

**State:** Pennsylvania **Filing Company:** Geisinger Health Plan  
**TOI/Sub-TOI:** HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)  
**Product Name:** HMO/POS  
**Project Name/Number:** Individual HMO/POS-2016 Exchange Filing/

## Filing at a Glance

Company: Geisinger Health Plan  
 Product Name: HMO/POS  
 State: Pennsylvania  
 TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)  
 Sub-TOI: HOrg021.005B Individual - Point-of-Service (POS)  
 Filing Type: Rate - Other (Not M.U. or G.I. Product)  
 Date Submitted: 05/15/2015  
 SERFF Tr Num: GSHP-130072597  
 SERFF Status: Assigned  
 State Tr Num: GSHP-130072597  
 State Status: Received Review in Progress  
 Co Tr Num: INDIV HMO  
  
 Implementation: 01/01/2016  
 Date Requested:  
 Author(s): Vicki Bardsley, Diana Ginitz, Rahmaire Brooks  
 Reviewer(s): Jim Laverty (AH) (primary)  
 Disposition Date:  
 Disposition Status:  
 Implementation Date:

State Filing Description:  
 Proposed 40.6% increase on 2016 on & off exchange individual POS rates.  
 Binder ID#: GSHP-PA16-125046933

**State:** Pennsylvania **Filing Company:** Geisinger Health Plan  
**TOI/Sub-TOI:** HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)  
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## General Information

Project Name: Individual HMO/POS-2016 Exchange Filing	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact: 40.6%	Filing Status Changed: 05/15/2015
	State Status Changed: 05/16/2015
Deemer Date:	Created By: Vicki Bardsley
Submitted By: Vicki Bardsley	Corresponding Filing Tracking Number: GSHP-130074018,GSHP-130073963,GSHP-130073964,GSHP-130073939
	PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null	
Exchange Intentions:	It is GHP's intention to offer these benefit plans on the Exchange.

Filing Description:  
Individual HMO/POS-2016 Exchange Filing

## Company and Contact

### Filing Contact Information

Vicki Bardsley, Manager Actuarial Services vbardsley@thehealthplan.com  
 100 North Academy Ave. 570-271-7842 [Phone]  
 Danville, PA 17822-3225 570-271-5474 [FAX]

### Filing Company Information

Geisinger Health Plan	CoCode: 95923	State of Domicile:
100 North Academy Ave.	Group Code: 1143	Pennsylvania
Danville, PA 17822	Group Name:	Company Type: Health
(570) 271-7842 ext. [Phone]	FEIN Number: 23-2311553	Insurance
		State ID Number:

## Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

**SERFF Tracking #:**

GSHP-130072597

**State Tracking #:**

GSHP-130072597

**Company Tracking #:**

INDIV HMO

**State:**

Pennsylvania

**Filing Company:**

Geisinger Health Plan

**TOI/Sub-TOI:**

HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)

**Product Name:**

HMO/POS

**Project Name/Number:**

Individual HMO/POS-2016 Exchange Filing/

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Redacted Actuarial Memorandum
<b>Comments:</b>	
<b>Attachment(s):</b>	Redacted_ActuarialMemorandum_2016 Filings_IndivHMO_05132015.pdf Individual HMO 2016 Filing-Cover Letter.pdf HIOS Part 2 Consumer Justification Narrative-Individual HMO-2016 Exchange Filing.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

## **Actuarial Memorandum—Individual HMO/POS**

### **General Information**

#### **Company Identifying Information**

Company Legal Name: Geisinger Health Plan

HIOS Issuer ID: 22444

Effective Date: 1/1/2016

State: Pennsylvania

Market: Individual

#### **Company Contact Information**

Primary Contact Name: Sarah MacDerment

Primary Contact Phone: 570-214-2348

Primary Contact email address: smmacderment@thehealthplan.com

### **Proposed Rate Increase**

#### **Reason for Rate Increase**

The proposed overall rate increase is **40.57%**. The components of this rate increase are:

- Single Risk Pool experience which is more adverse than assumed in current rates;
- Cost trend;
- Utilization trend;
- Changes in administrative expenses;
- Changes in ACA fees (including Reinsurance Program);
- Changes in population demographic;
- Changes in plan selection;
- Changes in morbidity load;
- Changes in Transitional Reinsurance coverage;
- Changes in Risk Adjustment.

Each of these components is discussed in detail under the “Projection Factors” section of this document.

### **Experience Period Premium and Claims**

#### **Paid Through Date**

The Experience Period data provided in the URRT Worksheet 1, Section I is incurred in calendar year 2014 and paid through 2/20/2015.

#### **Premiums (net of MLR Rebate) in Experience Period**

Premiums include earned premiums for calendar year 2014 for the Single Risk Pool. Premiums are not reduced by taxes and/or assessments.

MLR rebates are not expected to be paid for this block of business. Initial estimates of rebates have been completed utilizing the methodology required for the CY 2014 rebate filing. Estimates suggest that the individual market MLR will be above the minimum MLR target of 80%.

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

The Experience Period Claims are based on individual non-grandfathered business incurred and paid claims with IBNR added for the tail of claims incurred but not paid. Allowed claims are directly from claim records. For both paid and allowed claims the same IBNR factors were used. The IBNR factors were based on legal-entity level claims completion tables which include individual and group commercial experience. This method is appropriate in order to assure proper credibility and because timing of claims payment to providers does not vary by market or product.

### **Benefit Categories**

<b><u>Benefit Category</u></b>	<b><u>Description</u></b>
Inpatient Hospital	Determined by place of service (Hospital—IP)
Outpatient Hospital	Determined by place of service (Hospital—OP)
Professional	Determined by place of service (Physician’s office)
Other Medical	Determined by place of service (any provider not Hospital or Physician’s office)
Capitation	Claims per Financial Department
Prescription Drug	Claims per contracted PBM

### **Projection Factors**

To best estimate the Projected Allowed Experience Claims for this Single Risk Pool the population was segmented into different cohorts that have different population demographics, experience and morbidity.

### **Credibility Manual Rate Development**

#### **Source and Appropriateness of Experience Data Used**

The Credibility Manual Rate is developed using the individual non-grandfathered business combined with the individual grandfathered business. Experience data for each segment of this population are incurred and paid in calendar year 2014 and paid through 2/20/15 with IBNR added for the remaining tail of claims incurred but not paid. IBNR is determined as described above in the Experience Period Premium and Claims section. This population is appropriate because each segment of this population is anticipated to make up a portion of the Projection Period based on renewals and transitioning to the ACA market.

#### **Adjustments Made to the Data**

Several segments are included in the development of the Credibility Manual Rate and adjusted to represent the expected experience in the projection period.

## **Changes in Benefits**

Additional benefits due to Essential Health Benefits requirements are included in both of the non-ACA Compliant Experience segments:

- + Autism benefit (aka “Habilitative” Services): 1.7% of claims
- + Pediatric/Adult Eye Exam: \$1.09 PMPM
- + Pediatric Eyewear: \$2.54 PMPM
- + 100% coverage of adult physicals: 0.75% of claims
- + Chiropractic Coverage: \$1.85 PMPM
- + Extraction of Wisdom Teeth: \$0.80 PMPM

## **Trend Factors**

Trend factors are projected for unit cost and utilization components:

- Unit cost trend factors are based on recorded anticipated increases in facility and professional fees from the Experience to Projection Period. These increases are composited across all facilities and provider groups.
- Utilization trend projections are based on least-square regression modeling, taking into account historical claims patterns, anticipated economic activity and changes in care patterns.
- Seasonality adjustments are made to the claims to account for changes in work days.
- Prescription drug trends are adjusted to account for expired patents for the blockbuster drugs as well as adjustments for other less significant changes in brand and generic utilization.
- Further adjustments have been made to the trends to reflect expected changes due to new medical management initiatives that are expected to yield savings in the projection period.

## **Inclusion of Capitation Payments**

All of the benefits provided under a capitated arrangement that are in the Projection Period are represented in the Experience Period.

## **Credibility of Experience**

The existing non-grandfathered business shown in the Experience Period section does not reflect the anticipated risk and composition of the Projection Period. The Credibility Manual Rate is developed using population segments that are in the Experience Period blended with population segments that are not in the Experience Period. In order to avoid double counting the Experience Period and avoid complicated adjustments to reflect the expected distribution of enrollment in each segment, the credibility of the Experience Period is set to 0.0%. This approach is consistent with the Actuarial Standard of Practice #25.

The Credibility Manual Rate is developed based on the expected enrollment in each of these segments. Each segment’s allowed claims are weighted on projected member months to determine a Projected Allowed Experience Claims PMPM.

### **Paid to Allowed Ratio**

The Paid to Allowed Average Factor is determined for the Projection Period based on the member weighted average AV Metal Value for each metallic level and the member months in each metallic level for January and February 2015 enrollment. There are variations between the AV Pricing Values and the AV Calculator values because of different cost structures and management approaches than what is reflected in the national average data used in the AV Calculator.

### **Risk Adjustment and Reinsurance**

#### **Experience Period Risk Adjustment and Reinsurance Adjustments PMPM**

There is not enough market information available for this Single Risk Pool to confidently estimate the Risk Adjustment transfer payment. We will receive notice of payment transfer amounts at the end of June 2015. Until that time we are relying on an external analysis performed by an outside consulting firm. Calendar year 2014 individual market experience was provided to the consultants. They estimated the Risk Adjustment transfer payment based on the population risk scores relative to an assumed market average risk score and market average premium.

The Experience Period Reinsurance amount was estimated using the 2014 attachment point of \$45k after which reinsurance payments begin, with a cap of \$250k where after payments stop for high cost enrollees. Reimbursement is set at 80% of a member's claims in that range. These threshold amounts are applied to each member in the Experience Period and a total reinsurance receivable amount is calculated.

#### **Projected Risk Adjustments PMPM**

The Experience Period Risk Adjustment transfer payment was determined by an external analysis performed by an outside consulting firm. This estimate relies upon the state average risk score and state average premium provided in the consultant's estimate based on 2014 ACA individual market experience. There is not enough information to project a Risk Adjustment payment transfer estimate at this time. The Risk Adjustment PMPM amount used to adjust the Index Rate to the Market Adjusted Index Rate is determined by dividing by the Paid to Allowed Average Factor in the Projection Period. This converts the PMPM estimate from a paid to an allowed basis.

#### **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium**

A reinsurance estimate model was developed based on our commercial book of business that included individual and small group experience to attain a credible population base. We ran the 2016 Reinsurance Program parameters through the model consisting of an attachment point of \$90K, cap of \$250K and 50% coinsurance. This amount is then reduced by the \$2.25 PMPM contribution amount from the HHS Notice of Benefit and Payment Parameters for 2016 to determine the Reinsurance payments net of Reinsurance contributions amount. The Reinsurance PMPM amount used to adjust the Index Rate to the Market Adjusted Index Rate is determined by dividing by the Paid to Allowed Average Factor in the Projection Period. This converts the PMPM estimate from a paid to an allowed basis.

## **Non-Benefit Expenses and Profit & Risk**

### **Administration Expense Load**

Administration expenses are based on activity-based allocation by product for calendar year 2016. This methodology applies for all variable costs and all fixed costs. An adjustment was made to the individual administration load to take into account additional broker commissions that are expected to result from shifting business from small group market to the individual market.

### **Profit & Risk Margin**

Profit was set at 5% of premium.

### **Taxes, Fees, and Subsidies**

The following taxes, fees, and subsidies are added to the rates:

<b><u>Tax/Fee</u></b>	<b><u>Unit</u></b>	<b><u>Amount</u></b>
Annual Fee on Health Insurance Providers	% of Premium	1.00%
Federally Facilitated Exchange User Fee	% of Premium	2.45%
Patient-Centered Outcomes Research Fee	PMPM	\$0.20
State Premium Tax	% of Premium	1.32%
Federal Income Tax	% of Premium	2.69%

The Federally Facilitated Exchange (FFE) User Fee for the individual market is **70%** of the 3.5% exchange user fee stated in the final HHS Notice of Benefit and Payment Parameters for 2016. This is the expected enrollment in the Federally Facilitated Marketplace as a percentage of total enrollments in this Single Risk Pool.

### **Projected Loss Ratio**

The anticipated loss ratio is **89.5%** in aggregate.

### **Single Risk Pool**

The Single Risk Pool has been established in accordance with the requirements in 45 CFR 156.80(d) as was discussed previously in the Experience Period Premium and Claims section. The Experience Period includes transitional policies and the Projection Period includes transitional policies only to the extent that we anticipate members will transition into the ACA Compliant products.

### **Index Rate**

The Experience Period Index Rate for this Single Risk Pool is the Allowed Claims PMPM. This represents the total combined EHB allowed claims for the Single Risk Pool divided by all covered lives in the Single

Risk Pool. There are no benefits covered in addition to Essential Health benefits in the policies being offered.

The Projected Index Rate for this Single Risk Pool is the Projected Allowed Experience Claims PMPM (w/applied credibility if applicable). The projected claims reflect the changes in morbidity, trend and benefits described earlier in this memorandum. This represents the Projection Period's total combined EHB allowed claims for the Single Risk Pool divided by all covered lives in the Single Risk Pool. There are no benefits covered in addition to Essential Health benefits in the policies being offered.

### **Market Adjusted Index Rate**

The Market Adjusted Index Rate is developed by adjusting the Index Rate for allowable market-wide modifiers. This includes the Federal Reinsurance Program, the Risk Adjustment Program and the Exchange User Fees. The Reinsurance and Risk Adjustment payments are determined on a PMPM basis and as described above under the Risk Adjustment and Reinsurance section these amounts are converted to an allowed basis. The Exchange User Fee is determined on a percentage basis and does not need to be converted to an allowed basis at this time.

### **Plan Adjusted Index Rates**

The Plan Adjusted Index Rates are developed by adjusting the Market Adjusted Index Rate by the allowable plan level modifiers. The Actuarial Pricing Values are described in detail in the AV Pricing Value section below. The following adjustments were applied in the development of these rates:

Plan Adjusted Index Rate = ((Market Adjusted Index Rate X Tobacco Adjustment X Actuarial Pricing Value) + Administrative Expenses + PCORI PMPM) / (1 - Risk Load - Taxes and Fees)

Per the Instructions, these rates have **not** been calibrated for either age or area. These will be discussed in the Calibrations section.

### **Experience Period Plan Adjusted Index Rates**

The Experience Period Plan Adjusted Index Rates were not calculated or filed during the 2014 rate filing. In order to enter this figure in the current URRT we reviewed the 2014 URRT and performed the following calculations. The Projected Allowed Experience Claims PMPM is the Projected Index Rate. The Market Adjusted Index Rate is adjusted for allowable market-wide modifiers as follows.

The Plan Adjusted Index Rates are then calculated as follows:

Plan Adjusted Index Rate = ((Market Adjusted Index Rate X Tobacco Adjustment X Actuarial Pricing Value) + Administrative Expenses + PCORI PMPM) / (1 - Risk Load - Taxes and Fees)

## **Calibrations**

### **Age Curve Calibration**

The federal age curve is used to determine a normalization factor to account for the age mix of business used in generating the Index Rate (as demonstrated in the supporting file "Calibration for Age"). The approximate weighted average age in the projection period is 50 years. The Plan Adjusted Index Rates are then divided by the overall normalization factor in order to preserve revenue-neutrality when applying the age-specific factors to the Plan Adjusted Index Rate.

### **Geographic Factor Calibration**

The geographic rating area factors used to determine premium rates were generated from a credibility-weighted average of base claim experience by region and relative provider contract factors. The normalization factor is determined using these factors weighted using membership by area. Since the overall factor is not equal to 1.0, the Plan Adjusted Index Rates are then divided by the normalization factor.

The calibration adjustments are applied uniformly to all benefit plans.

### **Consumer Adjusted Premium Rates**

The Consumer Adjusted Premium Rates are developed by applying the following allowable rating factors to the **calibrated** Plan Adjusted Index Rates:

1. Age – reflecting the HHS defined age curve
2. Geographic – as displayed on the previous page
3. Tobacco status – as discussed below.

The final Premium rates for **all** filed benefit plans are displayed in the QHP Rating Template.

### **Tobacco Factor**

A standard load is applied for applicants who indicate tobacco usage by affirmatively answering the question—“Have you used tobacco at least four times a week for the past six months?” This load assumption was validated using the study “*Impact of height, weight, and smoking on medical claims costs*”, a research report done by Milliman to update their Medical Underwriting Guidelines in April 2009.

We utilized the 2014 ACA compliant population to determine the percentage of members that admit to the use of tobacco and pay the increased premium for their entire contract in 2014.

### **AV Metal Values**

The actuarial values generated from the AV Calculator are shown in the table below.

<b>Plan ID</b>	<b>Per AV Calculator</b>
22444PA0010001	88.54%
22444PA0010002	80.82%
22444PA0010003	71.63%
22444PA0010004	68.92%
22444PA0010005	61.87%
22444PA0010006	78.16%
22444PA0010007	79.68%
22444PA0010008	78.16%
22444PA0010009	79.68%
22444PA0010016	78.16%

22444PA0010017	79.68%
22444PA0010018	78.16%
22444PA0010019	79.68%
22444PA0010020	88.54%
22444PA0010021	80.82%
22444PA0010022	71.63%
22444PA0010023	68.92%
22444PA0010024	61.87%
22444PA0010025	90.57%
22444PA0010026	90.57%
22444PA0010027	90.57%
22444PA0040002	81.64%
22444PA0040007	79.55%
22444PA0040008	79.50%
22444PA0040010	71.31%
22444PA0040014	71.02%
22444PA0040018	61.13%
22444PA0040019	58.00%
22444PA0040047	81.64%
22444PA0040050	71.31%
22444PA0040051	71.02%
22444PA0040052	61.13%
22444PA0040053	58.00%
22444PA0040054	81.64%
22444PA0040055	79.55%
22444PA0040056	79.50%
22444PA0040057	79.55%
22444PA0040058	79.50%
22444PA0040059	71.31%
22444PA0040060	71.02%
22444PA0040061	61.13%
22444PA0040062	58.00%
22444PA0040063	81.64%

22444PA0040064	79.55%
22444PA0040065	79.50%
22444PA0040066	71.31%
22444PA0040067	71.02%
22444PA0040068	61.13%
22444PA0040069	58.00%

The AV Metal Values included in worksheet 2 of the Unified Rate Review Template were based on the federal AV Calculator. The pharmacy benefit was modified in order to fit the 3 tier drug structure of the calculator. Our products have three generic tiers that were entered into the AV Calculator’s generic category by combining the three copays based on utilization.

**AV Pricing Values**

The AV Pricing Values used to develop the Plan Adjust Index Rates include the following allowable modifiers described in 45 CFR 156.80(d)(2).

**Actuarial Value and Cost-Sharing design of the plan**

An internal pricing model was used to develop the Pricing AV based on the cost-sharing design of the plan.

**Plan’s provider network, delivery system characteristics and utilization management practices**

The plans listed below have specific adjustments to their Plan Adjusted Index Rate based on county specific provider network contracts and coverage networks that require unique consideration.

Plan ID
22444PA0010008
22444PA0010009
22444PA0010020
22444PA0010021
22444PA0010022
22444PA0010023
22444PA0010024
22444PA0040047
22444PA0040050
22444PA0040051
22444PA0040052
22444PA0040053
22444PA0040055
22444PA0040056

**Administrative costs, excluding Exchange user fees**

All of the benefit plans have the same administrative cost PMPM amount added to the Plan Adjusted Index Rate.

**Catastrophic plans only are adjusted for eligibility requirements for that plan**

Enrollment in the catastrophic plan is limited to individuals who have not attained the age of 30 by the effective date or are certified exempt from buying coverage by the Federally Facilitated Marketplace.

**Membership Projections**

Membership projections are based on expectations of sales and renewals for each segment of the projected Single Risk Pool.

**Terminated Plans and Products**

No products are to be terminated in 2016. The following ACA Compliant plans are included in the Experience Period data and are identified as terminated in the Unified Rate Review Template. These plans were not offered starting in calendar year 2015.

Terminated Plans
22444PA0040013
22444PA0040015
22444PA0040016
22444PA0040017

**Plan Type**

All plan offerings meet the plan type definitions available in the URRT Worksheet 2, Section I.

**Warning Alerts**

The following Warning Alerts are noted in Worksheet 2 as described below.

- **Plan Adjusted Index Rate row 54**: The Plan Adjusted Index Rate in the Experience Period for ACA Compliant plans would have been \$263.84 if it were required to be calculated in the 2014 rate filing. This does not reflect the premiums collected in the Experience Period due to non-ACA Compliant experience and does not represent differences in the distribution of ages, geography and benefits from when the rates were developing versus what actually emerged.
- **Total Premium row 56**: The total premium calculated here does not represent the Experience Period data since non-ACA Compliant experience does not have a Plan Adjusted Index Rate in row 54 and the ACA Compliant Plan Adjusted Index Rate does not represent differences in the distribution of ages, geography and benefits from when the rates were developing versus what actually emerged.
- **Total Incurred claims, payable with issuer funds row 67**: Worksheet 2 calculates total incurred claims by subtracting row 64 from row 60. Row 60 is the total allowed claims in the experience period and matches the amounts from worksheet 1. Row 64 is the portion of allowed claims which are not the issuer’s obligation, which includes the Transitional Reinsurance and Risk



6. The Federal AV Calculator was utilized, with an acceptable alternative methodology when appropriate, to determine the AV Metal Values shown above and in Worksheet 2, Section I of the URRT.

I confirm that the rates submitted comply with the ACA rating requirements and with the Single Risk Pool per market requirement. The URRT does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Marketplaces, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

I certify that rating factors are limited to:

- (i) Age (ratio of highest age rate to lowest age rate does not exceed 3:1, and federally approved age rating curve).
- (ii) Tobacco (ratio does not exceed 1.5:1).
- (iii) Family size (will limit charge to first three dependent children under 19 and cost-sharing requirements for families will be equal to two-times the individual cost-sharing requirements, per federal law).
- (iv) Geography (with federally approved regions).



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**Sarah MacDerment**  
**FSA, MAAA**  
**Attesting Actuary**



May 15, 2015

Mr. Peter Camacci  
HMO/PPO Review Division  
Bureau of Accident and Health Insurance  
Office of Rate Policy and Regulation  
Commonwealth of Pennsylvania  
Department of Insurance  
1311 Strawberry Square  
Harrisburg, PA 17120

**re: Geisinger Health Plan -NAIC #95923  
Individual HMO/POS Rate Filing-for Non-Grandfathered Subscribers  
Effective January 1, 2016**

Dear Mr. Camacci:

Enclosed for your review and approval is a copy of Geisinger Health Plan's proposed Individual HMO/POS rate filing. The projected effective date is January 1, 2016.

The main purpose of this filing is to establish the required revenue for our individual HMO/POS non-grandfathered single risk pool based on all applicable market reforms of the Affordable Care Act (ACA).

As you are aware, the federal government established risk corridors, reinsurance and risk adjustment to protect insurance providers in the first three years of the Marketplace from unpredictable losses associated with caring for members with complex medical needs. Working with an outside actuarial firm, Geisinger Health Plan has projected a proposed average increase of approximately 15 to 40 percent. This broad range was determined by following the federally prescribed rating formula and takes into account the estimated payment transfer as part of risk adjustment. Due to the proposed range, we are unable to determine the specific amount of additional revenue. This filing is expected to affect approximately 16,750 non-grandfathered members.

Unfortunately, the risk adjustment payment transfer amount will not be provided until late June. This payment transfer could have a significant impact on our 2016 rates. Once we are made aware of the payment transfer, we would revise our 2016 individual HMO/POS rate filing.

Geisinger Health Plan is committed to offering Marketplace plans and is working to make sure our proposed rates have minimal impact on our members. We support a Pennsylvania Department of Insurance request of all insurance providers to reevaluate their 2016 rate filings upon receipt of the risk adjustment payment information in late June.



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Please refer to the “Actuarial Memorandum & Attestation” uploaded in SERFF under the “Supporting Documentation” tab for a detailed explanation of our rate development.

Thank you for your consideration. Please contact me if you have any additional questions.

Sincerely,



Kurt J. Wrobel, FSA, MAAA

Chief Actuary

Geisinger Health Plan

cc. Sarah MacDerment, FSA, MAAA, Manager, Actuarial Services

Victoria Bardsley, Manager Product & Pricing, FAHM

Everard Riley, Actuarial Consultant II

HPACT02

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Dev: 5/15/15



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Tel. 800-447-4000 • Fax 570-271-5475 • TTY/TDD 711

## **HIOS Part 2 Consumer Justification Narrative**

### **Individual HMO**

Geisinger Health Plan has proposed an overall base rate increase of up to 40.6% for Individual HMO/POS members renewing in the Marketplace effective January 1, 2016 through December 1, 2016. The overall increase is largely due to the claims experience in ACA compliant individual market plans being much higher than what was assumed in current rates. Other contributing factors include annual claims trend, federally-prescribed ACA fees and reduced benefits in the Transitional Reinsurance Program.

June 19, 2015

Vicki Bardsley, Manager Actuarial Services  
Geisinger Health Plan  
100 North Academy Ave.  
Danville, PA 17822-3225

RE: Proposed 40.6% increase for 2016 on and off exchange individual HMO rates;  
Pennsylvania Insurance Department ID #: GSHP-130072597

Dear Ms. Bardsley:

The Pennsylvania Insurance Department has received and conducted a review of the above captioned filing. In order to complete the review, we are requesting the following information. To facilitate a timely review, we request this information be provided within 14 days of the date of this letter. If you have any questions or difficulties in providing the information within this time frame, please call me.

1. Please certify that you are in compliance with 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I, II, and III version 2/21/15).
2. Please be advised that any time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding of this requirement.
3. Please provide an actuarial narrative regarding the rate impact on this filing of a court decision that ends federal subsidies in Pennsylvania during 2016.
4. Page 2 of the actuarial memorandum describes the credibility manual rate development. Please confirm that the benefit categorization used to develop the credibility manual rate is materially consistent with the category definitions provided in the HHS Unified Rate Review Template instructions.
5. Page 2 of the actuarial memorandum indicates that the credibility manual rate is developed using experience from both grandfathered and non-grandfathered individual experience. Using this data, please show the development of the "utilization per 1000" and "average cost/service" figures, as shown in URRT Worksheet 1, Section II, by the six prescribed benefit categories. The requested development should follow the methodology of the URRT. Please provide an explanatory narrative for any adjustments from the experience period to the projection period. What was the total number of member months for this experience period?
6. What is the basis for the trend selection of 7.1% as shown on page 3 of the actuarial memo? Please provide support.
7. Page 4 of the actuarial memorandum mentions that new medical management initiatives are expected to yield savings in the projection period. Please discuss these initiatives.

8. Worksheet 1 of the URRT indicates that individual GHP HMO enrollment is expected to increase by 11% from the 2014 experience period to the 2016 projection period (180,978 mm to 200,996 mm) while individual GQO PPO enrollment is projected to fall by 63.5%. Please discuss the reasons for this difference and show the derivation of the GHP HMO projected member months of 200,996.

9. The proposed overall rate increase is 40.6%. Page 1 of your actuarial memo lists the following factors contributing to this rate change:

- (a) Single Risk Pool experience which is more adverse than assumed in current rates (morbidity);
- (b) Cost trend;
- (c) Utilization trend;
- (d) Changes in administrative expenses;
- (e) Changes in ACA fees (including the Reinsurance Program);
- (f) Changes in population demographics;
- (g) Changes in plan selection;
- (h) Changes in morbidity load;
- (i) Changes in Transitional Reinsurance coverage;
- (j) Changes in Risk Adjustment.

Please show the proportions that each factor contributes to the 40.6% rate change.

10. Page 4 of the actuarial memorandum indicates that early 2015 enrollment was roughly 22% in platinum and 15% in gold plans. Was the proportion of sales in platinum and gold plans higher than expected? If so, can you explain the sales pattern?

11. Worksheet 2 of the URRT seems to indicate that the rate change is a consistent 40.6% over all plans offered. The Rate/Rule Schedule tab in SERFF indicates that the rate change varies from 43.4% to 35.9%. Please explain.

12. Worksheet 1 of the URRT shows a projected membership of 16,750 (i.e. 200,996/12). The Rate/Rule Schedule tab shows the number of policyholders as 12,086. Please explain the differing results.

13. In order to verify that only allowed adjustments were made to the index rate we need you to translate your process into the one described in the 2016 URRT Instructions. Each element should be as accurate as possible without any element being a balancing adjustment. If a balancing adjustment is needed please show it as a separate item. Please provide the development (in Excel, with formulas) of the age 21 non-tobacco rate in the SERFF Rates Table Template for all plans, starting with the index rate on the URRT Worksheet 1 and reflecting all applicable factors, including the following (as appropriate):

- a. Risk Adjustment;
- b. Reinsurance;
- c. Exchange User Fee;
- d. AV and cost sharing;

- e. Utilization changes due to benefit richness;
- f. Adjustment for tobacco load;
- g. Provider network adjustment;
- h. Benefits in addition to EHBs;
- i. Non-benefit expenses including administrative costs, margin, taxes and fees;
- j. Adjustment for eligibility for catastrophic plans (on catastrophic plans only);
- k. Age calibration; and
- l. Geographic calibration.

14. The Rate Justification Part II is a brief, non-technical, consumer-oriented explanation of the rate increase. As suggested in the HHS Part II instructions, the justification should address: (a) the scope and range of the rate increase, (b) the financial experience of the product, (c) changes in medical service costs, (d) changes in benefits, and (e) changes in administrative costs and anticipated profits. Please provide a comprehensive Part II Rate Justification to the Department.

Please be advised that there may be additional questions based on the responses to the above. Should you have any questions regarding this correspondence, please contact me at [jlaverty@pa.gov](mailto:jlaverty@pa.gov) or by telephone at (717) 787-2117.

Sincerely,

James Laverty ASA, MAAA  
Actuarial Review Division  
Bureau of Accident & Health Insurance

The following is in response to your 6/19/15 request for additional information:

1. We are certifying that the subject filing is in compliance with 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I, II, and III version 2/21/15).

2 We understand that any time the URRT is changed in SERFF, the URRT in HIOS must also be updated.

3. The King vs Burwell court decision of June 25th, 2015 effectively ruled in favor of federal subsidies continuing for 2016 and beyond. Therefore, this has no impact on our proposed rate filings.

4. As noted, page 2 of our actuarial memorandum describes the credibility manual rate development. We are in confirmation that the benefit categorization used to develop the credibility manual rate is consistent with the category definitions provided in the HHS Unified Rate Review Template instructions.

5. Page 2 of the actuarial memorandum indicates that the credibility manual rate is developed using experience from both grandfathered and non-grandfathered individual experience. Using this data, an Excel file ("URRT Development") has been uploaded to the SERFF "Supporting Documentation" tab showing the development of the "utilization per 1000" and "average cost/service" figures, as shown in URRT Worksheet 1, Section II, by the six prescribed benefit categories. All adjustments from the experience period to the projection period are explained. The total number of member months for this experience period is 180,978.

6. The cost and utilization components of the 7.1% annual trend (shown on page 3 of the actuarial memo) used to develop the 2016 rates is shown on the "Medical Trends Narrative" file (uploaded in SERFF).

7. Page 4 of the actuarial memorandum mentions that new medical management initiatives are expected to yield savings in the projection period. These initiatives are discussed in the "Medical Management Initiatives" document uploaded in SERFF.

8. The Projected Member Months shown in the URRT (i.e. 200,996) were developed by the GHP actuarial team, in conjunction with our Sales team. We estimated the number of members from our transitional and grandfathered blocks which we expect to move to the Exchange in 2016, along with the existing Exchange members. These projected members will thus differ from the experience period enrollment (i.e. 180,978 member months) since the projected figure includes 22,782 member months from our current grandfathered block.

9. Based on our original submitted filing, the proposed overall rate increase is 40.6% (but we are still reviewing our final 2016 rate filing position). Page 1 of our actuarial memo lists all of the requested factors contributing to this rate change. The proportions that each factor contributes to the 40.6% rate change are shown on the uploaded Excel file "Proj Rate Increase Allocation".

10. Page 4 of the actuarial memorandum indicates that early 2015 enrollment was roughly 22% in platinum plans and 15% in gold plans. This proportion of sales in platinum and gold plans was not higher than expected.

11. Worksheet 2 of the URRT shows the OVERALL rate increase (i.e. 40.6%) for each of the benefit plans offered since the CMS-developed macros supporting the URRT automatically populate each cell following the percentage input for the initial plan. The Rate/Rule Schedule tab in SERFF shows the actual range of rate increases (i.e. minimum 35.9% to a maximum 43.4%).

12. Worksheet 1 of the URRT shows the average projected members to be 15,082 (i.e. 180,978/12). The Rate/Rule Schedule tab shows the

number of policyholders (or subscribers) as 12,086. The difference in these figures is accounted for by the fact that we have rolled up all members from the same family unit in our 12,086 policyholder figure.

13. In order to demonstrate that only allowed adjustments were made to our index rate, we have uploaded an Excel file ("Rate Calculation Examples") demonstrating the process used to develop our rates (consistent with the 2016 URRT Instructions). This file shows the development for an age 21 non-tobacco rate in the SERFF Rates Table Template for all plans, starting with the index rate on the URRT Worksheet 1 and reflecting all applicable factors.

14. The Rate Justification Part II has been expanded to address: (a) the scope and range of the rate increase, (b) the financial experience of the product, (c) changes in medical service costs, (d) changes in benefits, and (e) changes in administrative costs and anticipated profits. This revised document has been uploaded in SERFF.