

SERFF Tracking #:

INAC-130336438

State Tracking #:

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Company Tracking #:

KHPE HMO SG 2Q16

State: Pennsylvania**Filing Company:** Keystone Health Plan East, Inc.**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO**Product Name:** KHPE Small Group HMO eff 4-1-2016**Project Name/Number:** /

Supporting Document Schedules

Bypassed - Item:	Transmittal Letter (A&H)
Bypass Reason:	NA
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	Attached is the cover letter.
Attachment(s):	khpe 2q16 sg cover letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Actuarial Memorandum
Comments:	See attached.
Attachment(s):	R-khpe_sg_2q16_fed_act_mem.pdf
Item Status:	
Status Date:	



December 14, 2015

Teresa D. Miller, Insurance Commissioner
Bureau of Accident and Health Insurance
Pennsylvania Insurance Department
1311 Strawberry Square
Harrisburg, PA 17120

SUBMITTED VIA SERFF

**RE: Keystone Health Plan East
Small Group HMO Rate Filing effective 4/1/2016
INAC-130336438**

Insurance Commissioner Miller:

Keystone Health Plan East is updating rates for HMO and Direct Point-of-Service (DPOS) plans in the small employer 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 April 1, 2016.

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

Sincerely,



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 small group 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: Small group
Effective Date(s): 4/1/2016-6/30/2016, 7/1/2016-9/30/2016, and 10/1/2016-12/31/2016

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 small group market for KHPE and AmeriHealth HMO, Inc. ("AHPA"). 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: [REDACTED]
Primary Contact Email Address: [REDACTED]

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 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.

[REDACTED]

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 [REDACTED]. Earned premiums and member months are for January through December 2014. The data are for all direct-written small group business of KHPE in the Commonwealth of Pennsylvania, including out-of-network claims written by KHPE but paid by QCC for POS plans.

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. No federal MLR rebates are payable 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 [REDACTED] 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 [REDACTED].

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 first quarter 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. [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

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 the 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.

[REDACTED]

Trend Factors

[REDACTED]

[REDACTED]

a. 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.

b. 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

[REDACTED]

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. [REDACTED]

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.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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

A Projected ACA Reinsurance Recoveries Net of Reinsurance Premium adjustment is not applicable in the small group market. However, the Reinsurance Program Funding fee is included and applied equally across all plans in the single risk pool.

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. [REDACTED]

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. [REDACTED]

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):* [REDACTED] applied equally across all plans in the single risk pool.
- *Exchange User Fee:* [REDACTED] applied to all plans as an adjustment to the index rate at the market level, as per regulation.
- *State Premium Tax:* [REDACTED]
- *Health Insurer Fee:* [REDACTED]

[REDACTED]

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.

SINGLE RISK POOL

The single risk pool reflects all covered lives for every small group non-grandfathered product and plan combination for KHPE in the state of Pennsylvania. It is established according to the Single Risk Pool requirements in 45 CFR § 156.80(d).

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 KHPE Small Group Plans in Pennsylvania. The Index Rate reflects the twelve month projection for calendar year 2016 and is based on the weighted average of claims, changes in the population risk morbidity, and changes in the demographics of the entire single risk pool. It has been developed following the specifications of 45 CFR § 156.80(d)(1).

We reserve the right to make subsequent filings to replace rates listed above with effective dates 7/1/2016 and beyond to reflect any changes which would affect the adequacy of the rates presented with this memorandum.

MARKET ADJUSTED INDEX RATE

[REDACTED] the calculation of the Market Adjusted Index rate, 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.

Note that the on-exchange premiums presented in the Unified Rate Review Template do not include coverage of pediatric dental that is expected to be available elsewhere on the exchange. Premiums for the same QHP plans offered off-exchange may differ to reflect costs due to the possible inclusion or exclusion of pediatric dental coverage.

PLAN ADJUSTED INDEX RATE

[REDACTED] the calculation of the Plan Adjusted Index Rate, 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.

TERMINATED PLANS

No 2015 KHPE Small Group products are being terminated.

Data shown in the experience period for terminated products are from KHPE plans terminated prior to 2016 that were in force during 2014.

WARNING ALERTS

There are no warning alerts in URRT part 1.

ACTUARIAL CERTIFICATION

I, [REDACTED], 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.

[REDACTED]
December 14, 2015

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit A**

2016 PA Small Group Pricing

REDACTED

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit B**

2016 PA Small Group Pricing

REDACTED

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit C**

2016 PA Small Group Pricing

REDACTED

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit I**

2016 PA Small Group Pricing

REDACTED

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit J**

2016 PA Small Group Pricing

REDACTED

PA Small Group

**Confidential Actuarial Memorandum - Addendum
Exhibit K**

2016 PA Small Group Pricing

REDACTED