Filing at a Glance

Company:	Optimum Choice, Inc.
Product Name:	DC-SG-OCI-2017-01
State:	District of Columbia
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.004E Small Group Only - Other
Filing Type:	Rate
Date Submitted:	04/29/2016
SERFF Tr Num:	UHLC-130538513
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2017
Author(s):	Bonnie Barboza, Sarah French, Michelle Lorenzo, Xiaoxi Jannsen, Sarah Mackey
Reviewer(s):	Efren Tanhehco (primary), John Morgan, Damon Siler
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *District of Columbia* **Filing Company:** *Optimum Choice, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only - Other*
Product Name: *DC-SG-OCI-2017-01*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 05/05/2016
State Status Changed:
Created By: Xiaoxi Jannsen
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact: 2.2%

Deemer Date:
Submitted By: Xiaoxi Jannsen

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Purpose of Filing: We are proposing to set our 1st quarter 2017 rates on average 1.8% lower than our current 4th quarter 2016 rates. In addition, we are filing for quarterly trend increases as follows: 2Q17 +2.5%, 3Q17 +2.5%, 4Q17 +2.6%. These quarterly trend increases incude an annual 7.1% trend rate and the build up of the insurer fee.

The proposed rates and rate factors are in Exhibit 1. Benefit plan descriptions are in Exhibit 2, which also displays the metal level and actuarial value of each benefit plan.

Company and Contact

Filing Contact Information

Boris Gerber, Director, Actuarial Pricing
185 Asylum St
Hartford, CT 06103

Boris_Gerber@uhc.com
860-702-5540 [Phone]
860-702-5042 [FAX]

Filing Company Information

Optimum Choice, Inc.
4 Taft Court
Rockville, MD 20850
(301) 294-1578 ext. [Phone]

CoCode: 96940
Group Code: 707
Group Name:
FEIN Number: 52-1518174

State of Domicile: Maryland
Company Type: HMO
State ID Number: 96940

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: District of Columbia **Filing Company:** Optimum Choice, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only - Other
Product Name: DC-SG-OCI-2017-01
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: Review & Approval
Rate Change Type: Decrease
Overall Percentage of Last Rate Revision: 5.000%
Effective Date of Last Rate Revision: 07/01/2016
Filing Method of Last Filing: Review & Approval

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):
Optimum Choice, Inc.	Increase	2.200%	2.200%	$130,518	137	$5,932,616	18.200%	-3.800%

Rate Review Detail

COMPANY:

Company Name: Optimum Choice, Inc.
HHS Issuer Id: 75753

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
HMO	75753DC001		1030
HMP	75753DC002		14

Trend Factors: The current annual trend factor is 7.8% The proposed 2017 annual trend factor is 7.1%

FORMS:

New Policy Forms: 0
Affected Forms:
Other Affected Forms: SHOP.POL.OCI.H.17.DC, SHOP.COC.OCI.17.DC, Platinum 1.SBN17.OCI.NET.12.SG.DC, Platinum 2.SBN17.OCI.NET.12.SG.DC, Platinum 4.SBN17.OCI.NET.12.SG.DC, Gold 8.SBN17.OCI.NET.12.SG.DC, Gold Gold 10.SBN17.OCI.NET.12.SG.DC, Gold 11.SBN17.OCI.NET.12.SG.DC, Silver 11.SBN17.OCI.NET.12.SG.DC, RID17.PDS.NET.OCI.12.SG.DC, RID17.PVCS.NET.OCI.12.SG.DC, RDR.RX.NET.17.OCI.12.DC, RDR.RXSBN.NET.17.OCI.12.SG.DC.152550 RDR.RXSBN.NET.17.OCI.12.SG.DC.104075

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 13,137
Benefit Change: Increase
Percent Change Requested: Min: -3.8 Max: 18.2 Avg: 2.2

PRIOR RATE:

Total Earned Premium: 5,932,615.83
Total Incurred Claims: 4,660,714.00
Annual $: Min: 164.90 Max: 1,370.84 Avg: 451.60

REQUESTED RATE:

Projected Earned Premium: 6,063,133.00
Projected Incurred Claims: 4,815,816.00
Annual $: Min: 181.75 Max: 1,334.06 Avg: 461.53

State: *District of Columbia* **Filing Company:** *Optimum Choice, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only - Other*
Product Name: *DC-SG-OCI-2017-01*
Project Name/Number: */*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Filing Exhibits	SHOP.POL.OCI.H.17.DC, SHOP.COC.OCI.17.DC, Platinum 1.SBN17.OCI.NET.12.SG.DC, Platinum 2.SBN17.OCI.NET.12.SG.DC, Platinum 4.SBN17.OCI.NET.12.SG.DC, Gold 8.SBN17.OCI.NET.12.SG.DC, Gold Gold 10.SBN17.OCI.NET.12.SG.DC, Gold 11.SBN17.OCI.NET.12.SG.DC, Silver 11.SBN17.OCI.NET.12.SG.DC, RID17.PDS.NET.OCI.12.SG.DC, RID17.PVCS.NET.OCI.12.SG.DC, RDR.RX.NET.17.OCI.12.DC, RDR.RXSBN.NET.17.OCI.12.SG.DC.152550 RDR.RXSBN.NET.17.OCI.12.SG.DC.104075	Revised	Previous State Filing Number: UHLC130414505 Percent Rate Change Request:	DC-SG-OCI-Exhibits 2017-01 (04-15-2016).pdf,

Rate Factors

Exhibit 1

(1) Base Rate: $517.68

(2) Benefit Plan Ratios

HMO Plans					
Product	Medical On-Exchange Plan Name	Rx Plan Name	Metal Level	Actuarial Value	Plan Ratio
HMO	AE-CM	YM	Platinum 1	89.1%	0.8171
HMO	AJ-EU	ZR	Platinum 2	90.5%	0.8058
HMO	AJ-ET	ZU	Platinum 4	91.8%	0.8590
HMO	63-Q	YM	Gold 8	81.0%	0.6767
HMO	AL-EJ	YM	Gold 10	81.4%	0.6862
HMO-HSA	AL-EL	YM	Gold 11	81.0%	0.6832
HMO-HSA	AL-EK	YM	Silver 11	71.7%	0.5529

(3) Effective Date Adjustment Factors (EDA's)

Effective Quarter	Trend	ACA Fees	Total
1st Quarter, 2017	1.0000	1.0000	1.000
2nd Quarter, 2017	1.0173	1.0079	1.025
3rd Quarter, 2017	1.0349	1.0158	1.051
4th Quarter, 2017	1.0528	1.0236	1.078

(4) Age Factors

Age	Factor	Age	Factor	Age	Factor
0-20	0.654	35	0.876	50	1.431
21	0.727	36	0.896	51	1.487
22	0.727	37	0.916	52	1.545
23	0.727	38	0.927	53	1.605
24	0.727	39	0.938	54	1.668
25	0.727	40	0.975	55	1.733
26	0.727	41	1.013	56	1.801
27	0.727	42	1.053	57	1.871
28	0.744	43	1.094	58	1.944
29	0.760	44	1.137	59	2.020
30	0.779	45	1.181	60	2.099
31	0.799	46	1.227	61	2.181
32	0.817	47	1.275	62	2.181
33	0.836	48	1.325	63	2.181
34	0.856	49	1.377	64 & older	2.181

DC Small Group - 2017 Portfolio - Optimum Choice, Inc.

Exhibit 2

	Plan Name					In-Network					Copayments							Medical	Rx					
				Metal	Act'l	Deductible			OOP Maximum						OP Surgery			Deduct.	Deduct.			Tier 2		Tier 3
Product	Medical	Rx	SCID	Level	Value	Indiv.	Family	Coins	Indiv.	Family	PCP	SCP	UC	ER	Free-St.	Hospital	IP	Type	Type	Deduct.	Tier 1	Tier 2	Spec.	Tier 3	Spec.
HMO	AE-CM	YM	75753DC0010056	Platinum 1	89.1%	$250	$500	100%	$2,000	$4,000	$15	$30				Ded+$250+Coins.		Emb	Sep		$10	$40	$100	$75	$300
HMO	AJ-EU	ZR	75753DC0010057	Platinum 2	90.5%			100%	$3,000	$6,000	$15	$30	$75	$250	$150	$300	$500 x 3	Emb	Sep	$50	$10	$40	$100	$75	$300
HMO	AJ-ET	ZU	75753DC0010058	Platinum 4	91.8%			100%	$5,000	$10,000	$15	$30	$75	$150		$150		Emb	Sep		$15	$25	$100	$50	$300
HMO	63-Q	YM	75753DC0010042	Gold 8	81.0%	$1,000	$2,000	80%	$3,500	$7,000	$30	$60				Ded+$250+Coins.		Emb	Sep		$10	$40	$100	$75	$300
HMO	AL-EJ	YM	75753DC0010030	Gold 10	81.4%	$600	$1,200	80%	$4,800	$9,600	$20	$40				Ded+$250+Coins.		Emb	Sep		$10	$40	$100	$75	$300
HMO-HSA	AL-EL	YM	75753DC0010067	Gold 11	81.0%	$1,400	$2,800	100%	$3,500	$7,000	$10	$20	$75	$100		$150	$250	Ded NonEmb/OOPM Emb	Comb		$10	$40	$100	$75	$300
HMO-HSA	AL-EK	YM	75753DC0010066	Silver 11	71.7%	$2,600	$5,200	100%	$6,500	$13,000	$25	$50	$75	$150		250	$500	Ded NonEmb/OOPM Emb	Comb		$10	$40	$100	$75	$300

Exhibit 3

Rate Changes - Base Rates, Benefit Plan Ratios and Effective Date Adjustment (EDA) Factors (from Exhibit 1)

				Current - 4th Quarter 2016 Rate				Proposed - 1st Quarter 2017 Rate			% Rate	Year Over Year Rate Change			
												Min: -3.8%		Max: 18.2%	
	Plan Name			Base	Plan	EDA	4Q2016	Index	Plan	1Q2017	Change	1Q16	2Q16	3Q16	4Q16
Product	2016	2017	Rx	Rate (a)	Ratio (b)	Factor (c)	Rate = (a x b x c)	Rate (d)	Ratio (e)	Rate = (d x e)	4Q16 to 1Q17	to 1Q17	to 2Q17	to 3Q17	to 4Q17
HMO	AE-CM	AE-CM	YM	$438.25	0.95009	1.058	$440.53	$517.68	0.8171	$423.00	-4.0%	-3.5%	-2.9%	2.9%	3.5%
HMO	636	AJ-EU	ZR	$438.25	0.93858	1.058	$435.19	$517.68	0.8058	$417.15	-4.1%	-3.7%	-3.1%	2.7%	3.3%
HMO	638	AJ-ET	ZU	$438.25	0.99053	1.058	$459.28	$517.68	0.8590	$444.69	-3.2%	-2.7%	-2.1%	3.7%	4.4%
HMO	63Q	63-Q	YM	$438.25	0.77629	1.058	$359.94	$517.68	0.6767	$350.31	-2.7%	-2.2%	-1.6%	4.3%	4.9%
HMO	AE-CL	AL-EJ	YM	$438.25	0.80052	1.058	$371.18	$517.68	0.6862	$355.23	-4.3%	-3.8%	-3.2%	2.5%	3.2%
HMO-HSA	FZK	AL-EL	YM	$438.25	0.72924	1.058	$338.13	$517.68	0.6832	$353.68	4.6%	5.1%	5.8%	12.1%	12.8%
HMO-HSA	AE-CN	AL-EK	YM	$438.25	0.56292	1.058	$261.01	$517.68	0.5529	$286.23	9.7%	10.2%	10.9%	17.5%	18.2%

DC Small Group - Terminated & Changed Plans - OCI

Exhibit 4

Terminated 2016 Benefit Plans

There are no terminated benefit plans

2016 Benefit Plans with Plan Changes (Uniform Modification)

SCID	Product	Metal Level	2016 Name	2017 Name	Benefit Plan Changes	Value of Benefit Change on Medical Portion of Rate
75753DC0010030	HMO	Gold 10	AE-CL	AL-EJ	Deductible changed from $500/$1000 to $600/$1200, OOPM changed from $4500/$9000 to $4800/$9600	-2.0%
75753DC0010067	HMO	Gold 11	FZ-K	AL-EL	OOPM changed from $3000/$6000 to $3200/$6400, OOPM type change from non-emb to emb	-0.9%
75753DC0010066	HMO	Silver 11	AE-CN	AL-EK	Deductible changed from $2300/$5750 to $2600/$5200, OOPM changed from $6500/$6850 to $6500/$13000, OOPM type change from non-emb to emb	-1.6%

Unchanged 2016 Benefit Plans - Continued into 2017

SCID	Product	Metal Level	Plan Name
75753DC0010056	HMO	Platinum 1	AE-CM
75753DC0010057	HMO	Platinum 2	636/AJ-EU
75753DC0010058	HMO	Platinum 4	638/AJ-ET
75753DC0010042	HMO	Gold 8	63-Q

Formula & Example

Exhibit 5

Rate Calculation Formula

Monthly premium =

Base Rate
x Plan ratio
x Effective date adjustment (EDA) factor for plan effective or renewal date
x Sum of member age factors for the group

Rating Example

Benefit Plan: HMO plan AE-CM with Rx YM
Effective Date: 1/1/17
Census:

	Member Ages				Age Factors			
	EE Age	Spouse Age	Child #1	Child #2	EE	Spouse	Child #1	Child #2
EE #1	43	41	10	15	1.094	1.013	0.654	0.654
EE #2	35	36	5	9	0.876	0.896	0.654	0.654
EE #3	53	55	19		1.605	1.733	0.654	

Total Members: 11

Sum of Age Factors: 10.487

Rate Calculation

	Rating Factor	Exhibit 1 Location
$517.68	Base Rate	(1)
0.8171	Benefit Plan Ratio (AE-CM w YM)	(2)
1.000	EDA Factor (1Q17)	(3)
10.487	Group Age Factor	(4)
$4,435.96		
Total Monthly Premium		

Benefit Plan Resloping to New Pricing Models - Determination of Average 4Q16 to 1Q17 Rate Change

Exhibit 6

		Plan Name		Jan-16	4Q16 Base Rates x 4Q16 Trend Factor		2016 Current Plan Ratios & PMPM			2017 Base Rate	*New Model Plan Ratios & PMPM		%
License	Product	Med.	Rx	Members	Medical	Rx	Medical	Rx	PMPM	Med + Rx	Medical	PMPM	Chg.
OCI	HMO-HSA	617	YM	1	422.34	143.66	0.5549	0.0000	234.36	517.68	0.4882	252.73	7.8%
OCI	HMO	626	ZV	2	422.34	143.66	0.8396	0.4967	425.95	517.68	0.8007	414.49	-2.7%
OCI	HMO-HSA	62A	YM	3	422.34	143.66	0.7859	0.0000	331.92	517.68	0.6497	336.34	1.3%
OCI	HMO-HSA	62B	YM	3	422.34	143.66	0.8315	0.0000	351.18	517.68	0.7120	368.57	5.0%
OCI	HMO-HSA	62S	YM	3	422.34	143.66	0.8315	0.0000	351.18	517.68	0.7120	368.57	5.0%
OCI	HMO	634	YM	4	422.34	143.66	0.8677	0.4823	435.75	517.68	0.8116	420.15	-3.6%
OCI	HMO	636	ZR	4	422.34	143.66	0.8745	0.4584	435.19	517.68	0.8048	416.65	-4.3%
OCI	HMO	638	ZU	5	422.34	143.66	0.9101	0.5214	459.28	517.68	0.8583	444.32	-3.3%
OCI	HMO	63A	ZV	5	422.34	143.66	0.8676	0.4967	437.78	517.68	0.8325	430.96	-1.6%
OCI	HMO	63C	ZU	5	422.34	143.66	0.8898	0.5214	450.70	517.68	0.8430	436.38	-3.2%
OCI	HMO	63E	YM	7	422.34	143.66	0.7219	0.4823	374.17	517.68	0.6982	361.47	-3.4%
OCI	HMO	63I	ZS	2	422.34	143.66	0.7000	0.4383	358.60	517.68	0.6702	346.96	-3.2%
OCI	HMO	63Q	YM	5	422.34	143.66	0.6882	0.4823	359.94	517.68	0.6767	350.34	-2.7%
OCI	HMO	644	YM	415	422.34	143.66	0.8677	0.4823	435.75	517.68	0.8116	420.15	-3.6%
OCI	HMO	646	ZR	145	422.34	143.66	0.8679	0.4584	432.40	517.68	0.8048	416.65	-3.6%
OCI	HMO	648	ZU	37	422.34	143.66	0.9057	0.5214	457.42	517.68	0.8583	444.32	-2.9%
OCI	HMO	64A	ZV	11	422.34	143.66	0.8676	0.4967	437.78	517.68	0.8325	430.96	-1.6%
OCI	HMO	64C	ZU	18	422.34	143.66	0.8898	0.5214	450.70	517.68	0.8430	436.38	-3.2%
OCI	HMO	64E	YM	56	422.34	143.66	0.7219	0.4823	374.17	517.68	0.6982	361.47	-3.4%
OCI	HMO	64Q	YM	30	422.34	143.66	0.6882	0.4823	359.94	517.68	0.6767	350.34	-2.7%
OCI	HMO	64S	YM	22	422.34	143.66	0.7293	0.4823	377.30	517.68	0.7045	364.68	-3.3%
OCI	HMO	64U	ZT	7	422.34	143.66	0.6079	0.4238	317.62	517.68	0.5917	306.29	-3.6%
OCI	HMO	AECL	YM	9	422.34	143.66	0.7148	0.4823	371.18	517.68	0.6931	358.82	-3.3%
OCI	HMO	AGHF	YM	30	422.34	143.66	0.8790	0.4823	440.52	517.68	0.8171	422.99	-4.0%
OCI	HMO	AGHI	ZU	64	422.34	143.66	0.9101	0.5214	459.28	517.68	0.8583	444.32	-3.3%
OCI	HMO-HSA	FY9	YM	21	422.34	143.66	0.6812	0.0000	287.70	517.68	0.6063	313.84	9.1%
OCI	HMO-HSA	FZK	YM	5	422.34	143.66	0.8006	0.0000	338.13	517.68	0.6893	356.85	5.5%
UHCMA	NAVIGATE-HSA	6U1	YM	2	405.92	143.66	0.6483	0.0000	263.16	497.54	0.5257	261.54	-0.6%
UHCMA	NAVIGATE-HSA	6U2	YM	3	405.92	143.66	0.5250	0.0000	213.11	497.54	0.4882	242.89	14.0%
UHCMA	NAVIGATE-HSA	6U3	YM	1	405.92	143.66	0.6812	0.0000	276.51	497.54	0.6063	301.63	9.1%
UHCMA	NAVIGATE-HSA	6U4	YM	32	405.92	143.66	0.8006	0.0000	324.98	497.54	0.6893	342.97	5.5%
UHCMA	CORE-HSA	6UR	YM	1	418.47	143.66	0.6676	0.0000	279.37	497.54	0.5392	268.28	-4.0%
UHCMA	CORE-HSA	6UT	YM	3	418.47	143.66	0.8436	0.0000	353.02	497.54	0.7340	365.19	3.4%
UHCMA	NAVIGATE-HSA	6UY	YM	1	405.92	143.66	0.8315	0.0000	337.52	497.54	0.7120	354.23	5.0%
UHCMA	NAVIGATE-HSA	6UZ	YM	3	405.92	143.66	0.6676	0.0000	270.99	497.54	0.5230	260.23	-4.0%
UHCMA	NAVIGATE-HSA	AD7F	YM	6	405.92	143.66	0.6180	0.0000	250.86	497.54	0.5618	279.5	11.4%
UHCMA	NAVIGATE-HSA	AD7G	YM	2	405.92	143.66	0.5349	0.0000	217.13	497.54	0.4719	234.78	8.1%
UHCMA	NAVIGATE-HSA	AD7N	YM	5	405.92	143.66	0.6180	0.0000	250.86	497.54	0.5618	279.5	11.4%
UHCMA	NAVIGATE-HSA	FW5	YM	3	405.92	143.66	0.6812	0.0000	276.51	497.54	0.6063	301.63	9.1%
UHCMA	NAVIGATE-HSA	FW6	YM	5	405.92	143.66	0.8006	0.0000	324.98	497.54	0.6893	342.97	5.5%
UHIC	EPO	609	YM	34	451.91	143.66	0.7219	0.4823	395.52	553.92	0.6982	386.77	-2.2%
UHIC	EPO	60B	ZS	22	451.91	143.66	0.7000	0.4383	379.30	553.92	0.6702	371.25	-2.1%
UHIC	EPO	60J	YM	30	451.91	143.66	0.6882	0.4823	380.29	553.92	0.6767	374.86	-1.4%
UHIC	EPO	60N	ZT	2	451.91	143.66	0.6079	0.4238	335.60	553.92	0.5917	327.73	-2.3%
UHIC	EPO	60W	ZU	1	451.91	143.66	0.9057	0.5214	484.20	553.92	0.8583	475.43	-1.8%
UHIC	EPO	60Y	ZV	162	451.91	143.66	0.8676	0.4967	463.43	553.92	0.8325	461.12	-0.5%
UHIC	EPO	612	ZR	21	451.91	143.66	0.8679	0.4584	458.07	553.92	0.8048	445.82	-2.7%
UHIC	EPO	614	ZU	88	451.91	143.66	0.9057	0.5214	484.20	553.92	0.8583	475.43	-1.8%
UHIC	EPO	61D	ZS	102	451.91	143.66	0.7000	0.4383	379.30	553.92	0.6702	371.25	-2.1%
UHIC	EPO	61L	YM	60	451.91	143.66	0.6882	0.4823	380.29	553.92	0.6767	374.86	-1.4%
UHIC	EPO	61N	YM	13	451.91	143.66	0.7293	0.4823	398.87	553.92	0.7045	390.21	-2.2%
UHIC	EPO	61Q	ZT	1	451.91	143.66	0.6019	0.4212	332.51	553.92	0.5931	328.54	-1.2%
UHIC	EPO	61S	D0	43	451.91	143.66	0.6055	0.3796	328.16	553.92	0.5923	328.07	0.0%
UHIC	EPO	61U	ZT	12	451.91	143.66	0.5886	0.4212	326.50	553.92	0.5890	326.25	-0.1%
UHIC	EPO	61Y	YM	155	451.91	143.66	0.8677	0.4823	461.41	553.92	0.8116	449.56	-2.6%
UHIC	EPO	6Y4	ZV	6	451.91	143.66	0.8396	0.4967	450.78	553.92	0.8007	443.51	-1.6%
UHIC	EPO-HSA	6Y6	YM	16	451.91	143.66	0.6166	0.0000	278.65	553.92	0.5440	301.34	8.1%
UHIC	EPO-HSA	6Y7	YM	4	451.91	143.66	0.5250	0.0000	237.25	553.92	0.4882	270.42	14.0%
UHIC	EPO-HSA	6YO	YM	1	451.91	143.66	0.6166	0.0000	278.65	553.92	0.5440	301.34	8.1%
UHIC	EPO-HSA	6YQ	YM	1	451.91	143.66	0.5275	0.0000	238.38	553.92	0.4899	271.34	13.8%
UHIC	EPO-HSA	6YS	YM	1	451.91	143.66	0.7859	0.0000	355.16	553.92	0.6497	359.88	1.3%
UHIC	EPO-HSA	6YU	YM	4	451.91	143.66	0.6281	0.0000	283.84	553.92	0.5230	289.72	2.1%
UHIC	EPO-HSA	6YV	YM	5	451.91	143.66	0.6330	0.0000	286.06	553.92	0.5519	305.68	6.9%
UHIC	EPO-HSA	6YW	YM	9	451.91	143.66	0.6258	0.0000	282.81	553.92	0.5257	291.18	3.0%
UHIC	EPO	6Z3	ZV	9	451.91	143.66	0.8676	0.4967	463.43	553.92	0.8325	461.12	-0.5%
UHIC	EPO	6Z5	ZU	48	451.91	143.66	0.8898	0.5214	477.01	553.92	0.8430	466.93	-2.1%
UHIC	EPO	6Z7	YM	3	451.91	143.66	0.7219	0.4823	395.52	553.92	0.6982	386.77	-2.2%
UHIC	EPO-HSA	6ZL	YM	105	451.91	143.66	0.7859	0.0000	355.16	553.92	0.6497	359.88	1.3%
UHIC	EPO-HSA	6ZM	YM	42	451.91	143.66	0.8315	0.0000	375.76	553.92	0.7120	394.37	5.0%

License	Product	Med.	Rx	Members	Medical	Rx	Medical	Rx	PMPM	Med + Rx	Medical	PMPM	Chg.
UHIC	EPO-HSA	6ZN	YM	65	451.91	143.66	0.6281	0.0000	283.84	553.92	0.5230	289.72	2.1%
UHIC	EPO-HSA	6ZO	YM	6	451.91	143.66	0.6330	0.0000	286.06	553.92	0.5519	305.68	6.9%
UHIC	EPO-HSA	6ZP	YM	19	451.91	143.66	0.6258	0.0000	282.81	553.92	0.5257	291.18	3.0%
UHIC	EPO	6ZW	ZV	64	451.91	143.66	0.8396	0.4967	450.78	553.92	0.8007	443.51	-1.6%
UHIC	EPO	AD7I	YM	118	451.91	143.66	0.7655	0.4823	415.22	553.92	0.7273	402.84	-3.0%
UHIC	EPO	AD7P	D0	1	451.91	143.66	0.6037	0.3796	327.35	553.92	0.5910	327.35	0.0%
UHIC	EPO-HSA	AGH3	YM	2	451.91	143.66	0.8006	0.0000	361.80	553.92	0.6893	381.83	5.5%
UHIC	EPO-HSA	AHSY	YM	5	451.91	143.66	0.5349	0.0000	241.73	553.92	0.4719	261.39	8.1%
UHIC	EPO	F46	YM	14	451.91	143.66	0.8677	0.4823	461.41	553.92	0.8116	449.56	-2.6%
UHIC	EPO	F48	ZR	5	451.91	143.66	0.8679	0.4584	458.07	553.92	0.8048	445.82	-2.7%
UHIC	EPO	F51	YM	15	451.91	143.66	0.7630	0.4823	414.09	553.92	0.7279	403.21	-2.6%
UHIC	EPO-HSA	FW1	YM	89	451.91	143.66	0.8006	0.0000	361.80	553.92	0.6893	381.83	5.5%
UHIC	EPO-HSA	FW4	YM	1	451.91	143.66	0.5807	0.0000	262.42	553.92	0.5290	293.02	11.7%
UHIC	EPO-HSA	FWZ	YM	17	451.91	143.66	0.6812	0.0000	307.84	553.92	0.6240	345.64	12.3%
UHIC	EPO-HSA	FY4	YM	1	451.91	143.66	0.5807	0.0000	262.42	553.92	0.5290	293.02	11.7%
UHIC	POS	608	ZU	139	465.47	143.66	0.8898	0.5214	489.08	553.92	0.8601	476.44	-2.6%
UHIC	POS	60C	ZS	8	465.47	143.66	0.7000	0.4383	388.80	553.92	0.6859	379.92	-2.3%
UHIC	POS	60G	ZS	4	465.47	143.66	0.7163	0.4383	396.38	553.92	0.6973	386.26	-2.6%
UHIC	POS	60I	ZR	25	465.47	143.66	0.7135	0.4584	397.97	553.92	0.6982	386.75	-2.8%
UHIC	POS	60K	YM	44	465.47	143.66	0.6882	0.4823	389.62	553.92	0.6926	383.64	-1.5%
UHIC	POS	60M	YM	9	465.47	143.66	0.7293	0.4823	408.75	553.92	0.7204	399.03	-2.4%
UHIC	POS	60R	D0	3	465.47	143.66	0.6055	0.3796	336.38	553.92	0.6055	335.38	-0.3%
UHIC	POS	60T	ZT	9	465.47	143.66	0.6015	0.4238	340.86	553.92	0.6022	333.56	-2.1%
UHIC	POS	60V	ZT	2	465.47	143.66	0.5952	0.4212	337.56	553.92	0.6066	335.99	-0.5%
UHIC	POS	60X	ZU	98	465.47	143.66	0.9057	0.5214	496.48	553.92	0.8755	484.93	-2.3%
UHIC	POS	60Z	ZV	519	465.47	143.66	0.8676	0.4967	475.20	553.92	0.8325	461.12	-3.0%
UHIC	POS	613	ZR	245	465.47	143.66	0.8679	0.4584	469.84	553.92	0.8194	453.89	-3.4%
UHIC	POS	615	ZU	1188	465.47	143.66	0.9057	0.5214	496.48	553.92	0.8755	484.93	-2.3%
UHIC	POS	61A	YM	442	465.47	143.66	0.7219	0.4823	405.31	553.92	0.7141	395.53	-2.4%
UHIC	POS	61E	ZS	56	465.47	143.66	0.7000	0.4383	388.80	553.92	0.6859	379.92	-2.3%
UHIC	POS	61G	ZT	37	465.47	143.66	0.7059	0.4212	389.08	553.92	0.6865	380.27	-2.3%
UHIC	POS	61I	ZS	102	465.47	143.66	0.7163	0.4383	396.38	553.92	0.6973	386.26	-2.6%
UHIC	POS	61K	ZR	38	465.47	143.66	0.7135	0.4584	397.97	553.92	0.6982	386.75	-2.8%
UHIC	POS	61M	YM	81	465.47	143.66	0.6882	0.4823	389.62	553.92	0.6926	383.64	-1.5%
UHIC	POS	61O	YM	257	465.47	143.66	0.7293	0.4823	408.75	553.92	0.7204	399.03	-2.4%
UHIC	POS	61T	D0	36	465.47	143.66	0.6055	0.3796	336.38	553.92	0.6055	335.38	-0.3%
UHIC	POS	61X	ZT	18	465.47	143.66	0.5952	0.4212	337.56	553.92	0.6066	335.99	-0.5%
UHIC	POS	61Z	YM	665	465.47	143.66	0.8677	0.4823	473.18	553.92	0.8262	457.64	-3.3%
UHIC	POS-HSA	6Y1	YM	5	465.47	143.66	0.6281	0.0000	292.36	553.92	0.5389	298.51	2.1%
UHIC	POS-HSA	6Y3	YM	17	465.47	143.66	0.6453	0.0000	300.37	553.92	0.5657	313.36	4.3%
UHIC	POS	6Y5	ZV	12	465.47	143.66	0.8396	0.4967	462.16	553.92	0.8007	443.51	-4.0%
UHIC	POS-HSA	6YY	YM	47	465.47	143.66	0.7875	0.0000	366.56	553.92	0.6689	370.54	1.1%
UHIC	POS-HSA	6YZ	YM	12	465.47	143.66	0.8315	0.0000	387.04	553.92	0.7324	405.69	4.8%
UHIC	POS	6Z4	ZV	66	465.47	143.66	0.8643	0.4967	473.66	553.92	0.8325	461.12	-2.6%
UHIC	POS	6Z6	ZU	72	465.47	143.66	0.8898	0.5214	489.08	553.92	0.8601	476.44	-2.6%
UHIC	POS	6Z8	YM	16	465.47	143.66	0.7219	0.4823	405.31	553.92	0.7141	395.53	-2.4%
UHIC	POS-HSA	6ZQ	YM	13	465.47	143.66	0.6166	0.0000	287.01	553.92	0.5596	309.98	8.0%
UHIC	POS-HSA	6ZR	YM	112	465.47	143.66	0.7859	0.0000	365.81	553.92	0.6689	370.54	1.3%
UHIC	POS-HSA	6ZS	YM	330	465.47	143.66	0.8315	0.0000	387.04	553.92	0.7324	405.69	4.8%

Total January, 2016 membership in ACA plans:	7135
Average 2016Q4 rate PMPM using the current pricing model:	435.77
Average rate PMPM using the new pricing model & the proposed 2017Q1 base rates:	427.80
Average Rate Change:	-1.8%

Exhibit A

Member Months, Earned Premium & Incurred Claim Experience - OCI

Month	Members	Earned Premium	Incurred Claims	Claim PMPM	Loss Ratio
Jan-13	1,625	801,873	377,927	232.57	47.1%
Feb-13	934	581,897	292,495	313.16	50.3%
Mar-13	1,176	593,549	196,039	166.70	33.0%
Apr-13	1,208	627,831	388,842	321.89	61.9%
May-13	1,165	486,051	296,820	254.78	61.1%
Jun-13	1,385	734,235	307,808	222.24	41.9%
Jul-13	1,523	783,970	430,415	282.61	54.9%
Aug-13	2,356	1,132,497	697,552	296.07	61.6%
Sep-13	2,392	1,210,102	683,667	285.81	56.5%
Oct-13	2,065	812,580	497,509	240.92	61.2%
Nov-13	2,280	1,144,436	361,338	158.48	31.6%
Dec-13	3,074	1,513,246	946,534	307.92	62.5%
Jan-14	1,764	867,963	692,623	392.64	79.8%
Feb-14	1,758	861,656	483,819	275.21	56.1%
Mar-14	1,743	852,874	550,057	315.58	64.5%
Apr-14	1,687	829,330	438,066	259.67	52.8%
May-14	1,673	820,533	600,810	359.12	73.2%
Jun-14	1,569	782,153	702,873	447.98	89.9%
Jul-14	1,545	769,164	531,796	344.20	69.1%
Aug-14	1,554	757,595	477,476	307.26	63.0%
Sep-14	1,519	739,211	420,456	276.80	56.9%
Oct-14	1,401	697,836	335,377	239.38	48.1%
Nov-14	1,322	644,564	341,309	258.18	53.0%
Dec-14	1,191	575,961	309,247	259.65	53.7%
Jan-15	1,189	555,999	244,869	205.95	44.0%
Feb-15	1,140	528,938	196,508	172.38	37.2%
Mar-15	1,138	519,866	342,842	301.27	65.9%
Apr-15	1,133	517,622	322,456	284.60	62.3%
May-15	1,095	500,633	211,369	193.03	42.2%
Jun-15	1,086	488,730	232,714	214.29	47.6%
Jul-15	1,068	478,793	407,694	381.74	85.2%
Aug-15	1,055	468,681	231,046	219.00	49.3%
Sep-15	1,075	469,624	268,724	249.98	57.2%
Oct-15	1,078	467,531	220,263	204.33	47.1%
Nov-15	1,054	456,104	221,891	210.52	48.6%
Dec-15	1,044	436,362	186,683	178.82	42.8%
2015 Total	13,155	5,888,884	3,087,060	234.67	52.4%

Certification for AV Calculator

Exhibit B

Estimation of fit of plan design into the parameters of AV calculator

Metallic Plan (e)	Imaging (CT/PET Scans, MRIs)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Specialty Drugs (i.e. high-cost)	Methodology
Bronze 1			$100.00	d, e
Bronze 3			$100.00	d, e
Bronze 4			$100.00	d, e
Silver 2			$100.00	d, e
Silver 3			$100.00	d, e
Silver 4			$100.00	d, e
Silver 5			$100.00	d, e
Silver 7	95.5%	95.8%	$100.00	b, c, d, e
Silver 8	95.5%	95.8%	$100.00	b, c, d, e
Silver 9	95.5%	95.8%	$100.00	b, c, d, e
Silver 10	95.5%	95.8%	$100.00	b, d, e
Silver 11	74.4%	96.1%	$100.00	a, b, c, d, e
Silver 13	59.5%	76.9%	$100.00	a, b, d, e
Silver 14	59.5%	76.9%	$100.00	a, b, d, e
Gold 1			$100.00	d, e
Gold 3	96.2%	96.5%	$100.00	b, c, d, e
Gold 4	95.4%	95.8%	$100.00	b, c, d, e
Gold 5	97.7%	97.9%	$100.00	b, c, d, e
Gold 6	97.7%	97.9%	$100.00	b, c, d, e
Gold 7			$100.00	d, e
Gold 8		76.9%	$100.00	b, c, d, e
Gold 9		86.5%	$100.00	b, c, d, e
Gold 10	58.9%	76.9%	$100.00	a, b, c, d, e
Gold 11	84.2%	97.7%	$100.00	b, c, d, e
Gold 12	67.3%	78.2%	$100.00	a, b, c, d, e
Gold 13	73.6%	96.1%	$100.00	a, b, c, d, e
Gold 15	58.9%	76.9%	$100.00	a, b, d, e
Gold 16	73.6%	96.1%	$100.00	a, b, d, e
Gold 17	96.2%	96.5%	$100.00	b, c, d, e
Gold 18	96.2%	96.5%	$100.00	b, c, d, e
Gold 19	96.2%	96.5%	$100.00	b, c, d, e
Platinum 1	72.1%	97.3%	$100.00	a, b, c, d, e
Platinum 2	64.1%	95.7%	$100.00	b, c, d, e
Platinum 3			$100.00	d, e
Platinum 4	83.3%	98.4%	$100.00	b, c, d, e
Platinum 5	64.9%	95.8%	$100.00	b, c, d, e
Platinum 6	82.0%	96.8%	$100.00	b, c, d, e
Platinum 11	83.3%	98.4%	$100.00	b, c, d, e
Platinum 12			$75.00	d, e
Platinum 13		98.4%	$75.00	b, d, e
Platinum 14			$75.00	d, e
Platinum 15	72.1%	97.3%	$100.00	a, b, d, e

Methodology

a) An effective coinsurance for Per-Occurrence Deductibles on Imaging services was calculated based on unit costs derived from UnitedHealthcare's proprietary pricing model.

b) Actuarial Value Calculator does not support outpatient copay, company's data was used to estimate effective coinsurance factor.

c) Actuarial Value is the blend of Free-Standing and Hospital setting run, where weight of Free Standing and Hospital Setting are adjusted based on actual utilization of free standing and hospital facilities by service categories.

d) Speciality Rx: Entered the Rx Tier cost share with the highest specialty drug utilization per UnitedHealthcare's proprietary pricing model.

e) See Exhibit 2 for plan benefit description, and for tie-in to benefit plan name.

Certification

For plan design features that do not fit into the parameters of the AV Calculator, I certify that both the methodology and the calculated estimated values are in accordance with generally accepted actuarial principles and methodologies.

Boris P. Gerber

Boris P. Gerber, FSA, MAAA

Exhibit C

Explanation of PPACA Fees
and Development of Fee Effective Date Adjustment Factors by Quarter

The Patient Protection and Affordable Care Act (PPACA) includes several taxes and fees which will increase health insurance costs and need to be reflected in premium.

Insurer Fee. This is a permanent fee that applies to fully insured coverage. This fee will fund tax credits for insurance coverage purchased on the exchanges. The total fee increases from $11.3B in 2016 to $14.3B in 2018 (indexed to premium for subsequent years.) Each insurance carrier's assessment will be based on net written health insurance premiums in the prior year, with certain exclusions. Using net premium estimates provided by Oliver Wyman, and premium growth estimates for 2017-2018 provided by Wakely, the estimated 2018 fee is $14.3B / $721.1B = 1.983%. The fee must then be grossed up for federal income tax, since the member fee is not a tax deductible expense: 1.983% / 63% FIT = 3.15%. The Dec-15 Omnibus Appropriations Act included a one year moratorium on the insurer fee for calendar year 2017. For policy periods with effective or renewal dates in 2017, this fee will be applied to the premiums that fall in the 2018 calendar year. For policy periods that become effective on January 1, 2017 no insurer fee will be required, because the entire policy year premiums are in the 2017 calendar year. For policy year periods that begin on February 1, 2017, one of the 12 months of premium is in calendar year 2018, requiring an insurer fee of 1/12 x 3.15% = 0.26%. Similarly, later policy period start dates in 2017 require a higher fee, as more of the premium is in calendar year 2018. The chart below details the needed fee by policy period effective month.

PCORI Fee. A $0.18 pmpm fee for 2015 was released in October 2015. Increases for future years will be based on the growth in National Health Expenditures (NHE). Using the 4% NHE growth that was used to develop the 2015 fee, the 2017 fee is estimated to be $0.20 pmpm, or an estimated 0.04% of premium.

Risk Adjustment Fee. The fee pmpm for 2017 of $0.15 pmpm is from the proposed 2017 CMS Notice of Benefit and Payment Parameters released in November 2015. The $0.15 pmpm represents an estimated 0.03% of premium.

Policy Period Effective Date	# Months in 2018 Year	Fees by Policy Period Effective Date				2017 Qtr	Average Fee Per Quarter	Fee Included in 1Q17 Base Rate	Additional Fee Required	Fee Effective Date Factor
		PCORI Fee	Risk Adj. Fee	Insurer Fee	Total					
1/1/17	0	0.04%	0.03%	0.00%	0.07%					
2/1/17	1	0.04%	0.03%	0.26%	0.33%	1Q17	0.33%	0.33%	0.00%	1.0000
3/1/17	2	0.04%	0.03%	0.53%	0.60%					
4/1/17	3	0.04%	0.03%	0.79%	0.86%					
5/1/17	4	0.04%	0.03%	1.05%	1.12%	2Q17	1.12%	0.33%	0.79%	1.0079
6/1/17	5	0.04%	0.03%	1.31%	1.38%					
7/1/17	6	0.04%	0.03%	1.58%	1.65%					
8/1/17	7	0.04%	0.03%	1.84%	1.91%	3Q17	1.91%	0.33%	1.58%	1.0158
9/1/17	8	0.04%	0.03%	2.10%	2.17%					
10/1/17	9	0.04%	0.03%	2.36%	2.43%					
11/1/17	10	0.04%	0.03%	2.63%	2.70%	4Q17	2.70%	0.33%	2.36%	1.0236
12/1/17	11	0.04%	0.03%	2.89%	2.96%					
1/1/18	12	0.04%	0.03%	3.15%	3.22%					

Exhibit D

DC Small Group - Development of Underwriting Loss Ratio

Total for UHIC, UHCMA and OCI

Experience 1/1/15-16	
1a. Member Months	105,961
1b. Incurred Claims	$32,032,626
1c. Claim PMPM (1b/1a)	$302.31
1d. Earned Premium	$46,958,631
1e. Premium PMPM (1d/1a)	$443.17
1f. Loss Ratio (1c/1e)	68.2%
2a. Claim trend	1.154
From center of experience period: 7/1/15	
to average center of 1/1/17 pricing period: 7/1/17, 8/1/17, 9/1/17	
(25 months at 7.1 % annual rate)	
2b. Total Claim Cost (1c x 2a)	$348.74
2c. Admin, Profit & Taxes	$95.71
2d. Needed revenue PMPM (2b + 2c)	$444.45
2e. Risk Adjustment (2.3% Payer)	$10.46
2f. Needed Revenue PMPM 1/1/17 eff	$454.92
3a. Proposed DCSG Total 1Q17 Medical Base Rate*	$449.98
3b. Current Average Med Plan Rel	0.8127
3c. Proposed DCSG Total 1Q17 Rx Base Rate*	$141.00
3d. Current Average Rx Plan Rel	0.4187
3e. Current Average Age Factor	1.071
3f. Current premium PMPM for 1/1/17 effective date	
(3a x 3b + 3c x 3d) x 3e	$454.91
4. Estimated Underwriting Loss Ratio (2b/2d)	78.5%

**Since our 2015 pricing experience is based on our current pricing methodology, this exhibit is using our current pricing methodology of two base rates (med and Rx) and two pricing relativities (Med and Rx). Please see Exhibit 6 for 2017 pricing methodology changes.*

UnitedHealthcare

Exhibit T

Healthcare Economics

WASHINGTON DC SMALL GROUP PRICING TREND DEVELOPMENT
RATE FILING SUPPORT

WASHINGTON DC SMALL GROUP PRICING TREND BY COMPONENT

	Notes:	Inpatient	Outpatient	Professional	Other	Capitation	Total Medical	Retail Pharmacy	Weighted Aggregate
Component Summary									
Utilization / Service Mix	[1] , [2]	0.4%	4.2%	1.8%	-0.5%	0.0%	1.9%	5.6%	**2.6%**
Unit Cost	[3]	4.5%	4.5%	1.9%	2.9%	2.5%	3.3%	4.8%	**3.6%**
Demographic Change	[5]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Benefit Leveraging	[4]	0.2%	0.7%	0.6%	0.7%	0.0%	0.5%	1.5%	**0.7%**
Margin		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Total Proposed Pricing Trend	[6]	**5.1%**	**9.6%**	**4.4%**	**3.2%**	**2.5%**	**5.9%**	**12.3%**	**7.1%**
Service Weight - Washington DC		18.7%	22.8%	30.6%	6.0%	2.5%	80.6%	19.4%	100.0%

Notes:

[1] Represents core utilization only, exclusive of demographic change impacts; includes expected impact of changes in business day content.
[2] Represents expected changes in intensity of services provided.
[3] Represents core unit pricing increases, exclusive of service mix / intenisty of services impact;
[4] Impact of member cost-share leveraging on net claims cost trend.
[5] Represents trend impact of age and gender changes; No provision included for Small Group business (age/gender community rating variable).
[6] Pricing models do not distinguish between Primary and Specialty medical care; same trends shown for both.

State: District of Columbia **Filing Company:** Optimum Choice, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only - Other
Product Name: DC-SG-OCI-2017-01
Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	PartIII-DC-OCI-2017-01.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	DC-SG-OCI-ActMemo-2017-01 (2016-04-20).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	PartIII-DC-OCI-2017-01.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	NA
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	required documentation is not yet available.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter All Filings
Comments:	
Attachment(s):	DC-SG-OCI-Cover-2017-01 (2016-04-20).pdf
Item Status:	
Status Date:	

State: District of Columbia **Filing Company:** Optimum Choice, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004E Small Group Only - Other
Product Name: DC-SG-OCI-2017-01
Project Name/Number: /

Satisfied - Item:	DISB Actuarial Memorandum Dataset
Comments:	
Attachment(s):	DISB Actuarial Memo Dataset -OCI.xlsx
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	NA
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	NA
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	DC_75753_OCI_on_SG_URRT_V01_04-25-2016_2016042616419.xml DC_75753_OCI_on_SG_URRT_V01_04-25-2016.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	District of Columbia Plain Language Summary
Comments:	
Attachment(s):	Part_II_Justification_Plain_Language_Summary_OCI.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Review Checklist
Comments:	
Attachment(s):	Checklist-UnitedHealthcare-2017-01.pdf
Item Status:	
Status Date:	

Attachment DISB Actuarial Memo Dataset -OCI.xlsx is not a PDF document and cannot be reproduced here.

Attachment DC_75753_OCI_on_SG_URRT_V01_04-25-2016_2016042616419.xml is not a PDF document and cannot be reproduced here.

Attachment DC_75753_OCI_on_SG_URRT_V01_04-25-2016.xlsx is not a PDF document and cannot be reproduced here.

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For Optimum Choice, Inc.

District of Columbia Rate Review

Purpose: The purpose of this rate filing is to comply with DC and Federal requirements. This filing is to outline manual base rates and rating factors compliant to the Patient Protection and Affordable Care Act (PPACA) Adjusted Community Rating requirements on non-grandfathered PPACA compliant small group policies. This filing may not be appropriate for other purposes.

This rate adjustment is for both new business and existing business with renewal dates on or after the effective date of the changes.

Company Identifying Information:

- **Company Legal Name:** Optimum Choice, Inc**.**
- **State:** District of Columbia
- **HIOS Issuer ID:** 75753
- **Market:** Small Group
- **Effective Date:** 1/1/2017

Company Contact Information:

- **Primary Contact Name:** Boris Gerber
- **Primary Contact Telephone Number:** 860-702-5540
- **Primary Contact Email Address:** boris_gerber@uhc.com

Proposed Rate Increase: Optimum Choice, Inc. is filing for revised medical and pharmacy base rates, and plan rating factors that comply with the requirements of PPACA.

The proposed rate changes are as below.

BASE PREMIUM RATES

Medical base rates have been revised due to favorable changes in emerging experience. The rates reflect the needed revenue to cover Essential Health Benefit requirements and other healthcare reform related costs. Base premium rates are provided in Exhibit 1.

AGE FACTORS

Age factors are provided in Exhibit 1. There are no changes from the age factors in our prior 2016 filings.

PRICING TREND

Pricing trend is being reduced to reflect favorable changes in projected claims trends.

Pricing trend is provided in Exhibit 1.

RATING FORMULA:

The rating formula for non-grandfathered small employer group business is shown below:

Base Rate x Plan Ratio x Effective Date Adjustment Factor (EDA) x Age Factor = Final Health Premium Rate

PLAN DESIGNS AND RATING FACTORS

This rate filing includes some PPACA compliant plans from last year's filing. The plan designs with plan relativities and actuarial value metal tiers are provided in Exhibits 1 and 2. Pharmacy plan details are included on Exhibit 2. All listed plans are designed based on the final Market Reform Rule requirements.

Actuarial Value calculations have been conducted to ensure actuarial values are within the allowed range for each metal tier. The metal tier for each plan has been provided in Exhibit 1. Mental Health Parity testing has been conducted, and final plan designs will ensure compliance.

All plans have been priced on an actuarially equivalent basis, based on the final Market Reform Rule requirement. The plan-specific adjustments to the market-wide index rate (plan relativities) do not reflect differences in health status or risk selection.

Experience Period Premiums and Claims:

- **Paid Through Date:** The experience period is 1/1/2015 to 12/31/2015 paid through 2/29/2016.
- **Premiums (net of MLR Rebate) in Experience Period:** Earned premium for the experience period, net of rebate, was $5,328,800. The estimated MLR rebate payment attributable to the Small Group business on this license is $560,084.
- **Allowed and Incurred Claims Incurred During the Experience Period:** Incurred claims were developed by first starting with actual claims paid through 2/29/2016 by incurred date. To these paid claims estimates of incurred but not paid were added. Here is a description of the reserve methodology:

The UnitedHealthcare Reserving process utilizes the Reserve Production System (RPS) to record reserves into the PeopleSoft general ledger. Fee for service and paid claim data is loaded into RPS and becomes the basis for the monthly reserve calculations at the various business unit, location, and line of business levels. The assignment of the paid claims into RPS packages is based on the mapping rules maintained by the Corporate Actuarial department. RPS calculates a preliminary best estimate Incurred But Not Reported (IBNR) for each reserving model (package) primarily using standard completion factors based on historical claim experience. The Claims Reserving Team adjusts the preliminary IBNR based on specific knowledge of the entity (i.e. catastrophic claims, pended claims, etc.) to calculate the final IBNR. In months where adjudicated claims experience is not complete enough for an estimate using completion factors, a seasonally adjusted PMPM is used to estimate incurred claims.

A description of the Sarbanes Oxley controls, audited by Deloitte & Touche, in place regarding the reserving process include:

1) Market Paid claim Tie-outs: To verify completeness and accuracy of financial data in RPS, paid claim data is tied out between source system (RPS) and PeopleSoft general ledger.
2) Market Expense Tie-outs: RPS reserve changes on the income statement are tied to the PeopleSoft general ledger to ensure that information is accurate subsequent to computing the reserve.

- Allowed claims by benefit category were obtained from UnitedHealthcare claim paying system reports.

Benefit Categories: Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

Projection Factors:

- **Changes in the Morbidity of the Population Insured:** No changes in morbidity are assumed.
- **Changes in Benefits:** No benefit changes are assumed.
- **Changes in Demographics:** No changes in demographics are assumed. The age factors adopted by the District of Columbia are used in rating.
- **Trend Factors:** UnitedHealthcare Medical Expense Forecasting Process Overview & Considerations:

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, benefit leveraging, and business mix identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also

consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence mix of procedures.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Business mix changes that influence medical cost trends are also reviewed and projected, with appropriate input from sales and underwriting staff. These factors include changing mix of employer groups, mix of benefits, and demographic changes. For the purposes of developing premium pricing trend projections, the component of trend attributable to business mix is excluded.

Credibility Manual Rate Development:

- **Source and Appropriateness of Experience Data Used:** The experience period source data used to develop manual rates is the actual total combined experience for UnitedHealthcare Insurance Company, Optimum Choice, Inc., and UnitedHealthcare of the Mid-Atlantic, Inc. in DC for employers with 2-50 employees.

Credibility of Experience: We have set our rate levels based on the combined experience of UnitedHealthcare Insurance Company and Optimum Choice, Inc. in DC with 105,961 member months in the experience period. For the base rate development purpose, we regard it to be fully credible.

Paid to Allowed Ratio: The paid to allowed average factor in the projection period is set to be consistent with the overall estimates of projected revenue and claims per member per month based on the projected membership.

Risk Adjustment and Reinsurance:

- **Projected Risk Adjustments (PMPMs):** Based on analysis done in conjunction with a national actuarial consulting firm, we estimate we will be a 2.3% risk payer in total for our small group licenses, this is assumed in the underwriting loss ratio development.

- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** No reinsurance recoveries are assumed.

Non-Benefit Expenses and Risk Margin: The expenses assumed in the development of the proposed rates are as follows: The administrative expenses are the total average expenses for the small group licenses. Except for the addition of PPACA fees, they are forecasted 2016 year expenses that are expected to continue in the future.

% of Premium	Expense Category
11.4%	Admin Expenses
4.2%	Profit
5.9%	Taxes & Fees
21.5%	Total

Projected Loss Ratio: The projected loss ratio using Federally prescribed MLR methodology is 83.9%.

Single Risk Pool:

The Single Risk Pool reflects all covered lives for every non-grandfathered product and is established according to the requirements in 45 CFR part 156.80(d) which includes all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act. The Single Risk Pool is specific to the legal entity and the state of this filing.

Index Rate:

The development of the Index Rate for Projection Period is shown in the table below. The Projected Allowed Claims for 1Q17 is the Projected Allowed Experience Claims from Section III. The Index Rate is then member weighted average for each effective date.

Projected Allowed Claims PMPM (for 1/1/2017 Renewals)			$441.51	
Projected Allowed Trend - Annualized			6.3%	
Quarterly Allowed Trend			1.5%	
Renewal Quarter	**Renewal Quarter Distribution**	**Index Rate By Renewal Quarter**	**Weighted ACA Reins. Fees & Risk Adj. Pmts**	**Market Adj. Index Rate By Renewal Quarter**
2017Q1	20.2%	$442.60	$15.80	$458.39
2017Q2	12.9%	$450.94	$15.80	$466.73
2017Q3	27.8%	$457.87	$15.80	$473.67
2017Q4	39.0%	$466.07	$15.80	$481.87
Total	**100.0%**	**$457.08**	**$15.80**	**$472.88**

Plan Adjusted Index Rate:

Plan Adjusted Index Rates are provided in the URRT Part I. The adjustments that have been applied to the development of the Plan Adjusted Index Rates include:

Provider Network: these adjustment factors are developed based on the underlining provider network features, contract terms, utilization and cost patterns due to the network features.

Actuarial Value and Cost Sharing: These values are developed with the method identified in the sections below and applied to each plan accordingly.

Distribution and Administrative Cost: This adjustment is developed based on the method described in the "Non-Benefit Expense and Profit & Risk" section. The same adjustment has been applied to all plans to develop the Plan Adjusted Index Rate.

The formula to develop the Plan Adjusted Index Rate is as below:

Plan Adjusted Index Rate= (Market Adjusted Index Rate X Provider Network Savings X Actuarial Value and Cost Sharing)/(1- Distribution and Administrative Cost).

Index Rate to Consumer Rate for Sample Plans

	Platinum	Gold	Silver
Plan Name	**OCI AE-CM**	**OCI AL-EJ**	**OCI AL-EK**
2017 Effective Date	1Q17	1Q17	1Q17
Index Rate	**$457.08**	**$457.08**	**$457.08**
Risk Adjustment and maketplace user fee	-3.5%	-3.5%	-3.5%
Reinsurance Assessment	0.00	0.00	0.00
Market Adjusted Index Rate	**$472.88**	**$472.88**	**$472.88**
Provider Network Savings1	1.000	1.000	1.000
Benefit Extra EHB	1.000	1.000	1.000
Actuarial Value and Cost Sharing2	0.8372	0.7032	0.5665
Distribution And Administrative cost	19.5%	19.5%	19.5%
Plan Adjusted Index Rate	**$492.10**	**$413.30**	**$332.99**
Calibration			
Age Factor Calibration	1.1270	1.1270	1.1270
Area Factor Calibration	1.000	1.000	1.000
Tobacco Factor Calibration	0.000	0.000	0.000
Calibrated PAIR without Normalization	$436.66	$366.74	$295.47
Trend Normalization			
Removal of average Trend for 1/1/2017 BR	1.0392	1.0392	1.0392
Calibrated Plan Adjusted Index Rate	$420.18	$352.90	$284.32
Actual Q1 Consumer Rate (age 21) after applying trend	**$422.99**	**$355.26**	**$286.22**

Calibration:

Age Curve Calibration is calculated as the premium weighted average age rating factors (based on the DC Age Scale) in experience period. The factor is calculated to be 1.069. This age curve value translates to a weighted average age of 43 years old.

Geographic Factor Calibration is calculated as the premium weighted average rating area factors (based ACR compliant rating area setting) in experience period. The factor is calculated to be 1.000.

Description of development of geographic rating factors

Geographic area rating factors are not used in pricing, which represents no change from the previously approved area factors.

The calibration factors are applied uniformly to all plans.

Calibrated Plan Adjusted Index Rate

Consumer Adjusted Premium Rate is developed with the formula below:

Consumer Adjusted Premium Rate = Plan Adjusted Index Rate x 1/ Age Curve Calibration X 1/ Geographic Factor Calibration X Age 21 Age Factor

Member level plan premium rate information is provided in Rate Data Template.

AV Metal Values: The below actuarial certification describes the methodology and the AV calculator input values used for the plan design features that do not fit into the parameters of the AV calculator.

The AV metal value was calculated using the Federal AV calculator. For the benefit designs that cannot be directly coded in the Federal AV calculator, claim distribution information provided in the Federal AV calculator has been used to convert the benefit design in to equivalent benefit designs that can be coded in the Federal AV calculator.

Certification for AV Calculator

Exhibit B

Estimation of fit of plan design into the parameters of AV calculator

Metallic Plan (e)	Imaging (CT/PET Scans, MRIs)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Specialty Drugs (i.e. high-cost)	Methodology
Bronze 1			$100.00	d, e
Bronze 3			$100.00	d, e
Bronze 4			$100.00	d, e
Silver 2			$100.00	d, e
Silver 3			$100.00	d, e
Silver 4			$100.00	d, e
Silver 5			$100.00	d, e
Silver 7	95.5%	95.80%	$100.00	b, c, d, e
Silver 8	95.5%	95.80%	$100.00	b, c, d, e
Silver 9	95.5%	95.80%	$100.00	b, c, d, e
Silver 10	95.5%	95.80%	$100.00	b, d, e
Silver 11	74.4%	96.10%	$100.00	a, b, c, d, e
Silver 13	59.5%	76.9%	$100.00	a, b, d, e
Silver 14	59.5%	76.9%	$100.00	a, b, d, e
Gold 1			$100.00	d, e
Gold 3	96.2%	96.48%	$100.00	b, c, d, e
Gold 4	95.4%	95.77%	$100.00	b, c, d, e
Gold 5	97.7%	97.89%	$100.00	b, c, d, e
Gold 6	97.7%	97.89%	$100.00	b, c, d, e
Gold 7			$100.00	d, e
Gold 8		76.92%	$100.00	b, c, d, e
Gold 9		86.53%	$100.00	b, c, d, e
Gold 10	58.9%	76.92%	$100.00	a, b, c, d, e
Gold 11	84.2%	97.69%	$100.00	b, c, d, e
Gold 12	67.33%	78.15%	$100.00	a, b, c, d, e
Gold 13	73.60%	96.15%	$100.00	a, b, c, d, e
Gold 15	58.88%	76.92%	$100.00	a, b, d, e
Gold 16	73.60%	96.15%	$100.00	a, b, d, e
Gold 17	96.18%	96.48%	$100.00	b, c, d, e
Gold 18	96.18%	96.48%	$100.00	b, c, d, e
Gold 19	96.18%	96.48%	$100.00	b, c, d, e
Platinum 1	72.09%	97.30%	$100.00	a, b, c, d, e
Platinum 2	64.1%	95.67%	$100.00	b, c, d, e
Platinum 3			$100.00	d, e
Platinum 4	83.3%	98.38%	$100.00	b, c, d, e
Platinum 5	64.9%	95.83%	$100.00	b, c, d, e
Platinum 6	82.0%	96.81%	$100.00	b, c, d, e
Platinum 11	83.25%	98.38%	$100.00	b, c, d, e
Platinum 12			$75.00	d, e
Platinum 13		98.38%	$75.00	b, d, e
Platinum 14			$75.00	d, e
Platinum 15	72.09%	97.30%	$100.00	a, b, d, e

Methodology

a) An effective coinsurance for Per-Occurrence Deductibles on Imaging services was calculated based o
UnitedHealthcare's proprietary pricing model.

b) Actuarial Value Calculator does not support outpatient copay, company's data was used to estimate

c) Actuarial Value is the blend of Free-Standing and Hospital setting run, where weight of Free Standing and H
adjusted based on actual utilization of free standing and hospital facilities by service categories.

d) Speciality Rx: Entered the Rx Tier cost share with the highest specialty drug utilization per UnitedHealthca
pricing model.

e) See Exhibit 2 for plan benefit description, and for tie-in to benefit plan name.

Certification

For plan design features that do not fit into the parameters of the AV Calculator, I certify that both the r
calculated estimated values are in accordance with generally accepted actuarial principles and methodo

Boris P. Gerber

Boris P. Gerber, FSA, MAAA

AV Pricing Values:

Plans are priced through the proprietary UnitedHealthcare pricing model. The model, which was updated for January 1, 2017 pricing, uses UHC fully-insured national small-group claim experience for groups that were in force for all of calendar-year 2013 and is fully-credible. Current claim data is then projected to the pricing period based on national projections of utilization, unit cost, and sloping. These projections are done at the service category (inpatient, outpatient, etc.) level.

At this point, benefit design parameters such as deductibles, copays, coinsurance, etc. are applied to the claim distributions of the matching service category. This cost-sharing is applied, and the values of each service category are summed to come up with the overall benefit value. This overall benefit value is then compared to a base benefit design to calculate the plan relativity.

In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

Membership Projections: Membership is projected to be the same as 2015, and will be distributed to plans based on current metal level, network and area distribution during experience period.

Terminated Plans and Products: No products are being terminated. No plans are terminated from plan year 2016 to 2017.

Plan Type: Not applicable.

Warning Alerts:

Line 55: The average premium PMPM does not match the member weighted Plan Adjusted Index Rate in the experience period. The differential is caused by a high proportion of experience in non-single risk pool compliant plans for which 0 is entered as the Plan Adjusted Index Rate for these plans.

Line 81 and 83: The small group Plan Adjusted Index Rates reflects the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate. The warning in line 83 is caused by Line 81.

Reliance: Not applicable.

Actuarial Certification:

I, Boris P. Gerber am an actuary of UnitedHealthcare and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),

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, and

d. Neither excessive nor deficient.

I certify that 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.

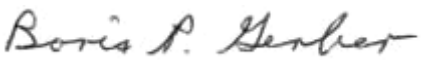
I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135. Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable to individuals in the actuarial value calculation.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is described in detail in my state submitted actuarial memorandum. 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.

Sincerely,



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Date: 4/28/2016

Actuarial Memorandum
Optimum Choice, Inc., NAIC #96940
DC Small Group Rate Filing

April 29, 2016

This rate filing presents proposed premium rates effective January 1, 2017 through December 31, 2017 for medical and Rx benefit plans to be sold by Optimum Choice, Inc. to small group employers.

The filing has been prepared as required by the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", as well as current ACA rules and more recent guidance from the DC Department of Insurance. This rate filing should not be used for any other purposes. Within that context, there are no limitations or constraints on the use or applicability of the rating items discussed herein. The intended user of this filing is the DC Department of Insurance.

The benefit plans and rates are for non-grandfathered employers. The proposed rates and rate factors are in Exhibit 1, which also displays the metal level and actuarial value of each benefit plan. Benefit plan descriptions are in Exhibit 2. Exhibit 4 identifies 2016 benefit plans with plan changes (uniform modification).

Responding to the items in the DC Rate Filing Checklist:

1. Purpose of Filing. UnitedHealthcare is filing for the first time rates for 2017. We are proposing to set our 1st quarter 2017 rates on average 1.8% lower than our current 4th quarter 2016 rates. The proposed 1st quarter 2017 rates are on average 1.3% lower than our 1st quarter 2016 rates. The rate changes vary by benefit plan as we have realigned our price relationships between plans. In addition, we are filing for quarterly rate increases as follows: 2Q17 +2.5%, 3Q17 +2.5%, 4Q17 +2.6%. These quarterly rate increases include two components: 1) trend, equivalent to an annual 7.1% trend rate, and 2) build-up of the insurer fee for portions of policy periods falling in the 2018 calendar year (described in Exhibit C). The average year-over-year renewal rate change is +2.2%, the minimum change is -3.8%, the maximum change is +18.2%. Please see Exhibit 3 for detail on the rate changes.

2) Form Numbers. The form numbers are as follows: SHOP.POL.OCI.H.17.DC, SHOP.COC.OCI.17.DC, Platinum 1.SBN17.OCI.NET.12.SG.DC, Platinum 2.SBN17.OCI.NET.12.SG.DC, Platinum 4.SBN17.OCI.NET.12.SG.DC, Gold 8.SBN17.OCI.NET.12.SG.DC, Gold 10.SBN17.OCI.NET.12.SG.DC, Gold 11.SBN17.OCI.NET.12.SG.DC, Silver 11.SBN17.OCI.NET.12.SG.DC, RID17.PDS.NET.OCI.12.SG.DC, RID17.PVCS.NET.OCI.12.SG.DC, RDR.RX.NET.17.OCI.12.DC, RDR.RXSBN.NET.17.OCI.12.SG.DC.152550 RDR.RXSBN.NET.17.OCI.12.SG.DC.104075

3) HIOS Product ID. The HIOS product ID for our HMO product is: 75753DC001.

4) Effective Date. 1/1/2017.

5) Market. The benefit plans will be offered in the small employer group market.

6) Status of Forms. The forms are open to new sales, and are for non-grandfathered groups.

7) Benefits/Metal Levels. The benefits by plan are summarized in Exhibit 2. The metal level for each benefit plan is indicated in Exhibit 1.

7.1) AV Value. The actuarial value for each plan design using the HHS provided AV calculator is indicated in Exhibit 1. For plan designs that do not fit into the AV calculator, certification of the methodology and input used is in Exhibit B.

8) Average Rate Increase Requested.

Incremental:
1Q17/4Q16: -1.8%
2Q17/1Q17: +2.5%
3Q17/2Q17: +2.5%
4Q17/3Q17: +2.6%

Year-over-year renewal:
1Q17/1Q16: -1.3%
2Q17/2Q16: -0.7%
3Q17/3Q16: +5.2%
4Q17/4Q16: +5.8%
Average year-over-year renewal: +2.2%

9) Maximum Rate Increase Requested.

Incremental:
1Q17/4Q16: +9.7%
2Q17/1Q17: +2.5%
3Q17/2Q17: +2.5%
4Q17/3Q17: +2.6%

Year-over-year renewal: 18.2%

10) Minimum Rate Increase Requested.

Incremental:
1Q17/4Q16: -4.3%
2Q17/1Q17: +2.5%
3Q17/2Q17: +2.5%
4Q17/3Q17: +2.6%

Year-over-year renewal: -3.8%

11) Absolute Maximum Premium Increase. The absolute maximum year-over-year renewal increase, including one year of aging, is +22.8%.

12) Average Renewal Rate Increase for a Year. The average renewal rate increase by HIOS product ID is: 75753DC001 +2.2%.

13) Rate Change History.
10/1/16: +1.9%
7/1/16: -3.2%
4/1/16: +1.9%
1/1/16: +5.0%
10/1/15: +1.9%

7/1/15: +2.0%
4/1/15: +1.9%
1/1/15: -10.4%
10/1/14: +2.6%
7/1/14: -7.7%
4/1/14: +2.6%

14) Exposure. As of January, 2016:
Policies: 130
Certificates: 584
Covered Lives: 967

15) Member Months. See Exhibit A.

16) Past Experience. See Exhibit A.

17) Index Rate. $457.08

17.1) Rate Development.

The base experience is shown in Exhibit A.

We are proposing to set our 1st quarter 2017 rates on average 1.8% lower than our current 4th quarter 2016 rates, and then apply quarterly rate increases in each of the last three quarters of 2017. The quarterly rate increases include two components: 1) trend, equivalent to an annual 7.1% trend rate, and 2) build-up of the insurer fee for portions of policy periods falling in the 2018 calendar year (described in Exhibit C). Our analysis, please see Exhibit D, indicates that these rates will yield a 78.5% underwriting loss ratio (claims divided by premium which includes PPACA fees).

18) Credibility Assumption. We have set our rate levels based on the combined DC experience on our small group licenses, which we believe is credible.

19) Trend Assumption. See Exhibit T. At UnitedHealthcare, we have a team of actuaries whose responsibilities include developing forward-looking trend projections and monitoring historical performance in relation to trend. We rely on this team to provide guidance on trends appropriate for DC rate development.

20) Cost Sharing Changes and 21) Benefit Changes.

Changes to member cost sharing were required for certain benefit plans. Use of the new federal Actuarial Value (AV) Calculator led to some benefit plans falling outside the allowed +/-2% AV metal ranges. Benefit plan changes were made to move these plans back into the allowed AV ranges. The benefit changes for these plans, and the estimated cost value of the changes, is shown in Exhibit 4.

22) Plan Relativities. We refined the medical plan price relativities to reflect the most recent methodology update using the most recent available models. The medical plan price relativities were developed using our pricing model ARC (Actuarial Relativity Calculator). The ARC model is based on UnitedHealthcare nationwide experience data, containing utilization frequencies and unit costs by service category, and claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket

maximums, etc. were input for each plan into ARC. The expected net-to-allowed relativity for each plan is then used to develop the plan relativities for each benefit plan. All benefit plans are priced consistently with each other, with the rates different only by the estimated value of the benefit differences. The prescription drug plan relativities were similarly developed using our Rx Pricing model: this model, based on nationwide UnitedHealthcare prescription drug experience, values the cost differences of Rx copays by tier, and other plan cost sharing features such as Rx deductibles and coinsurance.

Using the new ARC and Rx models, we set the new 2017Q1 rates to be 1.8% lower, using our January, 2016 membership by benefit plan as weights, than the 2016Q4 rates. This is demonstrated in Exhibit 6.

23) Rating Factors. We are resetting our 1st quarter 2017 Effective Date Adjustment (EDA) factors to 1.000. Rating factors are displayed on Exhibit 1, Exhibit 3 details the changes to rating factors.

23.1) Wellness Programs. No wellness programs are included in this rate filing.

24) Distribution of Rate Increases. The distribution of rate increases is shown in the DISB Actuarial Memorandum Dataset.

25) Claim Reserve Needs. The DISB Actuarial Memorandum Dataset presents the claims separately for paid claims, and estimated incurred claims (including claim reserve). The incurred period used for the base period is 1/1/15 through 12/31/15, using claims paid through February, 2016. A description of our reserving methodology is included in the Part III Actuarial Memorandum.

26) Administrative Costs of Programs that Improve Health Care Quality. The amount of administrative costs included with claims in the numerator of the MLR calculation is 1.3%. This amount is consistent with the most recently filed (2015 calendar year) Supplemental Health Care Exhibits, where the Improving Health Care Quality costs in total for our small group licenses is 1.3% of premium.

27) Taxes and Licensing or Regulatory Fees. The amount of taxes, licenses, and fees subtracted from premium in the denominator of the medical loss ratio calculation is 5.9%. Differences from amounts in the Supplemental Health Care Exhibit are due to different amounts of PPACA fees by year, and different Federal Income Taxes due to different underwriting loss ratios.

28) Medical Loss Ratio (MLR). The anticipated Federal MLR is 83.9%, which is greater than the 80% minimum. The estimated Federal MLR components, adjustments, and formula are as follows:

78.5% Underwriting loss ratio
1.3% QI/HIT Medical costs added
-0.7% GAAP Medical reclass to MLR SG&A
5.9% Taxes, regulatory fees and assessments

MLR formula: [(UW LR) x (1 + QIT) x (1+ medical reclass)] / (1 – taxes)

29) Risk Adjustment. Based on analysis done in conjunction with a national actuarial consulting firm, we estimate we will be a 2.3% risk payer in total for our small group licenses, this is assumed in the underwriting loss ratio development.

29.1) Reinsurance. No Reinsurance recoveries or reinsurance fees are assumed or included.

29.2) Risk Corridor. No charges or payments are assumed.

30) Past and Prospective Loss Experience Within and Outside the State. Only loss experience on DC plans, written on DC employers, was used in the development of the rates. This experience does include medical services provided outside DC, to employees of DC employers who live outside DC, or to DC residents who obtain medical services outside DC. We have set our rate levels based on the total overall experience of our small group licenses in DC, which we believe is credible, thus not requiring use of loss experience outside the state.

31) A Reasonable Margin for Reserve Needs.

The profit margin assumed in the development of the proposed rates is 4.2% of premium. This assumption was derived as: 100% – projected underwriting loss ratio – projected expenses (including PPACA fees) as % of premium – projected taxes (including FIT) as % of premium. This methodology has not changed from prior filings.

32) Past and Prospective Expenses.

The expenses assumed in the development of the proposed rates are as follows. These are the total average expenses for the small group licenses. Except for difference in PPACA fees which vary by calendar year, they are forecasted 2016 year expenses that are expected to continue in the future.

% of Premium	Expense Category
2.7%	Salaries, wages, employment taxes, and other employee benefits
3.1%	Commissions
5.9%	Taxes, licenses, and other regulatory fees
2.2%	Cost containment programs / quality improvement activities
3.4%	All other administrative expenses
17.3%	Total

33) Any Other Relevant Factors Within and Outside the State. None.

34) Other. None.

35) Actuarial Certification.

I, Boris P. Gerber, an Actuary at UnitedHealthcare, am a FSA and MAAA. I satisfy the 2015 continuing professional development requirements of the Academy and therefore am qualified to issue this 2016 statement of actuarial opinion. I have reviewed applicable ASOPs during the preparation of this rate filing. I have worked on pricing group medical insurance for over 35 years. There are no known cautions with regard to risk or uncertainty in the items discussed in this rate filing. There are no conflicts of interest with regards to my production of this rate filing.

I certify that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of DC and all applicable Actuarial Standards of Practice, including ASOP No. 8, and the rates are not unfairly discriminatory.

Boris P. Gerber

Boris P. Gerber, FSA, MAAA

Date: 4/29/2016

36) Part I Preliminary Justification for Grandfathered Plan Filings. Not applicable.

36.1) Unified Rate Review Template. This is provided via SERFF.

37) Part II Preliminary Justification. This is provided via SERFF.

38) DISB Actuarial Memorandum Dataset. This is provided via SERFF.

39) DC Plain Language Summary. This is provided via SERFF.

40) Additional Requirements for Stand-Alone Dental Plans. Not applicable.

List of exhibits included in rate filing:

Exhibit 1: Rates and rate factors.
Exhibit 2: Benefit plan descriptions.
Exhibit 3: Rate factor changes.
Exhibit 4: New, terminated and changed benefit plans.
Exhibit 5: Rating example.
Exhibit 6: Determination of average rate change.
Exhibit A: Member months, earned premium & incurred claim experience.
Exhibit B: Certification for AV calculator.
Exhibit C: PPACA fees & development of fee EDA factors by quarter.
Exhibit D: Development of underwriting loss ratio.
Exhibit T: Trend assumptions and development.

Please keep these rates confidential to the extent allowed by DC law.

If you have questions, or need any further information, please do not hesitate to contact me.

Sincerely,

Boris P. Gerber

Boris P. Gerber, FSA, MAAA
Actuary
UnitedHealthcare

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For Optimum Choice, Inc.

District of Columbia Rate Review

Purpose: The purpose of this rate filing is to comply with DC and Federal requirements. This filing is to outline manual base rates and rating factors compliant to the Patient Protection and Affordable Care Act (PPACA) Adjusted Community Rating requirements on non-grandfathered PPACA compliant small group policies. This filing may not be appropriate for other purposes.

This rate adjustment is for both new business and existing business with renewal dates on or after the effective date of the changes.

Company Identifying Information:

- **Company Legal Name:** Optimum Choice, Inc**.**
- **State:** District of Columbia
- **HIOS Issuer ID:** 75753
- **Market:** Small Group
- **Effective Date:** 1/1/2017

Company Contact Information:

- **Primary Contact Name:** Boris Gerber
- **Primary Contact Telephone Number:** 860-702-5540
- **Primary Contact Email Address:** boris_gerber@uhc.com

Proposed Rate Increase: Optimum Choice, Inc. is filing for revised medical and pharmacy base rates, and plan rating factors that comply with the requirements of PPACA.

The proposed rate changes are as below.

BASE PREMIUM RATES

Medical base rates have been revised due to favorable changes in emerging experience. The rates reflect the needed revenue to cover Essential Health Benefit requirements and other healthcare reform related costs. Base premium rates are provided in Exhibit 1.

AGE FACTORS

Age factors are provided in Exhibit 1. There are no changes from the age factors in our prior 2016 filings.

PRICING TREND

Pricing trend is being reduced to reflect favorable changes in projected claims trends.

Pricing trend is provided in Exhibit 1.

RATING FORMULA:

The rating formula for non-grandfathered small employer group business is shown below:

Base Rate x Plan Ratio x Effective Date Adjustment Factor (EDA) x Age Factor = Final Health Premium Rate

PLAN DESIGNS AND RATING FACTORS

This rate filing includes some PPACA compliant plans from last year's filing. The plan designs with plan relativities and actuarial value metal tiers are provided in Exhibits 1 and 2. Pharmacy plan details are included on Exhibit 2. All listed plans are designed based on the final Market Reform Rule requirements.

Actuarial Value calculations have been conducted to ensure actuarial values are within the allowed range for each metal tier. The metal tier for each plan has been provided in Exhibit 1. Mental Health Parity testing has been conducted, and final plan designs will ensure compliance.

All plans have been priced on an actuarially equivalent basis, based on the final Market Reform Rule requirement. The plan-specific adjustments to the market-wide index rate (plan relativities) do not reflect differences in health status or risk selection.

Experience Period Premiums and Claims:

- **Paid Through Date:** The experience period is 1/1/2015 to 12/31/2015 paid through 2/29/2016.
- **Premiums (net of MLR Rebate) in Experience Period:** Earned premium for the experience period, net of rebate, was $5,328,800. The estimated MLR rebate payment attributable to the Small Group business on this license is $560,084.
- **Allowed and Incurred Claims Incurred During the Experience Period:** Incurred claims were developed by first starting with actual claims paid through 2/29/2016 by incurred date. To these paid claims estimates of incurred but not paid were added. Here is a description of the reserve methodology:

The UnitedHealthcare Reserving process utilizes the Reserve Production System (RPS) to record reserves into the PeopleSoft general ledger. Fee for service and paid claim data is loaded into RPS and becomes the basis for the monthly reserve calculations at the various business unit, location, and line of business levels. The assignment of the paid claims into RPS packages is based on the mapping rules maintained by the Corporate Actuarial department. RPS calculates a preliminary best estimate Incurred But Not Reported (IBNR) for each reserving model (package) primarily using standard completion factors based on historical claim experience. The Claims Reserving Team adjusts the preliminary IBNR based on specific knowledge of the entity (i.e. catastrophic claims, pended claims, etc.) to calculate the final IBNR. In months where adjudicated claims experience is not complete enough for an estimate using completion factors, a seasonally adjusted PMPM is used to estimate incurred claims.

A description of the Sarbanes Oxley controls, audited by Deloitte & Touche, in place regarding the reserving process include:

1) Market Paid claim Tie-outs: To verify completeness and accuracy of financial data in RPS, paid claim data is tied out between source system (RPS) and PeopleSoft general ledger.
2) Market Expense Tie-outs: RPS reserve changes on the income statement are tied to the PeopleSoft general ledger to ensure that information is accurate subsequent to computing the reserve.

- Allowed claims by benefit category were obtained from UnitedHealthcare claim paying system reports.

Benefit Categories: Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

Projection Factors:

- **Changes in the Morbidity of the Population Insured:** No changes in morbidity are assumed.
- **Changes in Benefits:** No benefit changes are assumed.
- **Changes in Demographics:** No changes in demographics are assumed. The age factors adopted by the District of Columbia are used in rating.
- **Trend Factors:** UnitedHealthcare Medical Expense Forecasting Process Overview & Considerations:

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, benefit leveraging, and business mix identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also

consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence mix of procedures.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Business mix changes that influence medical cost trends are also reviewed and projected, with appropriate input from sales and underwriting staff. These factors include changing mix of employer groups, mix of benefits, and demographic changes. For the purposes of developing premium pricing trend projections, the component of trend attributable to business mix is excluded.

Credibility Manual Rate Development:

- **Source and Appropriateness of Experience Data Used:** The experience period source data used to develop manual rates is the actual total combined experience for UnitedHealthcare Insurance Company, Optimum Choice, Inc., and UnitedHealthcare of the Mid-Atlantic, Inc. in DC for employers with 2-50 employees.

Credibility of Experience: We have set our rate levels based on the combined experience of UnitedHealthcare Insurance Company and Optimum Choice, Inc. in DC with 105,961 member months in the experience period. For the base rate development purpose, we regard it to be fully credible.

Paid to Allowed Ratio: The paid to allowed average factor in the projection period is set to be consistent with the overall estimates of projected revenue and claims per member per month based on the projected membership.

Risk Adjustment and Reinsurance:

- **Projected Risk Adjustments (PMPMs):** Based on analysis done in conjunction with a national actuarial consulting firm, we estimate we will be a 2.3% risk payer in total for our small group licenses, this is assumed in the underwriting loss ratio development.

- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** No reinsurance recoveries are assumed.

Non-Benefit Expenses and Risk Margin: The expenses assumed in the development of the proposed rates are as follows: The administrative expenses are the total average expenses for the small group licenses. Except for the addition of PPACA fees, they are forecasted 2016 year expenses that are expected to continue in the future.

% of Premium	Expense Category
11.4%	Admin Expenses
4.2%	Profit
5.9%	Taxes & Fees
21.5%	Total

Projected Loss Ratio: The projected loss ratio using Federally prescribed MLR methodology is 83.9%.

Single Risk Pool:

The Single Risk Pool reflects all covered lives for every non-grandfathered product and is established according to the requirements in 45 CFR part 156.80(d) which includes all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act. The Single Risk Pool is specific to the legal entity and the state of this filing.

Index Rate:

The development of the Index Rate for Projection Period is shown in the table below. The Projected Allowed Claims for 1Q17 is the Projected Allowed Experience Claims from Section III. The Index Rate is then member weighted average for each effective date.

Projected Allowed Claims PMPM (for 1/1/2017 Renewals)			$441.51	
Projected Allowed Trend - Annualized			6.3%	
Quarterly Allowed Trend			1.5%	
Renewal Quarter	**Renewal Quarter Distribution**	**Index Rate By Renewal Quarter**	**Weighted ACA Reins. Fees & Risk Adj. Pmts**	**Market Adj. Index Rate By Renewal Quarter**
2017Q1	20.2%	$442.60	$15.80	$458.39
2017Q2	12.9%	$450.94	$15.80	$466.73
2017Q3	27.8%	$457.87	$15.80	$473.67
2017Q4	39.0%	$466.07	$15.80	$481.87
Total	**100.0%**	**$457.08**	**$15.80**	**$472.88**

Plan Adjusted Index Rate:

Plan Adjusted Index Rates are provided in the URRT Part I. The adjustments that have been applied to the development of the Plan Adjusted Index Rates include:

Provider Network: these adjustment factors are developed based on the underlining provider network features, contract terms, utilization and cost patterns due to the network features.

Actuarial Value and Cost Sharing: These values are developed with the method identified in the sections below and applied to each plan accordingly.

Distribution and Administrative Cost: This adjustment is developed based on the method described in the "Non-Benefit Expense and Profit & Risk" section. The same adjustment has been applied to all plans to develop the Plan Adjusted Index Rate.

The formula to develop the Plan Adjusted Index Rate is as below:

Plan Adjusted Index Rate= (Market Adjusted Index Rate X Provider Network Savings X Actuarial Value and Cost Sharing)/(1- Distribution and Administrative Cost).

Index Rate to Consumer Rate for Sample Plans

	Platinum	Gold	Silver
Plan Name	**OCI AE-CM**	**OCI AL-EJ**	**OCI AL-EK**
2017 Effective Date	1Q17	1Q17	1Q17
Index Rate	**$457.08**	**$457.08**	**$457.08**
Risk Adjustment and maketplace user fee	-3.5%	-3.5%	-3.5%
Reinsurance Assessment	0.00	0.00	0.00
Market Adjusted Index Rate	**$472.88**	**$472.88**	**$472.88**
Provider Network Savings1	1.000	1.000	1.000
Benefit Extra EHB	1.000	1.000	1.000
Actuarial Value and Cost Sharing2	0.8372	0.7032	0.5665
Distribution And Administrative cost	19.5%	19.5%	19.5%
Plan Adjusted Index Rate	**$492.10**	**$413.30**	**$332.99**
Calibration			
Age Factor Calibration	1.1270	1.1270	1.1270
Area Factor Calibration	1.000	1.000	1.000
Tobacco Factor Calibration	0.000	0.000	0.000
Calibrated PAIR without Normalization	$436.66	$366.74	$295.47
Trend Normalization			
Removal of average Trend for 1/1/2017 BR	1.0392	1.0392	1.0392
Calibrated Plan Adjusted Index Rate	$420.18	$352.90	$284.32
Actual Q1 Consumer Rate (age 21) after applying trend	**$422.99**	**$355.26**	**$286.22**

Calibration:

Age Curve Calibration is calculated as the premium weighted average age rating factors (based on the DC Age Scale) in experience period. The factor is calculated to be 1.069. This age curve value translates to a weighted average age of 43 years old.

Geographic Factor Calibration is calculated as the premium weighted average rating area factors (based ACR compliant rating area setting) in experience period. The factor is calculated to be 1.000.

Description of development of geographic rating factors

Geographic area rating factors are not used in pricing, which represents no change from the previously approved area factors.

The calibration factors are applied uniformly to all plans.

Calibrated Plan Adjusted Index Rate

Consumer Adjusted Premium Rate is developed with the formula below:

Consumer Adjusted Premium Rate = Plan Adjusted Index Rate x 1/ Age Curve Calibration X 1/ Geographic Factor Calibration X Age 21 Age Factor

Member level plan premium rate information is provided in Rate Data Template.

AV Metal Values: The below actuarial certification describes the methodology and the AV calculator input values used for the plan design features that do not fit into the parameters of the AV calculator.

The AV metal value was calculated using the Federal AV calculator. For the benefit designs that cannot be directly coded in the Federal AV calculator, claim distribution information provided in the Federal AV calculator has been used to convert the benefit design in to equivalent benefit designs that can be coded in the Federal AV calculator.

Certification for AV Calculator

Exhibit B

Estimation of fit of plan design into the parameters of AV calculator

Metallic Plan (e)	Imaging (CT/PET Scans, MRIs)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Specialty Drugs (i.e. high-cost)	Methodology
Bronze 1			$100.00	d, e
Bronze 3			$100.00	d, e
Bronze 4			$100.00	d, e
Silver 2			$100.00	d, e
Silver 3			$100.00	d, e
Silver 4			$100.00	d, e
Silver 5			$100.00	d, e
Silver 7	95.5%	95.80%	$100.00	b, c, d, e
Silver 8	95.5%	95.80%	$100.00	b, c, d, e
Silver 9	95.5%	95.80%	$100.00	b, c, d, e
Silver 10	95.5%	95.80%	$100.00	b, d, e
Silver 11	74.4%	96.10%	$100.00	a, b, c, d, e
Silver 13	59.5%	76.9%	$100.00	a, b, d, e
Silver 14	59.5%	76.9%	$100.00	a, b, d, e
Gold 1			$100.00	d, e
Gold 3	96.2%	96.48%	$100.00	b, c, d, e
Gold 4	95.4%	95.77%	$100.00	b, c, d, e
Gold 5	97.7%	97.89%	$100.00	b, c, d, e
Gold 6	97.7%	97.89%	$100.00	b, c, d, e
Gold 7			$100.00	d, e
Gold 8		76.92%	$100.00	b, c, d, e
Gold 9		86.53%	$100.00	b, c, d, e
Gold 10	58.9%	76.92%	$100.00	a, b, c, d, e
Gold 11	84.2%	97.69%	$100.00	b, c, d, e
Gold 12	67.33%	78.15%	$100.00	a, b, c, d, e
Gold 13	73.60%	96.15%	$100.00	a, b, c, d, e
Gold 15	58.88%	76.92%	$100.00	a, b, d, e
Gold 16	73.60%	96.15%	$100.00	a, b, d, e
Gold 17	96.18%	96.48%	$100.00	b, c, d, e
Gold 18	96.18%	96.48%	$100.00	b, c, d, e
Gold 19	96.18%	96.48%	$100.00	b, c, d, e
Platinum 1	72.09%	97.30%	$100.00	a, b, c, d, e
Platinum 2	64.1%	95.67%	$100.00	b, c, d, e
Platinum 3			$100.00	d, e
Platinum 4	83.3%	98.38%	$100.00	b, c, d, e
Platinum 5	64.9%	95.83%	$100.00	b, c, d, e
Platinum 6	82.0%	96.81%	$100.00	b, c, d, e
Platinum 11	83.25%	98.38%	$100.00	b, c, d, e
Platinum 12			$75.00	d, e
Platinum 13		98.38%	$75.00	b, d, e
Platinum 14			$75.00	d, e
Platinum 15	72.09%	97.30%	$100.00	a, b, d, e

Methodology

a) An effective coinsurance for Per-Occurrence Deductibles on Imaging services was calculated based o
UnitedHealthcare's proprietary pricing model.

b) Actuarial Value Calculator does not support outpatient copay, company's data was used to estimate

c) Actuarial Value is the blend of Free-Standing and Hospital setting run, where weight of Free Standing and H
adjusted based on actual utilization of free standing and hospital facilities by service categories.

d) Speciality Rx: Entered the Rx Tier cost share with the highest specialty drug utilization per UnitedHealthca
pricing model.

e) See Exhibit 2 for plan benefit description, and for tie-in to benefit plan name.

Certification

For plan design features that do not fit into the parameters of the AV Calculator, I certify that both the r
calculated estimated values are in accordance with generally accepted actuarial principles and methodo

Boris P. Gerber

Boris P. Gerber, FSA, MAAA

AV Pricing Values:

Plans are priced through the proprietary UnitedHealthcare pricing model. The model, which was updated for January 1, 2017 pricing, uses UHC fully-insured national small-group claim experience for groups that were in force for all of calendar-year 2013 and is fully-credible. Current claim data is then projected to the pricing period based on national projections of utilization, unit cost, and sloping. These projections are done at the service category (inpatient, outpatient, etc.) level.

At this point, benefit design parameters such as deductibles, copays, coinsurance, etc. are applied to the claim distributions of the matching service category. This cost-sharing is applied, and the values of each service category are summed to come up with the overall benefit value. This overall benefit value is then compared to a base benefit design to calculate the plan relativity.

In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

Membership Projections: Membership is projected to be the same as 2015, and will be distributed to plans based on current metal level, network and area distribution during experience period.

Terminated Plans and Products: No products are being terminated. No plans are terminated from plan year 2016 to 2017.

Plan Type: Not applicable.

Warning Alerts:

Line 55: The average premium PMPM does not match the member weighted Plan Adjusted Index Rate in the experience period. The differential is caused by a high proportion of experience in non-single risk pool compliant plans for which 0 is entered as the Plan Adjusted Index Rate for these plans.

Line 81 and 83: The small group Plan Adjusted Index Rates reflects the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate. The warning in line 83 is caused by Line 81.

Reliance: Not applicable.

Actuarial Certification:

I, Boris P. Gerber am an actuary of UnitedHealthcare and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),

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, and

d. Neither excessive nor deficient.

I certify that 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.

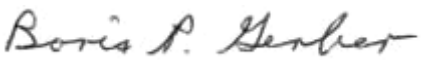
I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135. Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable to individuals in the actuarial value calculation.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is described in detail in my state submitted actuarial memorandum. 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.

Sincerely,



Boris P. Gerber, FSA, MAAA
Actuary, UnitedHealthcare
185 Asylum Street, CT039-16B, Hartford, CT 06103
Phone 860-702-5540 Fax 860-702-5016
Date: 4/28/2016

185 Asylum Street, CT039-16B
Hartford, CT 06103
Phone 860-702-5540 Fax 860-702-5016
E-Mail: boris_gerber@uhc.com

April 29, 2016

Efren Tanhehco, Actuary
DC Department of Insurance Securities & Banking
810 First Street, NE Suite 701
Washington, DC 20002

Re: Optimum Choice, Inc.
Small Group Rate Filing

Dear Mr. Tanhehco:

This rate filing presents proposed premium rates effective January 1, 2017 through December 31, 2017 for medical and Rx benefit plans to be sold by Optimum Choice, Inc. to small group employers. The benefit plans and rates are for non-grandfathered employers.

A. Company Name: Optimum Choice, Inc.

B. NAIC Company Code: 79413

C. SERFF Tracking #: UHLC-130538513

D. Date Filing Submitted: 4/29/2016

E. Proposed Effective Date: 1/1/2017

F. Type of Product: Medical and prescription drug insurance.

G. Market: Small group, employers with 50 or fewer eligible employees.

H. Scope and Purpose of Filing: 2017 rates for small group plans meeting the requirements of the Patient Protection and Affordable Care Act (PPACA).

I. Initial Filing or Rate Change: Initial filing for 2017, rate change to previously filed and approved 2016 rates.

J. Rates apply to existing DC policyholders.

K. Overall Premium Impact of Filing on DC Policyholders: An average 2.2% renewal rate increase.

L. Contact Information: Boris Gerber, 860-702-5540, fax: 860-702-5016, boris_gerber@uhc.com.

If you have any questions, please do not hesitate to call.

Sincerely,

Boris P. Gerber

Boris P. Gerber, FSA, MAAA
Actuary, UnitedHealthcare

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	Optimum Choice, Inc.
SERFF tracking number	UHLC-130538513
Submission Date	April 29, 2016
Product Name	Medical and Prescription Drug Insurance
Market Type	○ Individual ◉ Small Group
Rate Filing Type	◉ Rate Increase ○ New Filing

Scope and Range of the Increase:

The 2.2 % increase is requested because:

To cover Essential Health Benefit requirements and other healthcare reform related costs.

This filing will impact:

# of policyholder's 130 # of covered lives 967

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 2.2 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved -3.8 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 18.2 %

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

The group's rate is based on the benefit plan selected and the attained ages of the members at the beginning of the policy period.

Financial Experience of Product

The overall financial experience of the product includes:

Calendar year 2015 earned premium of $5,888,884 from 13,155 member months of coverage.

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

The projected loss ratio using the Federal prescribed MLR methodology is 83.9%

Components of Increase

The request is made up of the following components:

Trend Increases – 2.2 % of the 2.2 % 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 % of the % 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 % of the % total filed increase.

Other Increases – % of the % 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 % of the % 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 % of the % 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 % of the % 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 % of the % total filed increase.

5. Other – Defined as:

   This component is % of the % total filed increase.

RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP
PLANS SOLD ON DC HEALTH LINK
CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.	yes	Act'l Memo
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	yes	Act'l Memo
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.	yes	Act'l Memo
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2017 and later, follow filing due date requirements.	yes	Act'l Memo
5	Market	Indicate whether the products are sold in the individual or small employer group market.	yes	Act'l Memo
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.	yes	Act'l Memo
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	yes	Exh. 2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	yes	Exh. 1
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. **In the small group market, please also provide weighted average rate increase requested for 2016Q1 over 2015Q1; etc.**	yes	Act'l Memo
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	yes	Act'l Memo
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	yes	Act'l Memo
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.	yes	Act'l Memo
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.	yes	Act'l Memo
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for ~~Maryland~~ DC and the nationwide average rate history.	yes	Act'l Memo
14	Exposure	Current number of policies, certificates and covered lives.	yes	Act'l Memo

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	yes	Exh. A
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	yes	Exh. A
17	Index Rate	Provide the index rate.	yes	Act'l Memo
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	yes	Act'l Memo Exh. A Exh. C Exh. D Exh. T
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	yes	Act'l Memo
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	yes	Exh. T
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	yes	Act'l Memo Exh. 4
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	yes	Act'l Memo Exh. 4

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.	yes	Act'l Memo Exh. 3
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	yes	Act'l Memo Exh. 1 Exh. 3
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	yes	Act'l Memo
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	yes	DISB Act'l Memo Dataset
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	yes	Act'l Memo DISB Act'l Memo Dataset Part III Act'l Memo
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	yes	Act'l Memo

Number	Data Element	Requirement Description	Individual/and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	yes	Act'l Memo
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in ~~Maryland,~~ DC the loss ratio meets the minimum.	yes	Act'l Memo
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.	yes	Act'l Memo

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
29.1	Reinsurance	Provide information on the Reinsurance contribution assumption, consistent with the national contribution rate for the projection period. In individual filings, provide information on the Reinsurance recovery assumption, consistent with the company's continuation table used in pricing. Provide previous year-end estimated reinsurance payable amount and quantitative support for the amount.	yes	Act'l Memo
29.2	Risk Corridor	Does the company assume Risk Corridor charges or payments? If so, provide support. Provide previous year-end estimated risk corridor payable or receivable amount and quantitative support for the amount.	yes	Act'l Memo
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	yes	Act'l Memo
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	yes	Act'l Memo

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: • Salaries, wages, employment taxes, and other employee benefits • Commissions • Taxes, licenses, and other regulatory fees • Cost containment programs / quality improvement activities • All other administrative expenses • Total	yes	Act'l Memo
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.	yes	Act'l Memo
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	yes	Act'l Memo
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.	yes	Act'l Memo

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. **Provide in Excel and PDF format.**	no, not applicable	
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel and PDF format.**	yes	Separate document in SERFF
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for *all* individual and small employer group filings (whether or not they are "subject to review" as defined by HHS).	yes	Separate document in SERFF
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel format only.**	yes	Separate document in SERFF
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.	yes	Separate document in SERFF

40	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: • Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule; • Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and • Demonstration that the plan has a reasonable annual limitation on cost-sharing.	no, not applicable	

CERTIFYING SIGNATURE

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

Boris P. Gerber

(Print Name)

Boris P. Gerber

(Signature)