED]

Calibration adjustments are applied uniformly to all plans

The calibration adjustment does not vary by plan and is evident in Appendix 16.1. The member-level adjustments as described in 45 CFR 147.102 are applied uniformly to all plans in the single risk pool, and these adjustments do not vary by plan.

[REDACTED]

The distribution of members by rating area is in Appendix 1.2. Appendix 1.4 lists the steps to calculate final premium rates and shows the calculation for an example policy with family coverage.

17. Consumer Adjusted Premium Rate Development

Each Plan Adjusted Index Rate is divided by the overall calibration factor to determine the Calibrated Plan Adjusted Index Rate.

The following allowable rating factors, as specified by 45 CFR Part 147.102, are applied to the Calibrated Plan Adjusted Index Rate to determine the rate that is charged to the health insurance purchaser:

- Age
 - The prescribed standard age factors were used.
- Rating Area
 - The area factors are listed in Appendix 1.3. The methodology for developing geographic factors is included in Section 16, “Calibration”.
- Tobacco status



- For family coverage, rates for children are charged to no more than the three oldest covered children under age 21

Appendix 1.3 lists the allowable rating factors and Appendix 1.4 has an example calculation of a family's rates.

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the Part I URRT were calculated using the final 2019 Federal AV Calculator released on December 28, 2017. Please refer to Appendix 18.1 for screenshots documenting the outcomes of the AV Calculator for each plan.

19. AV Pricing Values

For each plan, we have indicated the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the Index Rate as described in 45 CFR Part 156, §156.80(d)(2). See Appendix 19.1 for this development.

Each plan's AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. The AV Pricing Values reflect the relative impact of the following items:

- The plan's provider network, delivery system characteristics, and utilization management
- The actuarial value and cost-sharing design of the plan, including full plan liability for CSR subsidies for members above 100% of the federal poverty level and full funding for Arkansas Works members below 100% of the federal poverty level. CSR costs are reflected as a uniform percentage load applied to each silver ACA-compliant plan (both those sold through the Exchange and those sold outside of the Exchange).
- The additional expected cost of non-essential health benefits provided under each plan
- Administrative costs, excluding Exchange user fees

Plan benefit relativities were developed using the Milliman Managed Care Rating Model (MCRM), calibrated to the expected population as described in Section 6, "Credibility Manual Rate Development." Demographic and risk characteristics were held constant for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan.

20. Membership Projections

[REDACTED]

[REDACTED]

[REDACTED]

21. Terminated Plans and Products

A list of the plans being terminated and the plans to which these are being mapped is included in the appendices as Appendix 21.1.

22. Plan Type



23. Warning Alerts



24. Effective Rate Review Information

See Appendix 24.1 for documents summarizing the capital and surplus position of Celtic.

25. Reliance

In the preparation of this filing, I relied upon data provided under the direction [REDACTED] [REDACTED] I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population, and other such factors.

See Appendix 25.1 for a listing of items received for the rate development.

26. Actuarial Certification

I, [REDACTED], am a member of the American Academy of Actuaries in good standing and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work. This filing is prepared on behalf of Celtic Insurance Company (the "Company") to comply with applicable State and Federal Statutes for individual rate filings.

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary of, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I certify the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis was placed on the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

I certify that to the best of my knowledge and judgment:

1. The Index Rate for the Projection Period is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102)
 - b. Developed in compliance with the applicable Actuarial Standards of Practice
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered

- d. Neither excessive nor deficient based on my best estimates of the 2019 individual market.
2. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
3. The percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice. The EHB portion of premium is appropriate as the basis of determining APTCs.
4. The geographic rating factors used reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.
5. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.


The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The 2019 plan year premium rates in this actuarial memorandum are contingent upon the status of the ACA statutes and regulations including any regulatory guidance, court decisions, or otherwise. Changes have the potential to greatly impact the 2019 plan year premium rates provided in this Actuarial Memorandum and the alignment of these premium rates with incurred costs. Changes include, but are not limited to, any legislative or regulatory amendment, court decision, 1332 waivers bringing reinsurance or other such programs to a state; or a decision by Congress, the Health and Human Services Secretary, or the Centers for Medicare and Medicaid Services director to fund cost-sharing reduction subsidies, alter advance premium tax credits, or further modify the individual mandate requirement and penalty. In the event that a material provision is impacted, a revision to the rates will be needed. In particular, rates were developed assuming steady funding of Advanced Premium Tax Credits (APTCs) and no funding of cost-sharing reduction (CSR) subsidy payments for members above 100% of the federal poverty level and full funding for Arkansas Works members below 100% of the federal poverty level. The continuity of this funding approach will impact whether rates are sufficient and not excessive. Milliman expresses no opinion with regard to the future funding of CSR payments.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Signed:

Name: 

Title: Principal & Consulting Actuary

Date: July 31, 2018

Appendices 1.1 – 25.1 have been redacted.

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company Celtic Insurance Company
 SERFF tracking number CELT-131502642
 Submission Date 8/1/2018
 Product Name Base Product, Base Product + Vision + Adult Dental
 Market Type Individual Small Group
 Rate Filing Type Rate Increase New Filing

Scope and Range of the Increase:

The 7.0 % increase is requested because:

of the following significant factors driving the proposed rate increase: Single risk pool experience, unit cost trend, utilization trend, prospective changes to benefits covered by the product or successor products, new taxes and fees imposed on the issuer, anticipated changes in the average morbidity of the risk pool, including elimination of the ACA Individual Mandate. Please see details on item 2 of the Actuarial Memorandum.

This filing will impact:

of Arkansas policyholder's 78977 # of Arkansas covered lives 85373

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 4.6 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved -1.7 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 38.0 %

Individuals within the group may vary from the aggregate of the above increase components as a result of:

Age, Rating Area, Plan Selection

Financial Experience of Product

The overall financial experience of the product includes:

The experience includes claims experience incurred in 2017 and paid through March 31, 2018.

The rate increase will affect the projected financial experience of the product by:

Prior to the requested 4.6% rate increase for 2019, the projected MLR is 89.5%. The rate increase reduces the projected MLR to 85.3%.

Components of Increase

The request is made up of the following components:

Trend Increases – 64 % of the 4.6 % total filed increase

1. Medical Utilization Changes – Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 45 % of the 4.6 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 19 % of the 4.6 % total filed increase.

Other Increases – 36 % of the 4.6 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is 0 % of the 4.6 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is 0 % of the 4.6 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 0 % of the 4.6 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is 0 % of the 4.6 % total filed increase.

5. Other – Defined as:

Morbidity & Risk Adjustment changes, Rx trend, increase in CSR cost

Note that due to HIF moratorium, administration cost does not contribute to increase.

This component is 36 % of the 4.6 % total filed increase.