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**: Group Hospitalization and Medical Services, Inc. (GHMSI) - NAIC # 53007
- **State**: Virginia
- **HIOS Issuer ID**: 40308
- **Market**: Individual, Non-Medigap (On & Off Exchange)
- **Effective Date**: 1/1/26 – 12/31/26
- **Company Filing Number**: 2832
- **SERFF Filing Number**: CFAP-134522715

Company Contact Information:

- **Primary Contact Name**: Mr. Cory Bream, ASA, MAAA
- **Primary Contact Telephone Number**: 410-998-5308
- **Primary Contact E-Mail Address**: Cory.Bream@CareFirst.com

4.3 Proposed Rate Changes

Base rates are changing 1.1% on average. The range is -6.0% to 1.6%. 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 978.

Reason for Rate Change(s):

The main drivers supporting the rate change are 1) decrease in the base period claims experience, 2) trend, 3) higher projected reinsurance factor, and 4) expiration of the enhanced premium tax credit subsidies at the end of 2025. For a more complete discussion of our morbidity projection, refer to 4.4.3.2, subsection 'Morbidity Adjustment' below.

Enhanced Premium Tax Credit Subsidy Expiration Impact

This filing submission includes adjustments to membership, morbidity, and risk adjustment due to the anticipated expiration of federal enhanced premium tax credit subsidies on 12/31/2025. To estimate this impact, the cohort of possible leavers was limited to On-Exchange membership that was active as of March 2025 for consistency with baseline morbidity modeling. Additive probabilities were assigned based on attributes such as member effective date, members with no HCCs, FPL level, percentage of premium subsidized, PLRS level, etc. Cumulative probabilities were then calculated by member. This approach resulted in an assumed membership loss of approximately 15 with a morbidity impact of 0.8% in the rating period.

To estimate the impact on risk adjustment, the results of the above analysis were first compiled by FPL level and the impact on PLRS was estimated. The PLRS impact at each FPL level was applied to publicly available competitor data to estimate the average PLRS impact on the remainder of the market. Finally, an assumption was made that 26.5% of the On-Exchange market will lapse. This assumption was validated using publicly available data, articles, etc. The results of this analysis were compiled to calculate a revised market share and PLRS ratio to the market compared to the subsidies continue scenario. The filed rate change for the subsidies continue scenario was 4.6%.

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: $17,172,596
Experience Period Member Months: 16,700
Current Date Members: 1,389

Allowed and Incurred Claims Incurred During the Experience Period

Allowed Claims
- **Processed through issuer's claim system:** $43,034,094
- **Processed outside issuer's claim system:** $0
- **IBNR:** $1,216,704

Incurred Claims
- **Processed through issuer's claim system:** $39,787,167
- **Processed outside issuer's claim system:** $0
- **IBNR:** $1,125,693

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 5.75%, which is a decrease compared to the 7.5% trend assumed in our prior filing. Current observed medical trends as of 202412 are -18.3%, down from -12.6% in 202312. Current observed drug trends are 2.6% as of 202412, up from -3.2% in 202312. The composite medical and drug trend is -13.7**%**

as of 202412, down from -10.7% in 202312. When normalized for induced demand, network, and demographics, the composite observed trends of -10.7% in 202312 and -13.7% in 202412 become -7.9% and -12.8%, respectively.

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 7.9%, after adjusting for credibility.

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.

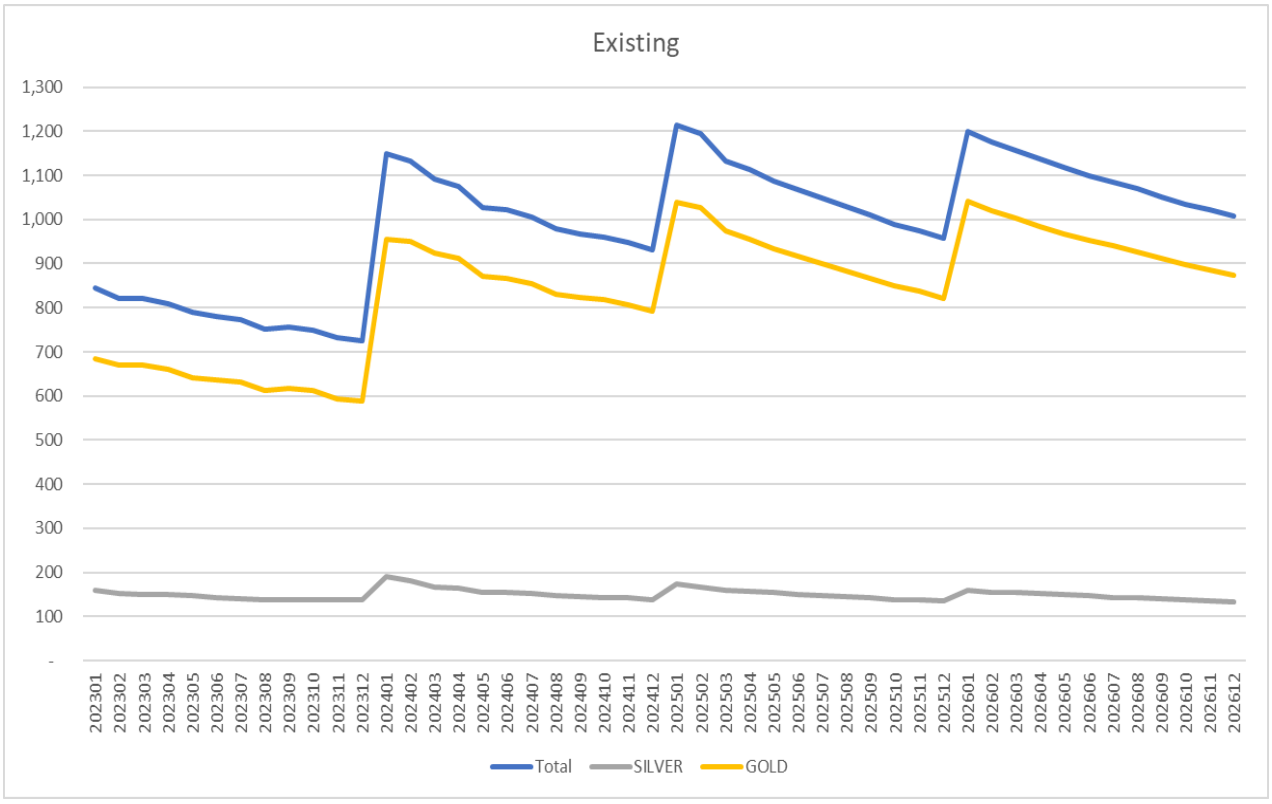
The three steps mentioned above are 1) projection of member cohorts from the experience period to the projection period, 2) the change in morbidity from the base period (2024) to the current year (2025), and 3) the expected change in morbidity from the current year to the projection period (2026). Each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

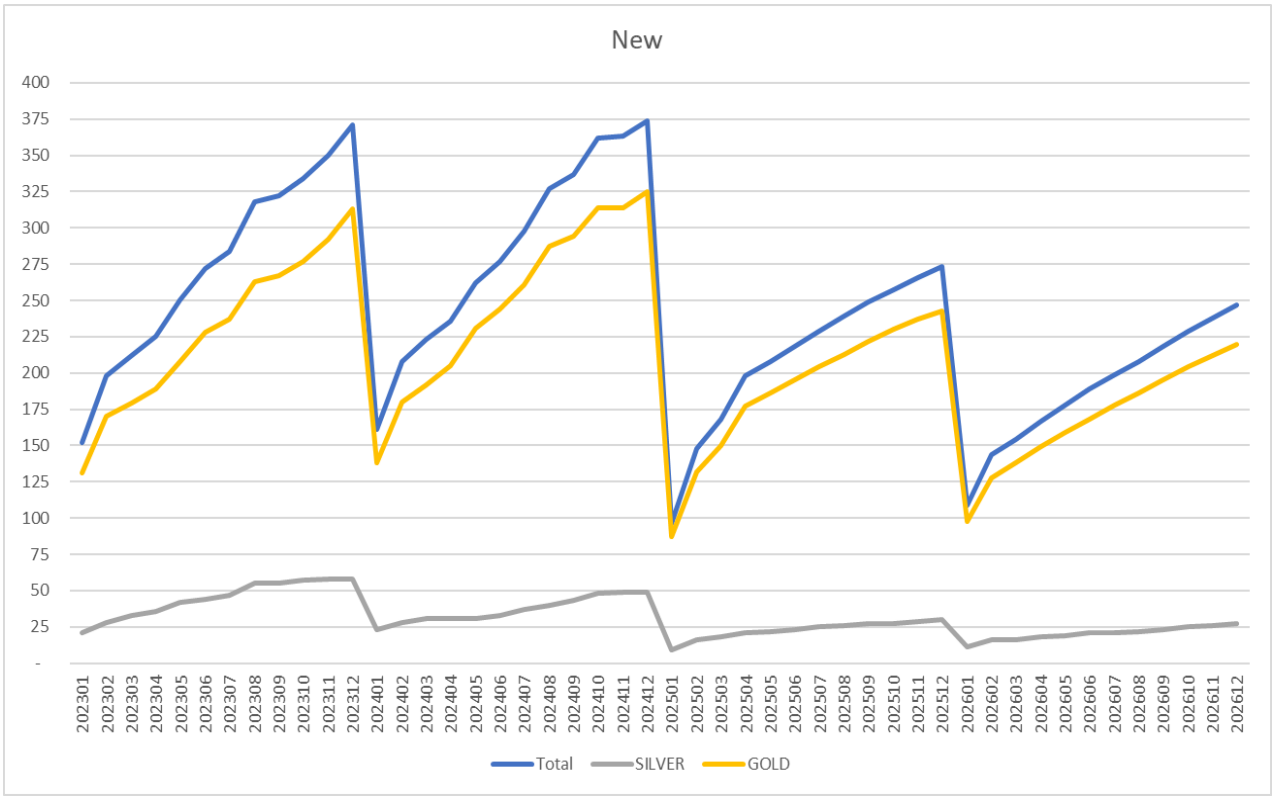
Projection of member cohorts:

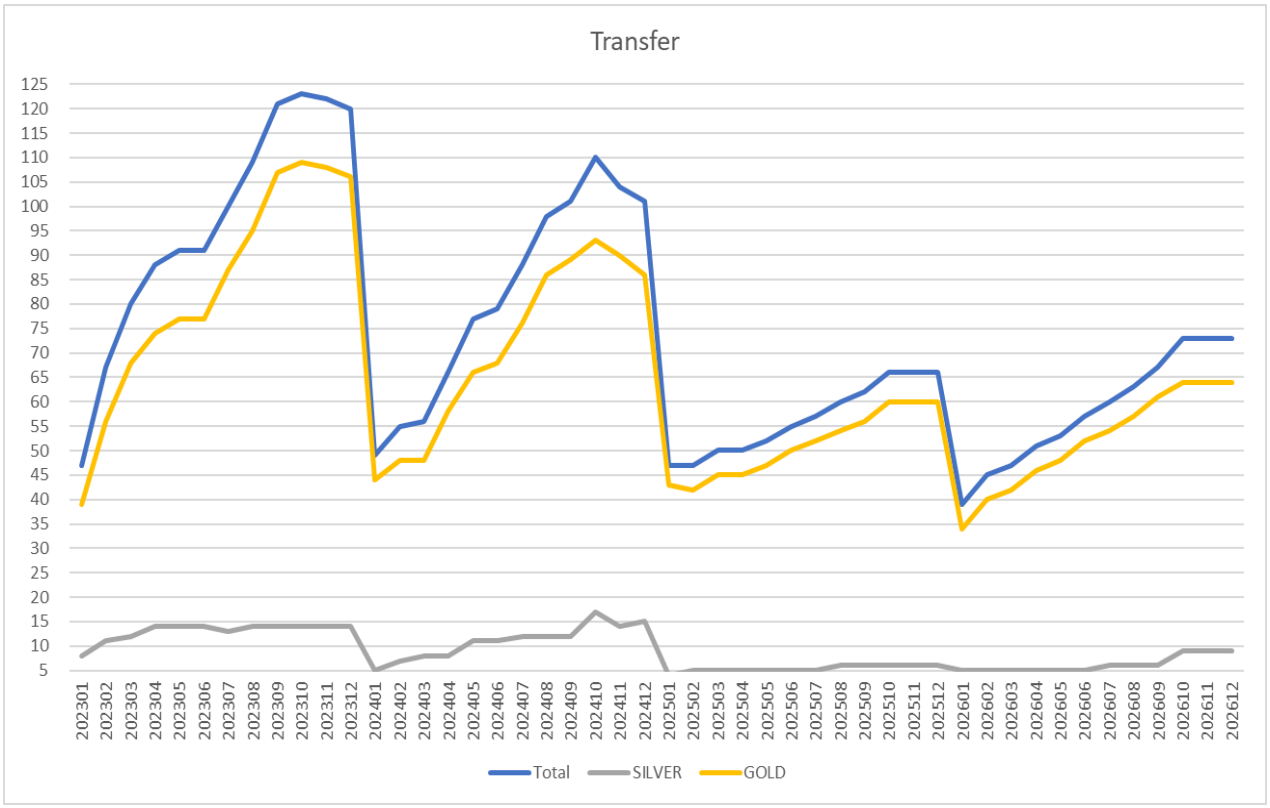
For the purposes of projecting morbidity changes, CareFirst considers three cohorts of members: existing, new and transfers. Existing members are those members who remain in the same segment and entity from the base period to the current year. New members are those members who are new to CareFirst ACA 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.

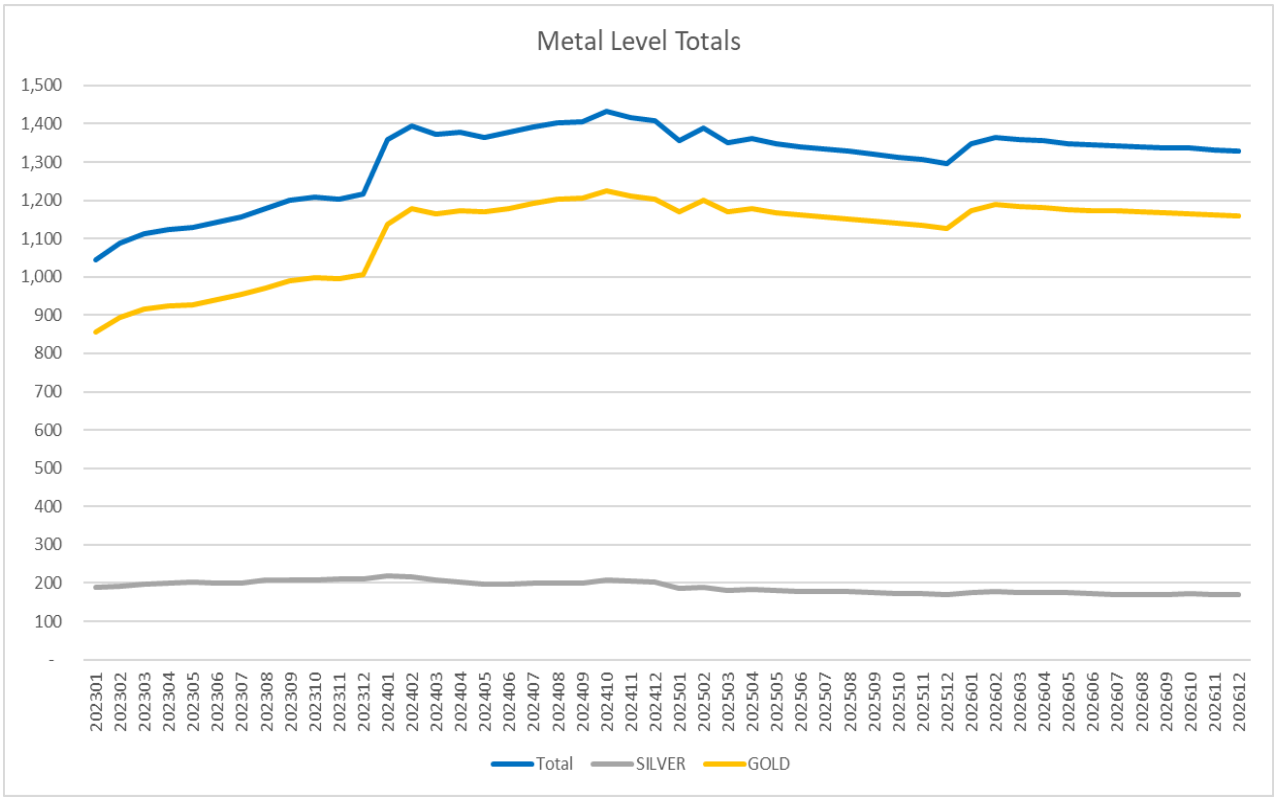
Each of the three cohorts described above is projected from the base period to the projection period based on historical patterns as well as expected levels based on projected rate changes. Below are four graphs depicting the total projected membership as well as each cohort for the historical periods 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.


Existing
1,300
1,200
1,100
1,000
900
800
700
600
500
400
300
200
100
-
202301 202302 202303 202304 202305 202306 202307 202308 202309 202310 202311 202312 202401 202402 202403 202404 202405 202406 202407 202408 202409 202410 202411 202412 202501 202502 202503 202504 202505 202506 202507 202508 202509 202510 202511 202512 202601 202602 202603 202604 202605 202606 202607 202608 202609 202610 202611 202612
Total
SILVER
GOLD


New
400
375
350
325
300
275
250
225
200
175
150
125
100
75
50
25
-
202301 202302 202303 202304 202305 202306 202307 202308 202309 202310 202311 202312 202401 202402 202403 202404 202405 202406 202407 202408 202409 202410 202411 202412 202501 202502 202503 202504 202505 202506 202507 202508 202509 202510 202511 202512 202601 202602 202603 202604 202605 202606 202607 202608 202609 202610 202611 202612
Total
SILVER
GOLD





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, the change from the base period average morbidity to the average morbidity of existing members (those that persisted from the prior year) is 9.0%, which is higher than the -3.1% from last year as shown in the table below. The relative morbidity of transfer members is -34.7%.

			PMPM
2021	Normalized Claims	Base	$1,559.50
		Existing a/o Feb 2022	$1,519.35
		Ratio	**0.974**

			PMPM
2022	Normalized Claims	Base	$1,708.13
		Existing a/o Feb 2023	$1,760.24
		Ratio	**1.031**

			PMPM
2023	Normalized Claims	Base	$1,614.54
		Existing a/o Feb 2024	$1,564.89
		Ratio	**0.969**

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 0.850 to the existing claims PMPM by metal, which results in a new to existing ratio of 0.848 for the Current Year YTD cohort and a new to existing ratio of 0.848 for the total 2025 cohort. Note that the total factor across all metals may be different due to different metal mix between new and existing members. The assumption that new members will have a 15.2% lower morbidity than existing members for 2025 is based on the historical relationship between new and existing members as shown in the table below along with a full year projection using past seasonality patterns applied to YTD 2025 data. 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.

		PMPM
2022 Normalized Claims	Existing	$1,709.05
	New	$1,857.51
	Ratio	**1.087**

		PMPM
2023 Normalized Claims	Existing	$1,765.52
	New	$1,164.23
	Ratio	**0.659**

		PMPM
2024 Normalized Claims	Existing	$1,444.02
	New	$1,175.07
	Ratio	**0.814**

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 4.5%.

Morbidity Change – current year to projection period:

For existing members, we are applying a 1.008 morbidity adjustment, which assumes a change in morbidity due to terminations between the pool in 2025 to 2026 of 0.8%. This is lower than the 9.0% mentioned above for 2024 to 2025. For new business, we are applying a morbidity adjustment of 0.850 to the existing claims PMPM by metal, which results in a new to existing ratio of 0.848. This new to existing ratio is similar to the 0.848 mentioned above. For transfer members, we are applying a 1.000 morbidity adjustment, which makes the relative morbidity to the projected 2025 base period -36.7% and lower than the -34.7% mentioned above.

The overall impact to the relative morbidity change from the current year to the projection period given the assumptions described above is -3.0%, which is lower than that of 2024 to 2025.

Using everything described above, the total morbidity change from 2024 to 2026 is expected to be 1.4%, 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.

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

Due to the lack of fully credible experience in the 2024 base period data, a fully credible manual rate was developed to blend with VA GHMSI's experience as described below.

Source and Appropriateness of Experience Data Used:

We started with the 2024 base period claim experience of our Maryland ACA Individual PPO block of business. It includes 236,766 member months and is considered fully credible for purposes of developing claim projections. We believe this data to be appropriate for use due to it being a similar population utilizing very similar PPO ACA product designs.

Adjustments Made to the Data:

To account for the change in morbidity and demographics, we adjusted the MD PPO metal level allowed claims PMPMs by the relative PLRS between VA GHMSI and MD PPO. We then weighted these PMPMs by the metal level membership distributions of VA GHMSI in order to adjust for metal mix and to develop a total PLRS-adjusted PMPM.

To account for the change in provider networks, we applied an additional geographic factor to the total PLRS-adjusted PMPM to develop our manual base period total allowed claims PMPM.

We did not specifically adjust for benefit differences as the plan offerings between VA GHMSI and MD PPO are very similar and any benefit difference adjustment to allowed claims would be immaterial.

This manual base period total allowed claims PMPM was reduced for VA GHMSI's experience period Rx rebates. Then we removed the same % of non-EHBs as was in VA GHMSI's total base period allowed to develop the manual EHB experience period index rate of $2,764.98.

To develop the manual EHB projection period index rate of $3,193.16, we applied the same projection factors that were used to develop the VA GHMSI EHB projection period index rate as shown in Exhibit 1 of the Memorandum.

We note that the Adjusted Trended EHB Allowed Claims PMPM in cell F36 on Worksheet 1 of the URRT could potentially be different from the Projected Index Rate on Exhibit 1 in the Actuarial Memorandum. The applied credibility % in cell F39 is set equal to 82%, as described in section 4.4.3.4. As a result, the Manual EHB Allowed Claims PMPM has been adjusted (and could potentially not match the $3,193.16 mentioned above), so that the Projected Index Rate in cell F42 matches the Projected Index Rate in the Actuarial Memorandum. This is done to minimize any differences that would otherwise be carried over to Worksheet 2 of the URRT.

4.4.3.4 Credibility of Experience

The resulting credibility level assigned to the base period experience when applying the credibility methodology below is 82%.

Our credibility formula is MIN(1, SQRT(projected member months / 24000)), which we believe is reasonable.

4.4.3.5 Establishing the Index Rate

The experience period index rate for this filing is $2,643.12 and the projection period index rate is $3,052.43. Blending this projected index rate with the manual projected index rate using the credibility mentioned above results in a projected index rate of $3,077.76. 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 $1,278.06 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, GHMSI received an estimated reinsurance PMPM of $584.95.

We have estimated a 2026 reinsurance PMPM for GHMSI of $641.95 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: 21.4%

We applied the first three reinsurance parameters above to CPDs of the past several years to determine the estimated percentage of paid claims that would have been subject to reinsurance and then compared these estimates to historical actuals to set the final assumption.

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, we have assumed an increase in the statewide premium of 20.7% which reflects an estimate of an average 4.0% increase in 2025 and 16.1% increase in 2026. We have assumed that our CFI non-Catastrophic market share will increase from 2.19% in 2024 to 2.77% in 2026 and that our CFI non-Catastrophic PLRS ratio to the state will decrease from 1.714 in 2024 to 1.573 in 2026, which is consistent with our morbidity assumptions. We have also assumed that 100% of our morbidity change will be reflected in our HCC PLRS values. The resultant estimate of risk adjustment is that the GHMSI receivable transfer PMPM will decrease from $1,042.84 in 2024 to $1,022.19 in 2026. Combined with the $1,022.19 is a projected HCRP net PMPM receivable of $4.34, which results in a total projected risk adjustment receivable of $1,026.52.

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 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 5.7%, 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**: All plans offered use the PPO network.

- **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 $0.00 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.

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 92.8% 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 85% of the designated services are rendered in higher cost-share setting and the remaining 15% 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.