

SERFF Tracking #:

INAC-129936718

State Tracking #:

INAC-129936718

Company Tracking #:

KHPE HMO INDIV 1Q16

State: Pennsylvania

Filing Company: Keystone Health Plan East, Inc.

TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO

Product Name: KHPE Individual HMO eff 1-1-2016

Project Name/Number: /

Supporting Document Schedules

Satisfied - Item:	Cover Letter
Comments:	Attached is the cover letter.
Attachment(s):	khpe indiv cover letter 2016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	REDACTED QHP Actuarial Memorandum
Comments:	Attached is the Federal Actuarial Memorandum.
Attachment(s):	33871_01012016_IND_RedactedAM.pdf
Item Status:	
Status Date:	



May 15, 2015

Mr. Peter Camacci, Director
Bureau of Accident and Health Insurance
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

SUBMITTED VIA SERFF

**RE: Keystone Health Plan East
Individual HMO Rate Filing effective 1/1/2016
INAC-129936718**

Dear Mr. Camacci:

Keystone Health Plan East is introducing new and renewing HMO plans in the individual (non-group) market of the Commonwealth of Pennsylvania to satisfy market reform requirements of the Affordable Care Act (ACA)—some plans are included in a concurrent application for certification as a Qualified Health Plan. This rate filing includes rates for these plans and specifies compliance with rating requirements of the ACA. The proposed effective date for the enclosed rates is January 1, 2016.

The off-exchange plans are available to members of a group policy with conversion privileges who exercise that privilege.

This rate filing is being submitted along with concurrent form filing(s) and SERFF Plan Management binder(s):

- INBC-130042021



- INBC-PA16-125043470

Please contact David Walker at (215) 640-7846 or David.Walker@ibx.com with any questions regarding this filing.

Sincerely,

A handwritten signature in blue ink that reads "Hugh Lakshman".

Hugh Lakshman, FSA, MAAA
Director and Actuary, Commercial Pricing

cc: Kathryn A. Galarneau, FSA, MAAA
Thomas Hutton
Richard F. Levins, Esquire
Mary Ellen McMillen
Daniel Rachfalski, FSA, MAAA

GENERAL OVERVIEW

PURPOSES

This Actuarial Memorandum is provided along with the Unified Rate Review Template (URRT) to provide certain information to support the gross premium for the single risk pool for individual market health care insurance underwritten by Keystone Health Plan East in the Commonwealth of Pennsylvania. It is provided as a component of an application for certification as a Qualified Health Plan and a state rate filing. This submission may not be appropriate for other purposes.

GENERAL INFORMATION

COMPANY IDENTIFYING INFORMATION

Company Legal Name: Keystone Health Plan East ("KHPE")
State: Pennsylvania
HIOS Issuer ID (5-digit): 33871
Market: Individual
Effective Date(s): 1/1/2016

Worksheet 1 of the accompanying URRT contains experience period data and development of the projected Single Risk Pool Gross Premium Average Rate PMPM for the individual market for the Keystone Health Plan East ("KHPE") and QCC Insurance Company ("QCC") entities. Worksheet 2 contains experience period data and projections by product for the single risk pool for the same entities. This memorandum pertains only to plans denoted in Worksheet 2 by Plan IDs starting with the sequence 33871.

COMPANY CONTACT INFORMATION

Primary Contact Name: David Walker
Primary Contact Telephone Number: 215-640-7846
Primary Contact Email Address: David.Walker@ibx.com

PROPOSED RATE INCREASE

The changes to the single risk pool gross premium average rate per member per month (PMPM) from calendar year 2014 to calendar year 2016 were incorporated into the pricing and reflected in the Unified Rate Review Template. The changes are driven for by factors including: changes in market-wide population risk morbidity and covered services, increasing unit costs for medical services, increasing utilization of medical services, increasing fees and taxes imposed by the federal government, anticipated

costs to administer the plan, anticipated revenue or payments due to market-wide risk adjustment, and anticipated net reinsurance payments from the Federal Transitional Reinsurance Program.

WORKSHEET 1: DATA COLLECTION TEMPLATE

SECTION I: EXPERIENCE PERIOD DATA

PAID THROUGH DATE

Experience period premium, claims, and member months are obtained from the company's internal data warehouse. The claims data is collected for incurred dates from January through December 2014 and paid through January 2015. Earned premiums and member months are for January through December 2014. The data are for all individual business in the Commonwealth of Pennsylvania for the following legal entities: Keystone Health Plan East ("KHPE") and QCC Insurance Company ("QCC").

PREMIUMS (NET OF MLR REBATE) IN EXPERIENCE PERIOD

Earned Premiums (net of MLR Rebate) in Experience Period are developed by summing the earned premium reported in the company's internal data warehouse and adjusting for MLR rebates, if any, for the period. Although 2014 federal MLR rebate calculations are not final as of the writing of this memorandum, no federal MLR rebates are expected for calendar year 2014, so no adjustment to earned premium for MLR rebates is needed.

The calculation for federal minimum loss ratio rebates is based on 2012, 2013, and 2014 experience of earned premium, incurred claims, quality improvement expenses, and taxes. The three years of experience is blended for all segments.

ALLOWED AND INCURRED CLAIMS INCURRED DURING THE EXPERIENCE PERIOD

Paid-to-Date and Incurred Claims, and Member Months

Insurer fee-for-service claims expenses and member liabilities for dates of service in January 2014 through December 2014 and paid through January 2015 are sourced from the IBCFOC's internal data warehouse. The claims and member liabilities are completed with incurred but not reported (IBNR) adjustments to develop ultimate incurred insurer fee-for-service claims expenses and member liabilities for the January through December 2014 period. Capitation amounts are also sourced from the internal data warehouse for the January through December 2014 period but they are not adjusted for IBNR.

IBNR Development

Medical fee for service incurred but not reported (IBNR) claims are modeled through the use of standard claim lag methodologies. A range of results is developed, and a provision for adverse deviation is

applied. The provision for adverse deviation is dependent on many factors such as stability, size, product mix, etc.

The completion factors are developed annually in the 2Q – 3Q period. We do not believe our IBNR is unusually high or unusually low for incurred 2014 paid through January 2015.

Allowed Claims

Allowed claims are determined by separately obtaining paid-to-date fee-for-service claims and member cost-sharing amounts, applying claim lag factors to those amounts to estimate ultimate incurred fee-for-service claims and member-sharing amounts and adding them together with capitation amounts.

Allowed claims do not include ineligible claims, payments for services other than medical care provided, recovery payments related to internal large claim pooling mechanisms, or active live reserves.

Experience Period Index Rate

The Index Rate of Experience Period is estimated by removing cost and utilization trend from the Index Rate for Projection Period.

SECTION II: ALLOWED CLAIMS, PMPM BASIS

BENEFIT CATEGORIES

Utilization and Unit Cost data for allowed claims in the experience period are provided in Section II. The data is provided by benefit category using a standardized indicator from the internal data warehouse that assigns each claim line to a category based on the type of provider and the location of the service. The utilization and unit cost data are provided for the following categories: Inpatient Hospital admits, Outpatient Hospital visits, Professional visits, Other Medical visits, Capitation per member per month (PMPM), and Prescription Drug scripts.

Experience Period capitation is reported as a per member per month (PMPM) value. In order to complete the URRT, the Utilization per 1,000 statistics for capitated services only is reported as 1,000 so that the appropriate capitation PMPM is reported.

PROJECTION FACTORS

The estimated incurred claims experience on an allowed basis for January 2014 through December 2014 is projected to the future rating period by several factors.

Changes in Population Risk Morbidity

Experience period allowed claims are adjusted to account for differences in the average morbidity of the single risk pool population underlying the experience and the anticipated population in the

projection period. This adjustment reflects changes in either the individual or small group market-wide morbidity due to one or more of the following: guarantee issue, the individual mandate, Medicaid and CHIP migration, take-up of insurance by the previously uninsured, health status of the newly insured, enrollment from prior high risk pools, subsidy effects, dumping of enrollment from group markets to the individual market, and market-wide impact of transitional products/plans.

Changes in Other Factors

Experience period allowed claims are adjusted to account for differences in the single risk pool population underlying the experience and the anticipated population in the projection period pertaining to several factors not due to changes in morbidity or the costs and utilization of medical care. This adjustment reflects: additional benefits required to be covered as essential health benefits; recently mandated benefits required by state law that are not reflected in the experience period data; benefits in the experience that are removed for the projection period; anticipated changes in the average utilization of services due to differences in average cost sharing requirements during the experience period and average cost sharing requirements in the projection period; changes in demographic characteristics of the single risk pool experience period population and the projection period population (including age, gender, region, and tobacco use); changes in the provider network (adding or removing a provider system or introducing a limited network option); and anticipated changes in pharmacy rebates.

Annualized Cost Trend

Annual cost trend reflects changes in costs of medical treatment due to medical inflation and changes in the distribution of services across network providers. The trend value is developed by reviewing historical medical costs for the single risk pool and adjusting them for anticipated future provider contracting reimbursement levels. The data is normalized for changes in age, benefit changes during the experience period, changes to provider contracts, and prescription drug formulary, and new drugs brought to market.

Annualized Utilization Trend

Annual utilization trend reflects the change in the number of units per 1,000 members for a fixed level of illness burden and includes changes due to the mix and intensity of services provided and changes related to shifts in product mix. It also includes effects of selection, if any, since this cannot be reflected in the relative cost of the various products and plans offered.

CREDIBILITY MANUAL RATE DEVELOPMENT

The experience period claims for the single risk pool are determined to be fully credible, therefore no credibility adjustment is required.

SECTION III: PROJECTED EXPERIENCE

PAID TO ALLOWED RATIO

The Projected Allowed Experience Claims PMPM shown in Worksheet 1 represents projected allowed claims experience PMPM for the projected portfolio of plans. The Paid to Allowed Average Factor in Projection Period adjusts the allowed down to Projected Incurred Claims before ACA reinsurance and risk adjustment for the population anticipated to be covered in the projection period. The Projected Incurred Claims before ACA reinsurance and risk adjustment represents the net amount of incurred insurer claim liability expected in the projection period, net of member cost sharing and cost sharing paid by HHS on behalf of low-income members. It reflects the average benefit level anticipated during the projection period.

RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustment PMPM

Projected Risk Adjustment is accounted for in Projected Incurred Claims before ACA Reinsurance and Risk Adjustment to reflect anticipated risk adjustment transfer amounts for the projection period. The amount reflects the projected morbidity for the single risk pool for IBCFOC in the projection period.

The estimated risk adjustment revenue for all of the plans in the risk pool is developed using the following methodology. We recognize that the HHS payment transfer formula implies that the projected incurred claims based solely on the experience period single risk pool claims need to be adjusted by the ratio of the current statewide market's risk relative to allowable rating factor (ARF) for age compared to the single risk pool's risk relative to ARF presented during the experience period. This adjustment, together with the assumed future changes in population risk morbidity, results in the issuer's pricing being consistent with the anticipated morbidity level of the future statewide market.

Estimating the current statewide market's risk and ARF is difficult, because we do not have access to the relevant data from other carriers operating in this market. In order to gain insight, we participated in the Wakely Consulting Group's risk adjustment reporting project for this market. Our assumptions are the result of a combination of measurements based on Wakely's reports and our own actuarial judgment.

The anticipated risk adjustment transfer revenue is allocated proportionally based on plan premium. The Projected Risk Adjustment is subtracted from Projected Incurred Claims before ACA Reinsurance and Risk Adjustment to reflect anticipated receipt of risk adjustment transfer amounts for the projection period.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market Only)

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium PMPM is subtracted from Projected Incurred Claims before Reinsurance Recoveries to reflect anticipated receipt of reinsurance recoveries from the temporary Federal Transitional Reinsurance Program. Anticipated recoveries are offset by the Reinsurance Program Funding Fee assessed by the federal government to fund the temporary Federal Transitional Reinsurance Program.

The reinsurance recoveries estimate is based on our 2014 experience of member level allowed claims trended to 2016. Claims experience is pooled for greater credibility. The impact of essential health benefits and market morbidity change is not included.

To measure the reinsurance recoveries, the out of pocket maximum for 2016 is first subtracted from the total allowed claims for each single member. The remaining amount, if any, will be subject to the reinsurance payments, and the reinsurance parameters for 2016, released in the Notice of Benefit and Payment Parameters (NBPP), are applied.

The reinsurance recoveries assumption is estimated as a percentage of projected reinsurance recovery payment over the projected total allowed claims, and this assumption is applied across all plans in the single risk pool.

Per HHS NBPP, reinsurance assessment will be collected from all health insurers for commercial business and third party administrators, on behalf of self-insured group health plans, on a per capita basis, and the 2016 rate will be \$2.25 PMPM. We are aware that there is possibility that the pool of reinsurance funding may not be sufficient to pay the requested reinsurance recoveries, and eventually all requests would be proportionately adjusted. However, we believe the 2016 pool of funds will be sufficient, and no adjustments are made to our reinsurance recovery assumption.

NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

An Administrative Expense Load is applied to Projected Incurred Claims to reflect expenses related to quality improvement and fraud detection/recovery and other expenses of operating a business, broker commissions, and premium payment processing fees.

Profit & Risk Load/Contribution to Surplus

A Profit & Risk Load/Contribution to Surplus for the single risk pool is applied to Projected Incurred Claims for the projection period, if applicable.

Taxes and Fees

A Taxes & Fees load is applied to Projected Incurred Claims to pass through the following fees and taxes levied by the federal and state governments:

- *Risk Adjustment Fee & PCORT (Comparative Clinical Effectiveness Research Tax)*: applied equally across all plans in the single risk pool.

- *Exchange User Fee*: applied to all plans as an adjustment to the index rate at the market level, as per regulation.
- *State Premium Tax*: not applicable to plans under the KHPE and AHPA Entities; applied to plans under the QCC entity.
- *Health Insurer Fee*: applied equally across all plans in the single risk pool

PROJECTED LOSS RATIO

The projected loss ratio for the single risk pool is estimated to exceed 80%, [REDACTED] reflecting premium adjustments permitted by the federal MLR calculation.

INDEX RATE

The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. The Index Rate is the same value for all non-grandfathered plans for an issuer in a state and market.

MARKET ADJUSTED INDEX RATE

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules: federal reinsurance program adjustment, risk adjustment and exchange user fees. The Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool.

PLAN ADJUSTED INDEX RATE

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rule. These include actuarial value and cost sharing adjustment, provider network, delivery system and utilization management adjustment, adjustment for benefits in addition to the EHBs, impact of specific eligibility categories for the catastrophic plan and administrative costs.

CALIBRATION

The plan adjusted index rate is projected for all products using the same anticipated age distribution and the mandated age curve. Therefore the consumer adjusted premium rate is the plan adjusted index rate divided by the average age and geographic factor for the expected distribution. [REDACTED]
[REDACTED]

There is only one geographic rating area for this filing. The geographic rating area factor for this filing is 1.0.

WORKSHEET 2: PRODUCT-PLAN DATA COLLECTION

AV METAL VALUES

The AV Metal Values included in Worksheet 2 of the URRT were valued using the AV Calculator, where possible, otherwise the AV Metal Values were developed under an alternate methodology. Actuarial certifications required by 45 CFR Part 156, §156.135 are provided in a separate document.

AV PRICING VALUES

The AV Pricing Value represents the cumulative effect of adjustments made by plan to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate.

MEMBERSHIP PROJECTIONS

Enrollment is projected based on current and anticipated enrollment by plan. Items impacting these projections include changes in the size of the market due to introduction of guarantee issue requirements, the individual mandate, and the introduction of a Basic Health Program.

TERMINATED PLANS

No 2015 KHPE Individual plans are being terminated.

WARNING ALERTS

There are no warning alerts in URRT part 1.

ACTUARIAL CERTIFICATION

I, Hugh Lakshman, am Director & Actuary of Commercial Markets for the Independence Blue Cross Family of Companies. I am a member of the Society of Actuaries and the American Academy of Actuaries with the education and experience necessary to perform the work necessary and meet the Qualification Standards of the American Academy of Actuaries to render the qualified actuarial opinion contained herein. The developed rates and memorandum have been prepared in conformity with appropriate Actuarial Standards of Practice and the Academy's Code of Professional Conduct.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the premium rates and allowable rating factors. Rather, it represents information required by Federal regulation to be provided in support of the review of gross premium 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.

I hereby certify that, to the best of my knowledge and judgment, the following:

- The projected index rate is:
 - In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.08(d)(1));
 - Developed in compliance with applicable Actuarial Standards of Practice;
 - Reasonable in relation to the benefits provided and the population anticipated to be covered; and
 - Neither excessive nor deficient.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
- The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans, unless an alternate methodology was required. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR Part 156, §156.135 will be included.



Hugh Lakshman, FSA, MAAA
May 15, 2015

SERFF Tracking #:

INAC-129936718

State Tracking #:

INAC-129936718

Company Tracking #:

KHPE HMO INDIV 1Q16

State: Pennsylvania

Filing Company: Keystone Health Plan East, Inc.

TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO

Product Name: KHPE Individual HMO eff 1-1-2016

Project Name/Number: /

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Additional Information Needed	Cherri Sanders-Jones (AH)	06/05/2015	06/05/2015

Response Letters

Responded By	Created On	Date Submitted
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State: Pennsylvania **Filing Company:** Keystone Health Plan East, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: KHPE Individual HMO eff 1-1-2016
Project Name/Number: /

Objection Letter

Objection Letter Status	Additional Information Needed
Objection Letter Date	06/05/2015
Submitted Date	06/05/2015
Respond By Date	06/19/2015

Dear Hugh Lakshman,

Introduction:

June 5, 2015

Hugh Lakshman
Director and Actuary - Commercial Markets
Keystone Health Plan East, Inc.
1901 Market Street
Philadelphia, PA 19103

RE: Keystone Health Plan East, Inc. - Individual - HMO
Received: May 11, 2015 SERFF ID# INAC-129936718

Dear Mr. Lakshman:

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. It is my understanding that Section I of worksheet I of the URRT is to contain the single risk pool data for a given issuer, state and market. Your actuarial memorandum indicates that the experience period data provided represents KHPE, AmeriHealth and QCC. Please revise to reflect data solely for the named issuer for calendar year 2014.
2. The filing indicates the weighted average increase across products/plans based on current ACA-compliant membership is 2.8%. Worksheet 2 of the URRT (row 28) shows a rate increase of 4.52% for a PPO Product and a 1.91% increase for the HMO product. Since HMOs are only allowed to do HMO/POS business, should the threshold product rate increase for the HMO be 1.91% and not 2.8%? Please review the URRT, company rate information contained in the Rate/Rule Schedule tab and any other items that may be impacted and revise as necessary.
3. The filing indicates the weighted average increase across plans based on current ACA-compliant membership is 2.8%. Please show how this average breaks down by the following:
 - Impact of medical claim trend;
 - Revisions to assumptions about population morbidity and the projected population distribution;
 - Changes to the reinsurance program;
 - Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;
 - Changes in pricing models used to determine the impact of cost sharing design;
 - Changes in provider networks and contracts.
4. Please provide the Federal Rate Template in the Rate/Rule Schedule tab.
5. Your actuarial memorandum does not meet the standard as prescribed by CMS in the 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I (v2.0.4, II, and III) version 2/21/15. Please provide.
6. Please provide further discussion of the rates in the Base Rate Schedule.
7. Please provide an Excel exhibit that shows the development of the 2016 projected Index Rate, starting from the 2014 experience data. Also, provide narrative that explains the development and all adjustments.
8. Please provide an Excel exhibit that shows the development of the Plan adjusted Index Rate for each plan design offered in 2016,

State: Pennsylvania **Filing Company:** Keystone Health Plan East, Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
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starting from the Index Rate.

9. Please provide Excel exhibits that show the development of all calibration adjustments.

10. What is the basis for the trend selection of 7.6%? Please provide support and a narrative that explains the trend development.

11. Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding and certify that you are in compliance.

12. Does your company offer transitional policies in Pennsylvania? If so, what markets (individual and/or small group). Please provide the SERFF # for the approved transitional rate filing(s) and the number of transitional members enrolled in each market as of April 1, 2015.

13. Under what pricing assumptions regarding the King v. Burwell Supreme Court Case has your filing been made? Please provide an actuarial narrative and justification regarding the rate impact for the alternate decision.

Response to this request should be provided via SERFF in Microsoft Excel spreadsheets (version 2010 or less). Please retain all formulas.

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 csandersjo@pa.gov or by telephone at (717) 787-5172.

Sincerely,

Cherri Sanders-Jones
Actuarial Review Division
Bureau of Accident & Health Insurance

Conclusion:

Sincerely,

Cherri Sanders-Jones (AH)

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KHPE HMO INDIV 1Q16

State: Pennsylvania**Filing Company:** Keystone Health Plan East, Inc.**TOI/Sub-TOI:** HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO**Product Name:** KHPE Individual HMO eff 1-1-2016**Project Name/Number:** /

Supporting Document Schedules

Satisfied - Item:	REDACTED Response to Objection Letter Dated June 5, 2015
Comments:	Attached are redacted versions of the exhibits sent in response to the June 5, 2015 objection letter.
Attachment(s):	R-Comparison To URRT Instructions.pdf R-Exhibit A - 2016 Projected Index Rate Calculation.pdf R-Exhibit C 2016 Plan Adjusted Indes Rate Calculation.pdf R-pa khpe ind AV screenshots question 14.pdf R-pa khpe ind certifications question 14.pdf R-khpe ind 2016 response to objection letter dated 6-5-15.pdf R-Calibration.pdf R-Trend Basis.pdf HPC_letter_to_HHS_King_v_Burwell_022415.pdf R-Exhibit B - 2016 Market Index Rate Calculation.pdf R-Breakdown of 2016 Consumer Rate Increase.pdf
Item Status:	
Status Date:	

LOCATION:

Page Paragraph Heading

4.2 General Information			Company Identifying Information
Company Legal Name			Company Identifying Information
State			Company Identifying Information
HIOS Issuer ID			Company Identifying Information
Market			Company Identifying Information
Effective Date			Company Contact Information
Company Contact Information			Company Contact Information
4.3 Proposed Rate Increase			Proposed Rate Increase
Reason for Rate Increase (List factors)			
4.4 Market Experience			
4.4.1 Experience Period Premium and Claims			
Paid through date			Paid Through Date
Premiums net of rebate in Experience Period			Premiums (Net of MLR Rebate) in Experience Period
Amount of (expected) rebates			Premiums (Net of MLR Rebate) in Experience Period
Allowed and Incurred Claims During the Experience Period (separately)			
Amount processed through issuer's claim system			Paid-to-Date and Incurred Claims
Amount processed outside issuer's claim system			Paid-to-Date and Incurred Claims
IBNR			IBNR Development
Method for determining Allowed Claims			Allowed Claims
Support for IBNR			IBNR Development
Benefit Categories			Benefit Categories
4.4.2 Describe methodology to determine into which category claims fall			Projection Factors
4.4.3 Description of each factor used and supporting information			Projection Factors
Changes in Morbidity			Changes in Population Risk Morbidity
Describe adjustment factors used			Changes in Other Factors
Changes in Benefits			Changes in Other Factors
Describe adjustment factors used during the projection period			Changes in Other Factors
Changes in Demographics			Changes in Other Factors
Describe adjustment factors used between average mix in experience and projection period			Changes in Other Factors
Other Adjustments			Changes in Other Factors
Describe adjustment factors used			Annualized Cost Trend
Trend factors			Credibility Manual Trend Development
Describe adjustment factors used and claim sources used			Credibility Manual Trend Development
4.4.4 Credibility Manual Development			Paid to Allowed Ratio
4.4.5 Credibility of Experience			Paid to Allowed Ratio
4.4.6 Paid to Allowed Ratio			Projected Risk Adjustment PMPM
4.4.7 Risk Adjustment and Reinsurance			Projected Risk Adjustment PMPM
Explain methodology used to estimate the amounts during experience period			Projected Risk Adjustment PMPM
Explain development of risk adjustment revenue for the risk pool			Projected ACA Reinsurance Recoveries
Explain how risk adjustment revenue was applied the Index Rate			Projected ACA Reinsurance Recoveries
Report Reinsurance payments net of contributions			Projected ACA Reinsurance Recoveries
Explain underlying experience data and assumptions			Projected ACA Reinsurance Recoveries
Explain how liability for claims liability between attachment point and cap			Projected ACA Reinsurance Recoveries
State assumed amount of assessment as PMPM			Administrative Expense Load
4.4.8 Non-Benefit Expenses and Profit & Risk			
Provide support for Administrative Expense Load			

4.5	Projected Loss Ratio	Describe methodology for estimating projection period amounts Describe target underwriting gain/loss margin and change from last filing Describe each tax and fee and indicate the amount for each that may be deducted in MLR formula Do not include contributions to federal reinsurance or risk adjustment Taxes and fees are considered Administrative Expenses per 45 CFR 156.80(d)	Administrative Expense Load Administrative Expense Load
4.6	Application of Market Reform Rating Rules	Indicate the projected MLR Single Risk Pool Provide support that it meets requirements Index Rate Support for the development in both the experience and projection periods Explain difference between total allowed claims PMPM and the Index Rate Individual Market - should match 12 month projection in Worksheet 1 SG - should reflect weighted average of projected index rates for all four quarters SG Quarterly trend factors should be filed Market Adjusted Index Rate Explain how the allowed variables are applied (market-wide)	Projected Loss Ratio Index Rate Index Rate Index Rate Market Adjusted Index Rate Market Adjusted Index Rate Market Adjusted Index Rate
4.6.1	Single Risk Pool	Federal reinsurance Risk adjustment Marketplace user fee adjustment	
4.6.2	Index Rate	Should not be calibrated Plan Adjusted Index Rates Explain how allowed modifiers were applied AV and cost-sharing Provider network, delivery system, and utilization management adjustment Benefits in addition to EHBs Specific eligibility for catastrophic plans Distribution and admin costs Tobacco surcharge	
4.6.3	Market Adjusted Index Rate		
4.6.4	Plan Adjusted Index Rates		
4.6.5	Calibration Age Curve	Provide average age rounded to a whole number associated with the projected single risk pool Explain factors used to determine the average age Actuarial justification and description of the calculation Demonstration of how the Plan Adjusted Index Rate and age curve are used to produce rate schedule Geographic Factor List all geographic factors Provide the geographic calibration if one is necessary	Plan Adjusted Index Rate Plan Adjusted Index Rate Plan Adjusted Index Rate Plan Adjusted Index Rate Calibration Calibration Calibration Calibration Calibration Calibration
4.6.6	Consumer Adjusted Premium Rate Development	Describe how allowable consumer level adjustments are applied to Plan Adjusted Index Rate SG - Consumer Adjusted should reflect appropriate quarter, trend	
4.7	AV Pricing Values		
4.7.1	AV Metal Values	Describe the methodology used to determine AV Metal Values	AV Metal Values
4.7.2	AV Pricing Values	Indicate the portion of the AV Pricing Value that is attributable to each of the allowable modifiers Membership Projections Describe how membership projections from Worksheet 2 were developed Explain differences relative to current membership For Silver Consumer, describe distribution by CSR level	AV Pricing Values Membership Projections
4.7.3	Membership Projections		

4.7.5	Terminated Plans and Products List terminated plans, products not in experience period but available later Provide cross-walks for terminated plans mapped to new plans	Terminated Plans
4.7.6	Warning Alerts Explain	Warning Alerts
4.8	Miscellaneous Instructions	
4.8.1	Effective Rate Review Information Optional	
4.8.2	Reliance Disclose reliance on other individuals (names)	
4.8.3	Actuarial Certification List of Elements	Actuarial Certification

PASML
Confidential Actuarial Memorandum - Addendum
Exhibit A
2016 PASML Pricing

	Experience Period Allowed Claims	PMPM
KHPE	[REDACTED]	[REDACTED]
QCC	[REDACTED]	[REDACTED]
Total	[REDACTED]	[REDACTED]
Trend	[REDACTED]	[REDACTED]
Projected to 2016		[REDACTED]
Value of Non-EHB Benefits		[REDACTED]
2016 Projected Index Rate		[REDACTED]

PA Consumer

**Confidential Actuarial Memorandum - Addendum
Exhibit C**

**2016 PA Consumer Pricing
Single Risk Pool**

Calculation of the Plan Adjusted Index rate, beginning from the Market Adjusted Index Rate

Market Adjusted Index Rate (Exhibit B) 1Q201

Plan Name	Plan ID	Pricing AV	1Q2016 Plan Adjusted Index Rate
Keystone HMO Platinum	33871PA0040001		
Keystone HMO Gold	33871PA0040002		
Keystone HMO Silver	33871PA0040003		
Keystone HMO Bronze	33871PA0040004		
Keystone HMO Gold Proactive	33871PA0040005		
Keystone HMO Silver Proactive	33871PA0040006		
Keystone HMO Platinum	33871PA0040020		
Keystone HMO Gold	33871PA0040021		
Keystone HMO Silver	33871PA0040022		
Keystone HMO Bronze	33871PA0040023		
Keystone HMO Gold Proactive	33871PA0040024		
Keystone HMO Silver Proactive	33871PA0040025		
Keystone HMO Silver Proactive Value	33871PA0040007		
Keystone HMO Silver Proactive Value	33871PA0040026		

ALL PAGES REDACTED

Unique Plan Design Supporting Documentation and Justification

HIOS Issuer ID: 33871

HIOS Product IDs: 33871PA004

Applicable HIOS Plan IDs (Standard Component): 33871PA0040005, 33871PA0040006, 33871PA0040007

Purpose of document:

The purpose of this document is to provide CMS with a justification of the methods used in calculating the actuarial value for unique plan designs offered in the individual or small group market for the plan year beginning 1/1/2016. As prescribed by law, the AV calculation was based on the AV calculator to the full extent possible. The AV is meant to represent the average percent of costs paid by the insurer for a standard population, and may vary from actual member experience. The AV was determined based on the plan's benefits and coverage data, the standard population, and utilization and continuance tables published by HHS for purposes of the valuation of AV. This actuarial analysis is not appropriate for any other purposes.

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

[REDACTED]

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

[REDACTED]

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

[REDACTED]

Description of the standardized plan population data used:



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

Copays for Outpatient Facility



Plan: 33871PA0040005 Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040005 Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040005 Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006 Tier 1

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006 Tier 2

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006 Tier 3

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-04 Tier 1

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-04

Tier 2

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-04

Tier 3

	Allowed PMPY ¹	Utilization PMPY ³	Allowed Per Service ³	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-05

Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-05

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040006-05

Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040006-06

Tier 1

	Allowed PMPY ¹	Utilization PMPY ⁴	Allowed Per Service ⁴	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040006-06

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ⁴	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040006-06

Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ⁴	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040007

Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007

Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040007-04

Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic	[REDACTED]				
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility	[REDACTED]			
OP Professional				
Total				

Plan: 33871PA0040007-04

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-04

Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Silver)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-05

Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-05

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-05

Tier 3

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Gold)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-06

Tier 1

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-06

Tier 2

	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

Plan: 33871PA0040007-06

Tier 3

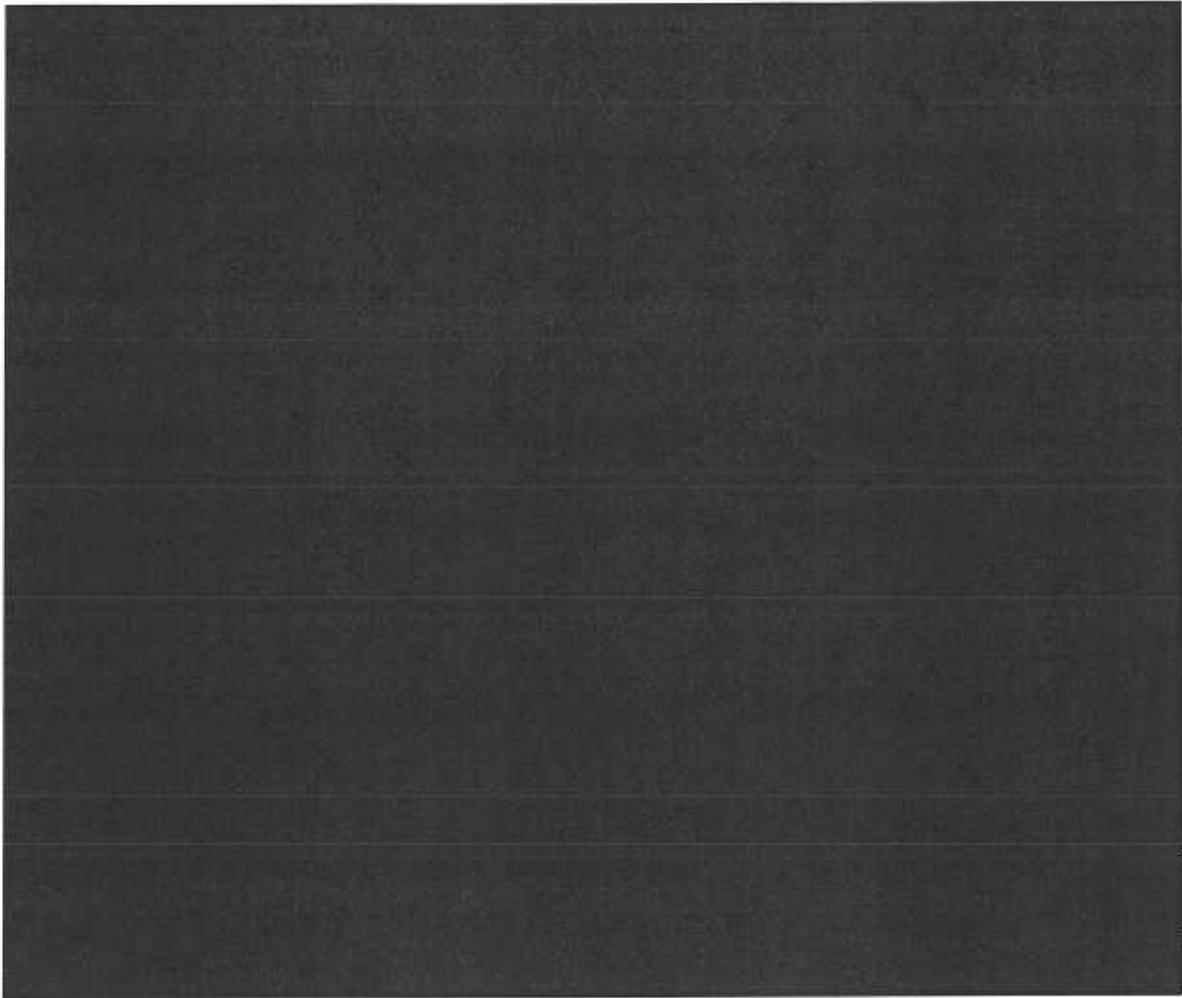
	Allowed PMPY ¹	Utilization PMPY ²	Allowed Per Service ²	Copay	Cost Share PMPY
Other Diagnostic					
Anesthesia					
Surgery					
Renal					
Total					

	PMPY from AVC (Platinum)	Cost Share PMPY	Member Coinsurance	Insurer Coinsurance
OP Facility				
OP Professional				
Total				

- 1 -
- 2 -
- 3 -
- 4 -



Combination of Copays and Coinsurance for IP Hospital



e
m

Plan	33871PA0040005		33871PA0040006		33871PA0040007	
	Tier 2	Tier 3	Tier 2	Tier 3	Tier 2	Tier 3
IP Cost Sharing						
Facility Copay per day (max 5)						
Professional Coinsurance						

AVC Continuance Table	Gold	Silver	Silver
	PMPY for IP		
Admit PMPY			
Claim per Admit			
Average LOS (days)			
Effective Copay Factor for 5 days			

Assumption From Data			
% Facility Cost			
% Professional Cost			

Calculated			
Professional Claim per Admit			
Professional Claim per Day			
Equiv. Copay Per Day no max			
Equiv. Copay Per Day, 5 day max			
Total IP Copay Per Day, 5 day max			

Plan	33871PA0040006-04		33871PA0040006-05		33871PA0040006-06	
Tier	Tier 2	Tier 3	Tier 2	Tier 3	Tier 2	Tier 3
IP Cost Sharing	[REDACTED]					
Facility Copay per day (max 5)						
Professional Coinsurance						

AVC Continuance Table	Silver	Gold	Platinum
PMPY for IP	[REDACTED]		
Admit PMPY			
Claim per Admit			
Average LOS (days)			
Effective Copay Factor for 5 days			

Assumption From Data	[REDACTED]		
% Facility Cost			
% Professional Cost			

Calculated	[REDACTED]		
Professional Claim per Admit			
Professional Claim per Day			
Equiv. Copay Per Day no max			
Equiv. Copay Per Day, 5 day max			
Total IP Copay Per Day, 5 day max			

Plan	33871PA0040007-04		33871PA0040007-05		33871PA0040007-06	
Tier	Tier 2	Tier 3	Tier 2	Tier 3	Tier 2	Tier 3
IP Cost Sharing						
Facility Copay per day (max 5)						
Professional Coinsurance						

AVC Continuance Table	Silver	Gold	Platinum
PMPY for IP			
Admit PMPY			
Claim per Admit			
Average LOS (days)			
Effective Copay Factor for 5 days			

Assumption From Data			
% Facility Cost			
% Professional Cost			

Calculated			
Professional Claim per Admit			
Professional Claim per Day			
Equiv. Copay Per Day no max			
Equiv. Copay Per Day, 5 day max			
Total IP Copay Per Day, 5 day max			

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



Utilization	Tier 1	Tier 2	Tier 3	Total
33871PA0040005				
33871PA0040006				
33871PA0040007				

Plan	Actuarial Value			
	Tier 1	Tier 2	Tier 3	Average
33871PA0040005				
33871PA0040006				
33871PA0040006-04				
33871PA0040006-05				
33871PA0040006-06				
33871PA0040007				
33871PA0040007-04				
33871PA0040007-05				
33871PA0040007-06				

Certification Language:

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

The analysis was

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

I am an employee of the issuer, I meet the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* promulgated by the American Academy of Actuaries, and I have the education and experience necessary to perform this work.

Actuary signature:



Actuary Printed Name:



Date:

4/28/2015



June 19, 2015

Mr. Peter Camacci, Director
Bureau of Accident and Health Insurance
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

SUBMITTED VIA SERFF

**RE: Keystone Health Plan East
Individual HMO Rate Filing effective 1/1/2016
INAC-129936718**

VIA SERFF

Dear Mr. Camacci:

The following is our response to the Objection letter received (via SERFF) June 5, 2015 regarding the above referenced filing. For ease of review, we have included the original questions along with our replies. Attachments in Supporting Documentation can be found under "Response to Objection Letter Dated June 5, 2015".

- 1. It is my understanding that Section I of worksheet I of the URRT is to contain the single risk pool data for a given issuer, state and market. Your actuarial memorandum indicates that the experience period data provided represents KHPE, AmeriHealth and QCC. Please revise to reflect data solely for the named issuer for calendar year 2014.*

We have replaced the Experience Data in Section 1 of Worksheet 1 to contain only the data for KHPE. The URRT has been updated in the Supporting Documentation tab.

2. *The filing indicates the weighted average increase across products/plans based on current ACA-compliant membership is 2.8%. Worksheet 2 of the URRT (row 28) shows a rate increase of 4.52% for a PPO Product and a 1.91% increase for the HMO product. Since HMOs are only allowed to do HMO/POS business, should the threshold product rate increase for the HMO be 1.91% and not 2.8%? Please review the URRT, company rate information contained in the Rate/Rule Schedule tab and any other items that may be impacted and revise as necessary.*

The revised URRT in the Supporting Documentation tab [REDACTED]

3. *The filing indicates the weighted average increase across plans based on current ACA-compliant membership is 2.8%. Please show how this average breaks down by the following:*
 - *Impact of medical claim trend;*
 - *Revisions to assumptions about population morbidity and the projected population distribution;*
 - *Changes to the reinsurance program;*
 - *Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;*
 - *Changes in pricing models used to determine the impact of cost sharing design;*
 - *Changes in provider networks and contracts.*

4. *Please provide the Federal Rate Template in the Rate/Rule Schedule tab.*

We have updated the Rate/Rule Schedule tab to include the Federal Rate Template.

5. *Your actuarial memorandum does not meet the standard as prescribed by CMS in the 2016 Unified Rate Review Instructions (Rate Filing Justification: Parts I (v2.0.4, II, and III) version 2/21/15. Please provide.*



6. *Please provide further discussion of the rates in the Base Rate Schedule.*



7. *Please provide an Excel exhibit that shows the development of the 2016 projected Index Rate, starting from the 2014 experience data. Also, provide narrative that explains the development and all adjustments.*



8. *Please provide an Excel exhibit that shows the development of the Plan adjusted Index Rate for each plan design offered in 2016, starting from the Index Rate.*



9. *Please provide Excel exhibits that show the development of all calibration adjustments.*

The calculations that produce the calibration factors



10. *What is the basis for the trend selection of 7.6%? Please provide support and a narrative that explains the trend development.*



11. *Please be advised that each time the URRT is changed in SERFF, the URRT in HIOS must also be updated. Please acknowledge your understanding and certify that you are in compliance.*

We acknowledge that the URRT in HIOS must be updated with changes made herein and will submit them during the revision period.

12. *Does your company offer transitional policies in Pennsylvania? If so, what markets (individual and/or small group). Please provide the SERFF # for the approved transitional rate filing(s) and the number of transitional members enrolled in each market as of April 1, 2015.*



13. *Under what pricing assumptions regarding the King v. Burwell Supreme Court Case has your filing been made? Please provide an actuarial narrative and justification regarding the rate impact for the alternate decision.*

The pricing assumptions in this filing assume that Premium subsidies are unaffected by King vs. Burwell. Given the range of possible outcomes, we have not determined a specific pricing impact, but our expectation is that we would be in line with the numbers in the February 24th letter from the American Academy of Actuaries assuming the specific scenario defined in that letter were to occur.

14. *The Department notes that several of the screenshots of the AV Output for CSR plans reflect errors indicating that the desired metal level was unsuccessful. Please provide a discussion of the methodology used to achieve the desired metal level for these plans as well as the appropriate actuarial certification.*



[REDACTED]

With the department's decision to post objection and response letters, we request that the information in this letter and attachments be considered the unredacted version. We will submit redacted versions once guidelines have been released.

Please contact [REDACTED] with any questions regarding this filing.

Sincerely,

[REDACTED]

[REDACTED]

Director and Actuary, Commercial Pricing

KHPE		
Age	% of Members	Factor
<21		
22		
23		
24		
25		
26		
27		
28		
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30		
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53		
54		
55		
56		
57		
58		
59		
60		
61		
62		
63		
64		
65+		

QCC		
Age	% of Members	Factor
<21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
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59		
60		
61		
62		
63		
64		
65+		

Total		
Age	% of Members	Factor
<21		
22		
23		
24		
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26		
27		
28		
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31		
32		
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35		
36		
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60		
61		
62		
63		
64		
65+		

Projected Average Factor for Tobacco Users
Projected Tobacco Use Prevalence

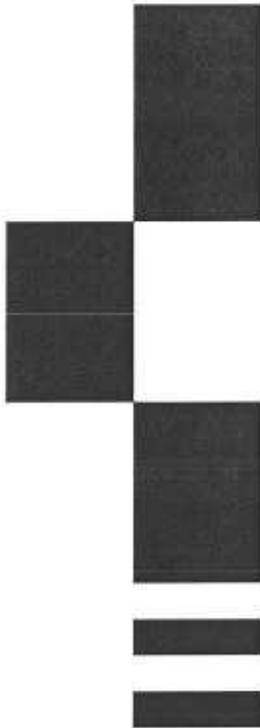


Tobacco Use Calibration Factor



Unit Cost

- Facility - Inpatient (non-capitated)
- Admits
- Days
- Facility - Outpatient (non-capitated)
- Facility - Capitated Services
- Professional - Non-Capitated
- Professional - Capitated
 - PCP
 - Mental health
 - Physical Therapy
 - Podiatry
 - Lab
- Other Medical (non-capitated)
- Other Medical (capitated)
 - Vision (Embedded)
 - Dental (Embedded)
- Total Medical Claims Experience





AMERICAN ACADEMY of ACTUARIES

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February 24, 2015

The Honorable Sylvia Mathews Burwell
Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Premium rate filing implications of *King v. Burwell*

Dear Madam Secretary:

On behalf of the American Academy of Actuaries'¹ Health Practice Council, I would like to urge you to consider implementing measures to counter the potential adverse consequences on health insurance premium rate filings in the event the Supreme Court rules for the petitioners in *King v. Burwell*. If no action is taken to allow enrollees access to premium subsidies in states participating in the federally facilitated marketplace (FFM),² there will be fewer individual market enrollees and higher average health care costs in those states. As a result, premiums for 2015, which are already in place, and premiums for 2016, which need to be submitted prior to the court's ruling, would likely be inadequate to cover claims. The U.S. Department of Health and Human Services (HHS) and state authorities should consider allowing contingent premium rate submissions and/or revised submissions to help mitigate the potential for inadequate 2016 premiums in FFM states.

Eliminating subsidies in FFM states would likely result in significantly fewer individual market enrollees and higher average health care costs

Along with the individual mandate, and other provisions of the Affordable Care Act (ACA), the premium tax credits are designed to increase participation in the health insurance market and help ensure that the insurance risk pools include not only higher-risk individuals, but also lower-risk ones. Without these provisions, the law's guaranteed issue and modified community rating requirements would put upward pressure on premiums.

If federal premium tax credits are no longer available to eligible enrollees in FFM states, enrollment could decline precipitously. Moreover, individuals with high-cost health care needs would be more likely to remain enrolled, while those with low-cost health care needs would be more likely to exit the market. Such adverse selection would cause average health care costs, and therefore premiums, to rise. Estimates from the Urban Institute suggest that nearly 10 million

¹ The American Academy of Actuaries is an 18,000+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² The federal government could act to make premium subsidies available in FFM states. FFM states could make premium subsidies available by establishing a state-based exchange.

fewer people would have coverage in the individual market and the change in the health mix of enrollees would increase premiums by 35 percent in the affected states.³ Another analysis from the RAND Corporation estimates that eliminating the premium subsidies in *all states* would result in a premium increase of nearly 45 percent.⁴

Issuers are limited in their ability to change premiums for 2015 and 2016

Although eliminating premium tax credits in FFM states would result in higher average health care costs in the individual market, the ability for issuers to increase premiums to meet those higher costs would be limited for the 2015 and 2016 plan years. For 2015, premiums are already in place and ACA regulations prohibit mid-year premium changes. If individual market plans experience significant disenrollment during the latter months of 2015, premiums likely would be insufficient to cover claims. This raises solvency concerns, especially among issuers for whom exchange business is a relatively large share of their book of business.

Based on the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) 2016 letter to issuers in the FFM, issuers are required to file their 2016 plan year premiums by May 15, and the deadline for states to approve rates is August 25.⁵ The May 15 submission deadline likely will occur before the Court issues its ruling. Although some states have flexibility in holding rate filings open until the August 25 deadline, many states have strict timeframes regarding how much time can elapse between a rate-filing submission and when that filing must be approved or denied (e.g., 30 days). If issuers are not allowed to submit revised rates after the CMS deadline, premiums likely would be insufficient to cover claims if the Court rules in favor of the petitioners.

Allowing contingent premium rate submissions and/or revised submissions would help mitigate the potential for inadequate 2016 premiums

If no action is taken to allow enrollees access to premium subsidies in the affected states, there are options to help mitigate the potential for inadequate 2016 premiums. One option is for HHS and states to allow issuers to submit two sets of contingent premium rates—one set reflecting pricing assumptions that would be appropriate if premium tax credits continue to be available and the other reflecting pricing assumptions that would be appropriate if premium tax credits are no longer allowed. Although issuers can submit only one unified rate review template (URRT) to the federal Health Insurance Oversight System (HIOS), this option would allow issuers to submit both sets of rates and corresponding justifications in the rate filings submitted to states.

Submitting both sets of rates and corresponding justifications would make it feasible for revised rates to be approved within the timeframes needed to implement the rates by the start of the open enrollment period.

Another option is to allow issuers in affected states more flexibility to revise and resubmit their rates should the Court rule that premium tax credits are not available. States that can hold filings open until the approval deadline could consider doing so to allow issuers to amend the rates. In states that have stricter timeframes, HHS could consider allowing revised filings to be submitted after the May 15 submission deadline. Using an open enrollment period and approval deadlines

³ Linda J. Blumberg, Matthew Buettgens, and John Holahan, "[The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums](#)." Robert Wood Johnson Foundation and the Urban Institute. January 2015.

⁴ Christine Eibner and Evan Saltzman, "[Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage](#)." RAND Corporation. 2014.

⁵ Available from: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf.

that are similar to those used in the 2015 plan year would help provide adequate time to review any revised rate-filing submissions.

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The American Academy of Actuaries' Health Practice Council encourages you to consider implementing these options in affected states to help ensure that premiums for 2016 are adequate. Otherwise, insurer solvency could be threatened. We would welcome the opportunity to discuss our concerns and comments with you in more detail. If you have questions or would like to meet with us, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

Catherine Murphy-Barron, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

Cc: Sen. Ben Nelson, Chief Executive Officer, NAIC
Monica J. Lindeen, President, NAIC
Members of the U.S. House of Representatives
Members of the U.S. Senate

PA Consumer

Confidential Actuarial Memorandum - Addendum Exhibit B

2016 PA Consumer Pricing Single Risk Pool

Experience Period: 01/01/2014 thru 12/31/2014 paid thru 01/01/2015 with IBNR
Projection Period: 01/01/2016 thru 12/31/2016 incurred

Calculation of the Market Adjusted Index rate, beginning from the Index Rate

Index Rate 1Q2016	[REDACTED]	
Non-EHB	[REDACTED]	
EHB		
Inpatient	[REDACTED]	
Outpatient	[REDACTED]	
Professional	[REDACTED]	
Capitation	[REDACTED]	
Pharmacy	[REDACTED]	
Other EHB	[REDACTED]	
Total EHB (Index Rate)	[REDACTED]	
Non-EHB	[REDACTED]	
Total EHB and Non-EHB	[REDACTED]	
Projected Allowed PMPM KHPE	[REDACTED]	Member Months
Projected Allowed PMPM QCC	[REDACTED]	Member Months
Projected Allowed PMPM Total	[REDACTED]	
EHB		
Inpatient	[REDACTED]	
Outpatient	[REDACTED]	
Professional	[REDACTED]	
Capitation	[REDACTED]	
Pharmacy	[REDACTED]	
Other EHB	[REDACTED]	
EHB	[REDACTED]	
Non-EHB	[REDACTED]	
Projected Allowed PMPM (EHB)	[REDACTED]	
Reinsurance Assessment	[REDACTED]	
Risk Adj Prog User Fee	[REDACTED]	
Exchange User Fees	[REDACTED]	
Market Adjusted Index Rate 1Q2016	[REDACTED]	

Breakdown of 2016 Consumer Base Premium Increase

Medical Claim Trend	
Population Distribution & Morbidity Changes	
Reinsurance Program Changes	
Benefit Changes / Comply With AV Requirements	
Actual vs. Expected Experience	
<u>Retention Changes</u>	
Total	

2016 Consumer Base Premium

2015 Base Premium	
<u>Rate Increase</u>	
2016 Base Premium	