

**Federal Rate Filing Justification Part III  
Actuarial Memorandum and Certification**

**Golden Rule Insurance Company**

**NAIC: 0707-62286**

**FEIN: 37-6028756**

**State of Kentucky Rate Review**

## Table of Contents

Section 1: Purpose .....	2
Section 2: General Information .....	2
Section 3: Proposed Rate Changes .....	2
Section 4: Experience Period Premium and Claims.....	3
Section 5: Benefit Categories.....	3
Section 6: Projection Factors.....	4
Section 7: Credibility Manual Rate Development .....	4
Section 8: Credibility of Experience.....	5
Section 9: Paid-to-Allowed Ratio .....	5
Section 10: Risk Adjustment and Reinsurance .....	6
Section 11: Non-Benefit Expenses and Profit.....	7
Section 12: Projected Loss Ratio .....	8
Section 13: Single Risk Pool .....	8
Section 14: Index Rate.....	8
Section 15: Market Adjusted Index Rate .....	9
Section 16: Plan Adjusted Index Rates .....	9
Section 17: Calibration .....	10
Section 18: Consumer Adjusted Premium Rate Development .....	10
Section 19: AV Metal Values .....	11
Section 20: AV Pricing Values.....	12
Section 21: Membership Projections .....	12
Section 22: Terminated Products .....	12
Section 23: Plan Type.....	12
Section 24: Warning Alerts .....	13
Section 25: Reliance .....	13
Section 26: Actuarial Certification.....	14
Appendix A: Average Age and Tobacco Factors.....	15

## Section 1: Purpose

Following is a rate filing prepared by Golden Rule Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template.

This filing establishes rates intended to be used for individual health benefit plans available off the health insurance exchange in Kentucky for the 2017 plan year. These plans will be available for purchase by all eligible individuals, in accordance with applicable law. A rate increase is being filed at this time.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the Kentucky Department of Insurance. It will demonstrate compliance with state and federal laws and regulations and is not intended to be used for any other purpose.

## Section 2: General Information

### Company Identifying Information

Company Legal Name: Golden Rule Insurance Company  
State: Kentucky  
HIOS Issuer ID: 47949  
Market: Individual  
Effective Date: January 1, 2017

### Primary Contact Information

Name: [REDACTED]  
Telephone Number: [REDACTED]  
Email Address: [REDACTED]

## Section 3: Proposed Rate Changes

Following are the proposed rate changes for each plan included in the single risk pool. These rate change percentages represent the average change in premium rates over the rates included in the prior rate filing for each renewing plan. They measure the change in premium rate tables using the current distribution of enrollment by age, geographic area, and tobacco status. These values are consistent with the rate change percentages reported in Worksheet 2 of the Unified Rate Review Template for each renewing plan.

Plan Name	Rate Change %
Silver Copay Select 1	43.27%
Bronze HSA 100	56.74%

### Reason for Rate Changes

All benefit plans are priced consistently with each other, with the rates differing only by the estimated value of the benefits. Significant factors driving the proposed rate change are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

## Section 4: Experience Period Premium and Claims

### Paid Through Date

The experience period is January 1, 2015 to December 31, 2015, with claims paid through February 29, 2016. The experience includes all ACA compliant single risk pool business and all transitional non-single risk pool business in Kentucky for the 2015 calendar year.

### Premiums (Net of MLR Rebate) in Experience Period

Earned premium for our individual market business in Kentucky for the 2015 calendar year was [REDACTED]. Therefore, premiums net of MLR rebates are [REDACTED].

### Allowed and Incurred Claims Incurred During the Experience Period

Claims Description	Allowed Claims	Incurred Claims
Claims Paid as of February 29, 2016	[REDACTED]	[REDACTED]
Claims Incurred but Not Paid as of February 29, 2016	[REDACTED]	[REDACTED]
Total Reported Claims for 2015 Experience Period	[REDACTED]	[REDACTED]

All incurred and allowed claims data was processed directly through the issuer's claim system. Unpaid incurred claim liabilities are estimated using average claims completion factors based on the company's historical pattern of paid claims. The business is split into duration and product type and a liability estimate is performed on each piece. The same completion factors are applied to both incurred and allowed claims amounts.

## Section 5: Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered.

### Inpatient Hospital

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

### Outpatient Hospital

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

### Professional

Includes non-capitated primary care, specialist care, 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

Includes non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services, and other services.

### Capitation

Includes all services provided under one or more capitated agreements.

### Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

## Section 6: Projection Factors

### Changes in Morbidity of the Population Insured

Because the experience for the 2015 calendar year includes both transitional and ACA compliant products, we make an adjustment to the data so the projected claims, before the credibility adjustment, reflect the claims/risk level of only the ACA compliant products included in this filing.

### Changes in Benefits

An adjustment was made to account for changes in benefits from the 2015 plan year to the 2017 plan year. Benefit adjustments are included within the 'Other' category on Worksheet 1 of the Unified Rate Review Template.

### Changes in Demographics

Adjustments were made to account for changes in the expected average age and tobacco factors from the 2015 experience period to the 2017 projection period. Our projected member distribution by age and tobacco use is based on current enrollment for this product in the 2016 plan year. Demographic adjustments are included within the 'Other' category on Worksheet 1 of the Unified Rate Review Template.

### Trend Factors (Cost/Utilization)

Two years of annual trend were applied to our 2015 experience to project it to the 2017 rating period. Our most recent analysis indicates annual trend in the state of Kentucky for the 2016 and 2017 calendar years will be [REDACTED] and [REDACTED] respectively. The table below details the components of each trend factor.

Trend Component	2016 (a)	2017 (b)	Annualized for Wksh1 (c) = $\sqrt{((1+a)*(1+b))}-1$
Unit Cost	[REDACTED]	[REDACTED]	[REDACTED]
Utilization	[REDACTED]	[REDACTED]	[REDACTED]
Total	[REDACTED]	[REDACTED]	[REDACTED]

## Section 7: Credibility Manual Rate Development

### Source and Appropriateness of Data Used

As Golden Rule Insurance Company does not have fully credible experience for individual medical guarantee issue products, our 2017 individual credibility manual rates are developed from the previously approved individual projections for the 2016 plan year.

### Adjustments Made to the Data

- Changes in Benefits:  
An adjustment was made to account for changes in benefits from the 2016 plan year to the 2017 plan year.
- Changes in Demographics:  
Adjustments were made to account for changes in the expected average age and tobacco factors from the 2016 plan year to the 2017 projection period. Our projected member distribution by age and tobacco use is based on current enrollment for this product in the 2016 plan year.
- Trend Factors (Cost/Utilization):  
Our 2016 rates have been adjusted for one year of annual trend, which is expected to be [REDACTED] in the state of Kentucky for the 2017 plan year, as shown in the table provided in Section 6 (*Projection Factors*) of this memorandum.

### Inclusion of Capitation Payments

No services in the projection period will be provided under a capitation arrangement.

## Section 8: Credibility of Experience

UnitedHealthcare (parent company of Golden Rule Insurance Company) has conducted a credibility study to estimate the level of credibility that should be assigned to the base period experience. Given the limited amount of UnitedHealthcare's ACA compliant individual market experience available at the time the study was completed, UnitedHealthcare's nationwide experience for groups with 1-3 members was used as a proxy for the individual market. Empirical analysis of this small group experience indicates that with [REDACTED] member months, the allowed claims PMPM of a group is within 5% of the population allowed claims PMPM at least 60% of the time. Therefore, [REDACTED] member months has been set as the standard for full credibility. Credibility is calculated using the following formula:

[REDACTED]

Golden Rule Insurance Company had [REDACTED] ACA compliant single risk pool member months in the state of Kentucky over the 2015 experience period, so partial credibility of [REDACTED] is applied to the base period experience. The remaining [REDACTED] weighting is applied to the credibility manual.

Following the guidance in ASOP 25, professional actuarial judgment was used in developing the aforementioned credibility formula. The formula was tested to ensure it produced reasonable results appropriate for the weighting of our experience and was practical to implement.

## Section 9: Paid-to-Allowed Ratio

The paid-to-allowed ratios were developed using the proprietary UnitedHealthcare (parent company of Golden Rule Insurance Company) pricing model. This model uses UnitedHealthcare nationwide experience data which is fully credible. Claim data is projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters, such as deductibles, copays, and coinsurance rates, are applied to the claim distributions of the matching service category. Cost-sharing is applied, and the values of each service category are summed to determine an overall benefit value, or paid-to-allowed ratio. In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

A paid-to-allowed ratio was produced for each plan using the model described above. The weighted average is then based on the projected membership by plan. Member distribution by plan is discussed under Section 21 (*Membership Projections*) of this memorandum.

Plan Name	Projected Member Months	Paid-to-Allowed Ratio
Silver Copay Select 1	[REDACTED]	[REDACTED]
Bronze HSA 100	[REDACTED]	[REDACTED]
Weighted Average	[REDACTED]	[REDACTED]

## Section 10: Risk Adjustment and Reinsurance

### Experience Period Risk Adjustment and Reinsurance Adjustments

Risk adjustment user fees for the 2015 plan year were ██████ per member per year as specified by the HHS Notice of Benefit and Payment Parameters for 2015. Our 2015 risk adjustment transfer payment of ██████ PMPM was estimated based on data provided to UnitedHealthcare (parent company of Golden Rule Insurance Company) as a result of participating in a multi-state study, using 2015 experience, done by a large actuarial consulting firm. The risk adjustment user fees and transfers only apply to the ACA compliant single risk pool business in the experience period.

Reinsurance fees for the 2015 plan year were ██████ per member per year as specified by the HHS Notice of Benefit and Payment Parameters for 2015. Reinsurance recovery estimates for the experience period were based on the current reinsurance parameters for the 2015 benefit year along with our current estimate of 2015 total claims, based on experience paid through February 29, 2016. Reinsurance fees apply to both the ACA compliant single risk pool business and transitional non-single risk pool business in the experience period, but reinsurance recoveries only apply to the ACA compliant single risk pool business.

### Projected Risk Adjustments

Golden Rule Insurance Company anticipates paying an average of ██████ PMPM for risk adjustment transfers in the state of Kentucky for the 2017 plan year. We are assuming the risk level of our business relative to that of our competitors for the 2017 plan year will be higher than what it was in the 2015 experience period, due to the expectation that a larger portion of our lower risk members will discontinue coverage due to the proposed rate increase. The HHS Notice of Benefit and Payment Parameters for 2017 specifies a risk adjustment user fee of ██████ per member per year, or ██████ PMPM.

Projected risk adjustment transfers net of risk adjustment user fees are therefore ██████ PMPM.

### Projected Reinsurance Adjustments

The reinsurance program will end with the 2016 benefit year, so there are zero reinsurance recoveries and user fees for 2017.

## Section 11: Non-Benefit Expenses and Profit

### Administrative Expense Load

The [REDACTED] administrative expense load includes commissions, quality improvements, and SG&A. Expenses do not vary by product.

- Commissions: We expect an average commission rate of approximately [REDACTED] for 2017 based on our anticipated commission schedule and the expected distribution of business by first year and renewal, as well as by distribution channel.
- Quality Improvements: We included [REDACTED] for quality improvements based on the company's annual Supplemental Health Care Exhibit.
- SG&A: Our general and administrative expense assumption of [REDACTED] PMPM is based on estimates provided by our finance department for the 2017 calendar year. For this product in the state of Kentucky, this amount equates to approximately [REDACTED] of premium for 2017.

### Profit and Risk Margin

Our projected margin for profit and risk contingencies for the 2017 rating period is approximately [REDACTED] of premium. Due to uncertainty in the individual health insurance market as a result of healthcare reform, our margin for profit and contingencies has increased, compared to the previous year, to account for the additional risk.

Premium	[REDACTED]	[REDACTED]
Claims	[REDACTED]	[REDACTED]
GAP Assessments	[REDACTED]	[REDACTED]
Premium Tax	[REDACTED]	[REDACTED]
Risk Adjustment User Fees	[REDACTED]	[REDACTED]
Risk Adjustment Transfers	[REDACTED]	[REDACTED]
PCORI Fee	[REDACTED]	[REDACTED]
Commissions	[REDACTED]	[REDACTED]
SG&A	[REDACTED]	[REDACTED]
Quality Improvements	[REDACTED]	[REDACTED]
<b>Pre-Tax Income</b>	[REDACTED]	[REDACTED]
Federal Income Tax	[REDACTED]	[REDACTED]
<b>Profit Margin &amp; Risk Contingencies</b>	[REDACTED]	[REDACTED]

*The figures above may not tally exactly due to rounding of the display.*

### Taxes and Fees

Taxes and fees are expected to be [REDACTED] including GAP assessments, premium tax, PCORI fees, and federal income tax.

- GAP Assessments: Kentucky GAP assessments are [REDACTED] of premium.
- Premium Tax: The premium tax rate is [REDACTED] in the state of Kentucky.
- PCORI Fees: These plans will be offered for the 2017 plan year, with a PCORI fee of [REDACTED] per member per year, or [REDACTED] PMPM. This equates to approximately [REDACTED] of premium for this product.
- Federal Income Tax: Federal income tax is projected to be [REDACTED] of premium and equals 35% of pre-tax income.

## Section 12: Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2017 is █████ Golden Rule Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Claims	█████	█████
Risk Adjustment Transfers	█████	█████
Quality Improvement	█████	█████
<b>Total MLR Claims</b>	█████	█████
Premium	█████	█████
GAP Assessments	█████	█████
Premium Tax	█████	█████
Risk Adjustment User Fee	█████	█████
PCORI Fee	█████	█████
Federal Income Tax	█████	█████
<b>Total MLR Premium</b>	█████	█████
<b>Federal Medical Loss Ratio</b>	█████	

*The figures above may not tally exactly due to rounding of the display.*

## Section 13: Single Risk Pool

The single risk pool reflects all covered lives for every individual non-grandfathered product and plan combination for Golden Rule Insurance Company in the state of Kentucky. It is established in accordance with the requirements of 45 CFR §156.80.

## Section 14: Index Rate

The experience for the 2015 calendar year includes both ACA and non-ACA compliant products. For the non-ACA compliant transitional products, essential health benefit (EHB) requirements were not applicable, so the percentage of allowed claims sustained for EHB requirements is 0%. For the ACA compliant products, approximately █████ of allowed claims were sustained for EHB requirements. The index rate of the experience period has been reported as a weighted average of the ACA and non-ACA compliant EHB claims, rounded to the nearest whole dollar value as required by the Unified Rate Review Template.

The index rate for the 2017 projection period represents █████ of allowed claims for this block of business. Benefits in excess of EHBs for 2017 include travel and lodging associated with organ transplants, which is expected to account for approximately █████ of allowed claims. These benefits are expected to have a minimal effect on total claims, and the reported percentage amount is based on informed actuarial judgment.

The projected index rate is calculated below.

Allowed Claims PMPM	Benefits in Excess of EHBs	Index Rate
█████	█████	\$357.36

*The figures above may not tally exactly due to rounding of the display.*

## Section 15: Market Adjusted Index Rate

The market adjusted index rate includes an adjustment for the risk adjustment program, which is described in Section 10 (*Risk Adjustment and Reinsurance*) of this memorandum. Incurred values were divided by the average paid-to-allowed ratio, discussed in Section 9 (*Paid-to-Allowed Ratio*) of this memorandum, to reflect an allowed basis. The reinsurance program will end with the 2016 benefit year, and these products will only be available outside of the individual exchange, so no adjustments are made for those market-wide modifiers.

Index Rate	Net Risk Adjustment (allowed basis)	Market Adjusted Index Rate
\$357.36	██████████	██████████

The figures above may not tally exactly due to rounding of the display.

## Section 16: Plan Adjusted Index Rates

Plan adjusted index rates include adjustments for all allowable plan level modifiers as defined in the market rating rules. The calculations are shown below, and the allowable adjustments are subsequently discussed in further detail.

Plan Name	Market Adjusted Index Rate	AV & Cost Sharing Adjustment	Benefits in Excess of EHBs	Distribution & Admin. Costs	Plan Adjusted Index Rate
Silver Copay Select 1	██████████	██████████	██████████	██████████	\$451.01
Bronze HSA 100	██████████	██████████	██████████	██████████	\$418.40

The figures above may not tally exactly due to rounding of the display.

The actuarial value and cost sharing adjustment accounts for benefit differences (e.g. a paid-to-allowed adjustment) and an adjustment for non-tobacco user status. Since we will be applying tobacco user rating factors, an adjustment must be made to remove the portion of costs that is expected to be recouped through the tobacco surcharge. The total average tobacco surcharge is expected to be about ██████ of premium, as detailed in Appendix A. Member distribution by age and tobacco use is based on current enrollment for this product in the 2016 plan year.

Benefits in excess of EHBs were previously discussed in Section 14 (*Index Rate*) of this memorandum, and are expected to be ██████ of allowed claims.

Distribution and Administrative Costs include PCORI fees, commissions, SG&A, quality improvements, GAP assessments, premium tax, federal income tax, and profit margin and risk contingencies. These items were previously discussed in Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum. Risk adjustment transfers and user fees are excluded because they are already accounted for in the market adjusted index rate.

## Section 17: Calibration

### Age Curve Calibration

The calculated age curve calibration is [REDACTED] which equals the average age factor of the expected member distribution by age. This corresponds with an approximate age of [REDACTED] years. A detailed distribution of members by age is included in Appendix A and is based on current enrollment for this product in the 2016 plan year.

### Geographic Factor Calibration

The geographic factor calibration is [REDACTED]. Our geographic area factors do not vary by rating region, and the statewide area factor is [REDACTED] which has not changed since our previously approved rate filing.

### Calibrated Premium Rates

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age, area, and tobacco status. The calculations are shown below.

Plan Name	Plan Adjusted Index Rate (a)	Age Curve Calibration (b)	Geographic Factor Calibration (c)	Calibrated Premium Rate (d) = a/(b*c)
Silver Copay Select 1	\$451.01	[REDACTED]	[REDACTED]	[REDACTED]
Bronze HSA 100	\$418.40	[REDACTED]	[REDACTED]	[REDACTED]

*The figures above may not tally exactly due to rounding of the display.*

## Section 18: Consumer Adjusted Premium Rate Development

The consumer adjusted premium rate is the final premium rate for each plan that is charged to an individual. It is developed by calibrating the plan adjusted index rate to the average age and geographic rating factors, and applying the consumer specific age, geographic, and tobacco status rating factors. Sample calculations are shown below and represent consumer adjusted premium rates for a 25-year old consumer, residing in rating region 1, with tobacco user status.

Plan Name	Calibrated Premium Rate (a)	25-Year-Old Age Factor (b)	Region 1 Area Factor (c)	25-Year-Old Tobacco Factor (d)	Consumer Adjusted Premium Rate (e) = a*b*c*d
Silver Copay Select 1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Bronze HSA 100	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

*The figures above may not tally exactly due to rounding of the display.*

## Section 19: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan. Please refer to Section 9 (*Paid-to-Allowed Ratio*) of this memorandum for further detail regarding our estimate of the portion of allowed costs covered by each plan.

### Copays Paid in Conjunction with Coinsurance

The Silver Copay Select 1 plan design includes copays that are paid in conjunction with coinsurance in the cost-sharing range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR §156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance in the cost sharing range, the following formula was used to estimate the insurer's cost share.

$$\text{Effective Insurer Coinsurance Rate} = \left( 1 - \frac{\text{Member Copay}}{\text{Average Unit Cost}} \right) * ( 1 - \text{Member Coinsurance Rate} )$$

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above.

The average unit cost was calculated based on the claims data included within the AV calculator Silver continuance table. All enrollees within the continuance table whose claims exceeded the plan deductible were included in the calculation of the average unit cost for each benefit type.

The chart below outlines which benefits were impacted by the above methodology.

Plan Name	Benefit Categories including Copays Paid in Conjunction with Coinsurance
Silver Copay Select 1	- Emergency Room Services - Imaging - Outpatient Facility Fee

### Prescription Drug Benefits

For the Silver Copay Select 1 plan design, our prescription drug benefits are based on a drug categorization of Tier 1 to Tier 4, instead of the categories presented in the AV calculator (i.e. Generic, Preferred Brand, Non-Preferred Brand, and Specialty). In addition, our Tier 3 and Tier 4 prescription drug benefits incorporate coinsurance rates along with minimum copay amounts. Based on historical experience of affiliated individual market carriers and our expectations regarding the organization of brand and generic drugs into Tiers, the prescription drugs were re-categorized to match the parameters of the AV calculator, and the benefits were converted to equivalent member copays for each category.

### Benefits that Vary Based on Place of Service

The Silver Copay Select 1 plan design includes different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility) for Imaging, Laboratory Services, and Outpatient Facility Fees. To incorporate this differentiation in benefits, the Blended Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

## Section 20: AV Pricing Values

The AV pricing values represent the cumulative effect of adjustments made by the issuer to move from the market adjusted index rate to the plan adjusted index. The AV pricing values are shown below. Each of the allowable modifiers to move from the market adjusted index rate to the plan adjusted index rate was previously discussed in Section 16 (*Plan Adjusted Index Rates*) of this memorandum.

Plan Name	Market Adjusted Index Rate	Plan Adjusted Index Rate	AV Pricing Value
Silver Copay Select 1	██████████	\$451.01	0.900
Bronze HSA 100	██████████	\$418.40	0.835

*The figures above may not tally exactly due to rounding of the display.*

## Section 21: Membership Projections

The total member month projection for the 2017 plan year was based on current 2016 enrollment and anticipated lapse rates. These plans will be available for purchase by all eligible individuals, in accordance with applicable law. Member distribution by plan was also based on current enrollment in the 2016 plan year.

Plan Name	Member Distribution	Projected Member Months
Silver Copay Select 1	██████████	██████████
Bronze HSA 100	██████████	██████████
Total	100%	██████████

## Section 22: Terminated Products

Since Golden Rule Insurance Company only had ACA compliant products available in Kentucky for the 2015 experience period, the Terminated Products column in Worksheet 2 of the Unified Rate Review Template includes members whose policies were issued in a different state, and then they moved to Kentucky at some point during 2015. When members move to Kentucky from another state, they are offered the ACA compliant plans available in Kentucky and given a 30 day notice prior to their current non-ACA policy being terminated. During that time, any incurred claims are included in the single risk pool for the resident state of Kentucky.

The following plan(s) contain single risk pool compliant business during the 2015 and 2016 plan years and are being terminated prior to the 2017 plan year.

Terminated Plan ID	Plan ID in which members will be auto-enrolled for 2017
47949KY0200001	47949KY0200003

## Section 23: Plan Type

A plan type of PPO has been selected in Worksheet 2 of the Unified Rate Review Template, which describes the plans exactly.

## Section 24: Warning Alerts

Worksheet 2 of the Unified Rate Review Template contains two warning alerts in Section III regarding the total incurred claims and the incurred claims PMPM for the experience period. Both of these items are calculated fields within the worksheet. As indicated in the Unified Rate Review Instructions, it is understood that the total incurred claims from Worksheet 1 may not match the total incurred claims from Worksheet 2 due to differences of reinsurance and risk adjustment. The total incurred claims from Worksheet 2 are calculated as the total allowed claims minus the allowed claims which are not the issuer's obligation. According to the instructions, allowed claims which are not the issuer's obligation include adjustments for reinsurance recoveries and risk adjustment transfer charges or payments. The total incurred claims from Worksheet 2 include adjustments for reinsurance recoveries and risk adjustment transfer charges or payments, whereas the total incurred claims from Worksheet 1 do not include such adjustments.

## Section 25: Reliance

Due to responsibility allocation, I have relied upon other members within the UnitedHealthcare (parent company of Golden Rule Insurance Company) organization to provide certain assumptions. Although I have reviewed the information for reasonableness and consistency, I have not reviewed it in detail due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions. A list of reliances is included below.

### UnitedHealthcare Finance Department

- Projected SG&A Assumption
- 2015 MLR Rebate Estimates

## Section 26: Actuarial Certification

I, [REDACTED] am a Senior Actuarial Analyst for UnitedHealthcare's individual line of business, which includes Golden Rule Insurance Company's health insurance products marketed to individuals. I am a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
  - In compliance with all applicable state and Federal statutes and regulations (45 CFR §156.80 and §147.102),
  - Developed in compliance with the applicable Actuarial Standards of Practice,
  - Reasonable in relation to the benefits provided and the population anticipated to be covered,
  - Neither excessive, deficient, nor unfairly discriminatory.
- 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.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV, were calculated in accordance with actuarial standards of practice.
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. One of our plan designs includes copays that are paid in conjunction with coinsurance in the cost-sharing range. Our prescription drug benefits are also based on a drug categorization of Tier 1 to Tier 4, instead of the categories presented in the AV calculator (i.e. Generic, Preferred Brand, Non-Preferred Brand, and Specialty). These benefit designs are not directly compatible with the AV calculator. Therefore, the alternate methodology described in 45 CFR §156.135(b)(2) was used to fit the plans into the parameters of the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. The unique plan design actuarial certification required by 45 CFR §156.135 has been attached to the end of the memorandum.
- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop their rates. Rather, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

[REDACTED]

[REDACTED] FSA, MAAA  
Senior Actuarial Analyst

07/08/2016

Date

## Appendix A: Average Age and Tobacco Factors

Age	Tobacco Distribution	Non-Tobacco Distribution	Age Factor	Tobacco Factor
0-20	█	█	0.635	█
21	█	█	1.000	█
22	█	█	1.000	█
23	█	█	1.000	█
24	█	█	1.000	█
25	█	█	1.004	█
26	█	█	1.024	█
27	█	█	1.048	█
28	█	█	1.087	█
29	█	█	1.119	█
30	█	█	1.135	█
31	█	█	1.159	█
32	█	█	1.183	█
33	█	█	1.198	█
34	█	█	1.214	█
35	█	█	1.222	█
36	█	█	1.230	█
37	█	█	1.238	█
38	█	█	1.246	█
39	█	█	1.262	█
40	█	█	1.278	█
41	█	█	1.302	█
42	█	█	1.325	█
43	█	█	1.357	█
44	█	█	1.397	█
45	█	█	1.444	█
46	█	█	1.500	█
47	█	█	1.563	█
48	█	█	1.635	█
49	█	█	1.706	█
50	█	█	1.786	█
51	█	█	1.865	█
52	█	█	1.952	█
53	█	█	2.040	█
54	█	█	2.135	█
55	█	█	2.230	█
56	█	█	2.333	█
57	█	█	2.437	█
58	█	█	2.548	█
59	█	█	2.603	█
60	█	█	2.714	█
61	█	█	2.810	█
62	█	█	2.873	█
63	█	█	2.952	█
64+	█	█	3.000	█
Total	█	█	█	█

# Chapter 10e: Unique Plan Design— Supporting Documentation and Justification

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Fill in the following information:

**Health Insurance Oversight System (HIOS) Issuer ID:** 47949

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**HIOS Product IDs:** 47949KY020

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**Applicable HIOS Plan IDs (Standard Component):** 47949KY0200002

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**Reasons the plan design is unique, that is, the benefits incompatible with the parameters of the Actuarial Value Calculator (AVC) and their materiality:**

The plan design includes copays that are paid in conjunction with coinsurance in the cost-sharing range for certain services.

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The plan design also includes drug categorization of Tier 1 to Tier 4, instead of the categories presented in the AV calculator.

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**Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):** \_\_\_\_\_

The alternate method described in 45 CFR 156.135(b)(2) was used for the AV calculation.

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**Confirmation that only in-network cost sharing, including multitier networks, was considered:**

Only in-network cost sharing was considered for the alternate methodology mentioned above.

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**Description of the standardized plan population data used:** \_\_\_\_\_

Claims and enrollment data enclosed in the AVC continuance tables were used for the metal level.

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**If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AVC:**

Please refer to 'Section 19: AV Metal Values' of the Federal Part III Actuarial Memorandum.

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**If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:**

Not applicable. Only the method described in 45 CFR 156.135(b)(2) was used for the AV calculation.

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**Certification Language:**

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for benefits that deviate substantially from the parameters of the AVC and have a material impact on the actuarial value.

The analysis was

- (i) conducted by a member of the American Academy of Actuaries, and
- (ii) performed in accordance with generally accepted actuarial principles and methods.

**Actuary Signature:** \_\_\_\_\_

**Actuary Printed Name:** \_\_\_\_\_

FSA, MAAA

**Date:** 07/08/2016

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If you don't have enough space here to list your justifications, print out another form to augment them as needed.