CareFirst BlueCross BlueShield
Part III Actuarial Memorandum

4.1 Redacted Actuarial Memorandum

CareFirst is making some redactions in the redacted Actuarial Memorandum.

4.2 General Information Section

Company Identifying Information:

- **Company Legal Name**: CareFirst BlueChoice, Inc. (CFBC) - NAIC # 96202
- **State**: Virginia
- **HIOS Issuer ID**: 10207
- **Market**: Individual, Non-Medigap (On & Off Exchange)
- **Effective Date**: 1/1/26 – 12/31/26
- **Company Filing Number**: [redacted]
- **SERFF Filing Number**: [redacted]

Company Contact Information:

- **Primary Contact Name**: [redacted]
- **Primary Contact Telephone Number**: [redacted]
- **Primary Contact E-Mail Address**: [redacted]

4.3 Proposed Rate Changes

Base rates are changing [redacted] on average. The range is [redacted] to [redacted]. This filing applies to all new and renewing, in-force business in the guaranteed renewable, non-grandfathered, ACA, metaled benefit plans. The approximate number of policyholders (contracts) affected by this rate change is [redacted].

Reason for Rate Change(s):

[redacted]

[redacted]

[redacted]

[redacted]

4.4 Market Experience

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

4.4.1 Experience and Current Period Premium, Claims, and Enrollment

The incurred period is 1/1/24 through 12/31/24, as required.

Paid Through Date: 2/28/25
Current Date: 2/28/25

Premiums (prior to MLR rebates) in Experience Period: [redacted]
Experience Period Member Months: [redacted]
Current Date Members: [redacted]

Allowed and Incurred Claims Incurred During the Experience Period

Allowed Claims
- **Processed through issuer's claim system:** [redacted]
- **Processed outside issuer's claim system:** [redacted]
- **IBNR:** [redacted]

Incurred Claims
- **Processed through issuer's claim system:** [redacted]
- **Processed outside issuer's claim system:** [redacted]
- **IBNR:** [redacted]

Method used for determining Allowed Claims

The allowed claims come directly from our claim records and account for capitations by applying contracted PMPM amounts directly to enrollment from the experience period. Drug rebates from the experience period are also included.

Support for IBNR estimates

Our estimates of IBNR paid claims were derived using a "chain and ladder" model based on the most recent 36 months to derive the completion factor and IBNR for each incurred month. Estimates of IBNR allowed claims were derived using the same completion factors as those estimated based on paid claims.

4.4.2 Benefit Categories

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

4.4.3 Projection Factors

4.4.3.1 Trend Factors

Trend Factors (Cost/Utilization):

Exhibit 8 in the Memorandum contains our selected annual utilization and unit cost trends by service category. Unit cost and utilization trends were set by service category to produce the overall anticipated trend of [redacted]

[redacted].

Using the proposed trend factor, in combination with other assumptions such as morbidity, etc., the annualized allowed PMPM change between 2026 and 2024 represented in this filing is [redacted].

4.4.3.2 Adjustments to Trended EHB Allowed Claims PMPM

Morbidity Adjustment:

The morbidity adjustment is summarized in Exhibit 4. A detailed discussion of the development of this factor is included below.

From page 17 of the URRT instructions, the morbidity adjustment is intended to reflect the change in the average allowed claims PMPM from the experience period to the projection period that will occur under the circumstances where all demographic and product mix, and all provider network contracts and time parameters are held constant. In short, it is the expected change in the relative sickness of the population.

CareFirst projects the expected change in morbidity in three steps, described below. Per the instructions, the factor that is produced is the change over 24 months and is applied in Exhibit 1 to the projected allowed claims as a market level adjustment.

The three steps mentioned above are 1) projection of member cohorts from the experience period to the projection period, 2) the change in morbidity from the base period (2024) to the current year (2025), and 3) the expected change in morbidity from the current year to the projection period (2026). Each of these steps is discussed next.

Projection of member cohorts:

For the purposes of projecting morbidity changes, CareFirst considers three cohorts of members: existing, new and transfers. Existing members are those members who remain in the same segment and entity from the base period to the current year. New members are those members who are new to CareFirst ACA in either the current year or the projection period. Transfer members are those members who move from the base period to the current year or from the current year to the projection period from either 1) the CareFirst individual ACA segment but a different jurisdiction/entity or 2) a different CareFirst ACA segment.

Each of the three cohorts described above is projected from the base period to the projection period based on historical patterns as well as expected levels based on projected rate changes. Below are four graphs depicting the total projected membership as well as each cohort for the historical periods of 2023 and 2024 as well as the current year of 2025 and the projection period of 2026. For 2025, actual member distributions by cohort are used through March 2025. Then a termination rate gets applied to the existing cohort and growth rates get applied separately to new and transfer cohorts for each month for the remainder of 2025. For 2026, one termination rate gets applied to the existing cohort from December 2025 to January 2026 and other termination rates get applied for each month for the remainder of 2026. For the new and transfer cohorts separately, a growth rate gets applied from December 2025 to January 2026 and other growth rates gets applied for each month for the remainder of 2026.

As can be seen in the graphs, existing members moving from one period to the next reflect the changes that occur during open enrollment and then decrease throughout the remainder of the year through attrition. Similarly, for new members, open enrollment is reflected early in the year and then net growth throughout the year results from SEPs. Transfers have some net growth throughout the year.

[Graph Redacted]

[Graph Redacted]

[Graph Redacted]

[Graph Redacted]

Morbidity Change - base period to current year:

Morbidity changes from the base period through the current period are calculated as described below and follow a similar process as in last year's filing. February 2025 membership is split between the three member cohorts and base period allowed claims normalized for age, induced demand and network (as required by URRT instructions – page 17) are calculated for each existing and transfer member as well as for the base period.

These normalized allowed claims are used as relative morbidity, when compared to the base period, for each existing and transfer member. As shown in Exhibit 4, [redacted].

[Table Redacted]

For new members, we set the claims PMPM by metal equal to that of the existing members, but then an assumption is made to project the expected relative morbidity of new members in the current year to that of the 2024 base period. For this filing, we are applying a morbidity adjustment of [redacted]. The relative morbidity of new members is one of the suggested adjustments listed in the URRT instructions on page 17. Of course, we will not know the actual relative morbidity of new members until we have complete and credible data based on total 2025 experience. As such, this is a critical assumption that could have a material impact on the results if the actual morbidity varies from the assumption.

[Table Redacted]

The relative morbidity between the base and current years described above for each of the three member cohorts is then combined with the projected membership for the remainder of 2025 also described above to calculate the total relative morbidity change from 2024 to 2025 of [redacted].

Morbidity Change – current year to projection period:

For existing members, [redacted]. For new business, [redacted]. For transfer members, [redacted].

The overall impact to the relative morbidity change from the current year to the projection period given the assumptions described above is [redacted].

Using everything described above, the total morbidity change from 2024 to 2026 is expected to be [redacted], which is the factor used in Exhibit 1 in the calculation of the market adjustment index rate.

As described in the section on risk adjustment, all assumptions made regarding expected morbidity are used consistently in the development of the risk adjustment factor.

Demographic Shift:

Exhibit 6 in the Memorandum contains support for our adjustment due to the anticipated change in the average age of this population between the experience and projection periods. Our methodology measures the change in average demographic factor between the base and rating periods. The demographic factors used are from an internal age/gender curve with an approximate 4.5:1 ratio (age 64+ to age 21 factors). Factors for both time periods are weighted using member months and the ratio of the two is applied as our market level adjustment.

Plan Design Changes:

Exhibit 5 in the Memorandum details our support for this adjustment to account for anticipated changes in the average utilization of services due to differences in average cost sharing requirements between the experience and projection periods. Our methodology measures the change in the average induced utilization factor between the base and rating periods. The factors used are the metal level factors from the

federal risk adjustment program. Once the average internal pricing AV, weighted by member months, is determined for both the experience and rating periods the linearly interpolated factor is determined. The ratio of these two factors is applied as our market level adjustment.

The benefits for the renewing plans in this product have remained the same, except for changes necessary to maintain actuarial value.

For 2026, BlueChoice will offer 1 Standard Bronze plan and 1 non-Standard Bronze plan, both on and off the exchange.

Other Adjustments:

Exhibit 7 in the Memorandum details our support for these adjustments. We are proposing additional other adjustments for changes to our capitation fees and drug rebates.

4.4.3.3 Manual Rate Adjustments

Not applicable, as experience was determined to be fully credible.

4.4.3.4 Credibility of Experience

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

4.4.3.5 Establishing the Index Rate

The experience period index rate for this filing is [redacted] and the projection period index rate is [redacted]. Both rates and the adjustments made to develop the projected amount from the experience period amount can be found in Exhibit 1 of the Memorandum. Specifically, these adjustments correspond to those outlined in sections 4.4.3.1 and 4.4.3.2.

4.4.3.6 Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate is [redacted] and is derived by multiplying the projection period index rate with the market level adjustments for the risk adjustment program, Virginia reinsurance program, and exchange user fee. Details for the Virginia reinsurance program and risk adjustment program can be found below.

Commonwealth Health Reinsurance Program (CHRP):

In 2024, BlueChoice received an estimated reinsurance PMPM of [redacted].

We have estimated a 2026 reinsurance PMPM for BlueChoice of [redacted] on a paid basis using the following parameters:

1) Attachment Point: $45,000
2) Coinsurance Rate: 65%
3) Reinsurance Cap: $170,000
4) Dampening Factor: 1.000
5) Reinsurance % of Paid Claims: [redacted]

[redacted].

More details of the reinsurance factor calculation can be found in Appendix - Reinsurance Factor Development in the Memorandum.

Risk Adjustment Payment/Charge:

The Experience Period Risk Adjustment transfers in the URRT are based on the 2024 CMS actual results.

Our projected 2026 risk adjustment transfers, found in Exhibit 9, have been calculated consistent with our membership and morbidity projections found elsewhere in this filing. To project the risk adjustment factors from 2024 to 2026, [redacted].

Exchange User Fees:

The assumed exchange user fee is 2.50% of on exchange premium since the rates in this filing are offered through the Virginia Health Benefit Exchange.

4.4.4 Plan Adjusted Index Rate

Exhibit 11 in the Memorandum displays the adjustments made for each plan. Every plan adjusted index rate is developed from the market adjusted index rate using only the allowable plan level modifiers as follows:

- **Actuarial value and cost-sharing design of the plan**: The actuarial value for each plan was determined using our own internal model and estimates the ratio of paid to allowed dollars given that plan's benefit design and the assumed allowed amount consistent with the projection period index rate. The assumed actuarial values also include a multiplicative factor applied uniformly across plans. The application of the AV to an index rate that is the same across all plans results in a member months weighted average AV (and resulting average paid PMPM assumed in rates) that may be materially deficient depending on the distribution of projected membership and actual cost. This factor accounts for the deficiency specific to this block of business. The URRT instructions state that this adjustment may take into account the benefit differences and utilization differences due to differences in cost-sharing. As a result, our plan adjusted index rates also include adjustments to account for the impact the metal level has on utilization.

  Note that since the federal government will not be paying cost sharing reduction (CSR) payments, we have developed a CSR load of [redacted], which is the factor applied to the on-exchange silver plan's internal Pricing AV in Exhibit 11. The development of this CSR loading factor can be found in Appendix - CSR Loading in the Memorandum.

- **Provider network**: There are 2 types of network factors: Lock In/Referral and Open Access.

- **Benefits in addition to EHBs**: There is an adjustment to account for abortion coverage, morbid obesity, acupuncture, adult vision, and gender affirming care (which are offered in addition to EHBs). See Exhibit 3 in the Memorandum for the assumed costs of all non-EHBs. No additional cost is included in the rate development for the following new 2025 EHBs: oral enteral nutrition and coverage of expanded prosthetic devices. Hearing aids for minors is a defrayed non-EHB so the cost for this coverage (approximately $0.10 PMPM) is not included in the rate development. Intravenous immunoglobulin therapy (IVIG) for prophylaxis, diagnosis, and treatment of PANDAS and PANS is a defrayed non-EHB beginning 1/1/26 so the cost for this coverage (approximately $0.00 PMPM) is not included in the rate development.

- **Administrative costs**: See Exhibit 10A in the Memorandum for the assumed values of the following additional items.

  1. Administrative Expense (G&A)
  2. Broker Commissions & Fees
  3. Federal Income Tax (FIT)
  4. Contribution to Reserve (Post-Tax)
  5. State Premium Tax
  6. PCORI Fee
  7. Risk Adjustment User Fee
  8. Exchange User Fee

  Please note we have included the Care Coordination PMPM of $0.08 into our G&A for the mandated VA Emergency Department Care Coordination Effort.

- **Catastrophic adjustment**: The catastrophic factor has been developed from the experience of the catastrophic population and is applied only to the catastrophic plan as required. See the Appendix in the Memorandum for more details. All other factors applied to the Market Adjusted Index Rate are the same across all plans.

For each plan, we have taken the applicable adjustment factor from each category above and multiplied them by the market adjusted index rate to derive each plan adjusted index rate.

4.4.5 Calibration

Age Curve Calibration

We have calibrated to the rounded weighted average age which was determined as the age for the factor nearest our projected average factor. We have used the standard CMS age curve factors and weighted them using member months in our calculation.

A demonstration of how the plan adjusted index rates and the age curve are used to generate the schedule of premium rates for each plan can be found in Exhibit 13.

Geographic Factor Calibration

We have elected not to rate for geographic region.

Tobacco Use Rating Factor Calibration

We have elected not to rate for tobacco usage.

4.4.6 Consumer Adjusted Premium Rate Development

The premium rate that a given consumer will be charged is calculated by first taking the plan adjusted index rate for that member's chosen plan and dividing by the projected average age rating factor. The resulting value is the base rate for that plan. The final step in determining a consumer adjusted premium rate is to take the rate from the first step and multiply it by the corresponding factor for that member's age from the standard CMS age curve. Rate charts are provided for all the consumer adjusted premiums.

4.5 Projected Loss Ratio

The projected loss ratio for the rates provided in this file, using the Federally-prescribed MLR methodology, is [redacted] and the details behind this calculation can be found in Exhibit 10B.

4.6 Plan Product Information

4.6.1 AV Metal Values

Several of our 2026 plans include varying cost share levels for some services that depend on the setting in which care is delivered. The HHS AV calculator was used to compute two separate AVs for each impacted plan – one which applied the higher level of cost-share, and one which applied the lower level of cost-share. The results were blended assuming [redacted] of the designated services are rendered in higher cost-share setting and the remaining [redacted] at the lower, consistent with experience from our small group and individual markets. Plans without these features used the AV calculator without modification.

Additional details regarding the unique plan designs not accommodated by the HHS AV Calculator along with printouts for each plan are provided in the "Actuarial Memorandum and Certifications" section of the Supporting Documentation tab of the SERFF filing.

4.6.2 Membership Projections

The membership projections found in Worksheet 2 of the URRT were developed from enrollment as of 2/28/25 using assumptions for termination rates, new sales and transfers. The projections also incorporate any plan mappings anticipated between that month and the rating period.

4.6.3 Terminated Plans and Products

Plan mappings from the experience period to the rating period can be found in Appendix – Mapping.

4.6.4 Plan Type

Each plan in Worksheet 2, Section I of the URRT contains a plan type that describes the plan exactly.

4.7 Miscellaneous Instructions

4.7.1 Effective Rate Review Information (Optional)

We have no additional exhibits.

4.7.2 Reliance

We do not have any reliance to state.

4.7.3 Actuarial Certification

Included in the Memorandum.