

SERFF Tracking #: INAC-129938930

State Tracking #: INAC-129938930

Company Tracking #: QCC INDIV PPO 1Q16

State: Pennsylvania

TO/Sub-TOI: H161 Individual Health - Major Medical/H161.005A Individual - Preferred Provider (PPO)

Product Name: QCC Individual PPO effective 1-1-2016

Project Name/Number: /

Filing Company: QCC Insurance Company

### Supporting Document Schedules

<b>Satisfied - Item:</b>	PID Rate Filing
<b>Comments:</b>	Attached is the PID Rate Filing.
<b>Attachment(s):</b>	QCC Indiv State Act Memo.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	REDACTED QHP Actuarial Memorandum
<b>Comments:</b>	Attached is the redacted QHP Actuarial Memorandum.
<b>Attachment(s):</b>	31609_01012016_IND_RedactedAM.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

# **QCC Insurance Company**

## **Confidential Actuarial Memorandum**

### **Individual Market**

#### **Purposes of Filing**

The purposes of this filing are to document the rating methodology applicable to the individual market health care insurance underwritten by QCC Insurance Company (“QCC”) in the Commonwealth of Pennsylvania and demonstrate compliance with rating requirements of the Affordable Care Act (“ACA”). This filing may not be appropriate for other purposes.

#### **Introduction**

This filing includes rates for all ACA compliant products and plans available off and on the Federally-Facilitated Exchange, if applicable, and underwritten by QCC and made available in the market effective January 1, 2016.

The rating methodology described herein includes only the allowable rating variables prescribed by the ACA. These are: (i) age, (ii) tobacco use, (iii) family size, and (iv) geography. The anticipated Federal MLR loss ratio is 88.2% for products in the single risk pool. To ensure compliance with the single risk pool per market requirement, this filing contains experience of all non-grandfathered business for the entire individual risk pool across the Keystone Health Plan East, AmeriHealth HMO, Inc., and QCC Insurance Company entities of the Independence Blue Cross Family of Companies (“IBCFOC”).

#### **Applicable Forms**

The forms relevant to this filing include:

<b>Form Number</b>	<b>Description</b>
08535 Rev. 1.16	PPO MSP, Non-HSA, and Non-Closed Panel plans
08536 Rev 1.16	PPO HSA Plans
08537 Rev. 1.16	PPO Catastrophic and Bronze Basic Closed Panel plans

#### **Description of Benefits**

The product portfolio is comprised of multiple benefit packages that were tested for ACA compliance. Please refer to the Plans & Benefits Template submitted as part of a SERFF Plan Management Binder for benefit descriptions related to on-exchange plans. Off-exchange plans are the same as on-exchange plans except that off-exchange plans include some coverage for elective abortions and PPO Bronze Basic is offered on exchange only.

#### **Market Segment**

The rating methodology described herein applies to non-grandfathered non-group individual coverages.

# QCC Insurance Company

## Confidential Actuarial Memorandum

### Individual Market

#### Effective Date

The base rates and base rating methodology described herein are effective on or after January 1, 2016.

#### Effective Period and Guarantee

Premium rates will be in effect for 12 months from January 1, 2016 through December 31, 2016.

#### Effective Date of Prior Rate Revision

The effective date of the prior rate revision is January 1, 2015.

#### Rate Comparison

The average increase for the IBCFOC Pennsylvania individual single risk pool is 2.8%.

#### Rating Methodology

The rating methodology described below for new and renewing non-grandfathered individual business is applied across all managed care entities of the IBCFOC.

Customers are rated using the following factors, as allowed by the ACA:

1. Age (as defined by the federally approved standard age curve)
2. Tobacco Use
3. Family Size
4. Geography (state rating regions as federally approved)

The premium rates are based on a member-level buildup starting with a per member per month (PMPM) base rate. The base rates are provided in the Base Rate Schedule on page 9 of this filing. The base rate is adjusted based on the member-specific characteristics as described above.

#### *Age*

The age rating factor curve is defined as the federally defined standard age curve. The federally defined standard age curve complies with the ACA premium band ratio not exceeding 3:1. See Exhibit 1 on page 5 of this filing.

#### *Tobacco Use*

The tobacco use rating factor curve varies by age and complies with the ACA premium band ratio not exceeding 1.5:1. A "tobacco user" is defined as one who consumes tobacco products four or more times a week and has done so within the last six months. This does not apply to anyone who uses tobacco products for religious or ceremonial use.

There are three categories of "tobacco user":

# **QCC Insurance Company**

## **Confidential Actuarial Memorandum**

### **Individual Market**

1. A tobacco user not in a certified cessation program,
2. A tobacco user in a certified cessation program, or
3. A non-tobacco user

A tobacco user in categories 1 or 2 above is rated as a Tobacco User and, therefore, the Tobacco Use factor applies. See Exhibit 2 on page 6 of this filing. In the individual market, tobacco users are charged the same rate regardless of whether or not they participate in a certified cessation program. A non-tobacco user in category 3 is rated as a Non-Tobacco User and, therefore, the Tobacco Use factor does not apply.

#### *Family Size*

As specified in the ACA, families with more than three dependent children under age 21 will only be charged for three dependent children under age 21.

#### *Geography*

State rating regions are as federally approved. QCC's applicable rating area is Rating Area 8. See Exhibit 3 on page 7 of this filing.

#### **Ancillary Products**

In addition to core benefits, individual subscribers have the option to choose to purchase stand-alone Adult Vision and stand-alone Adult Dental coverages. The rating methodology for these products is filed separately, at a later date as is consistent with stand alone ancillary coverages.

**QCC Insurance Company**  
**Confidential Actuarial Memorandum**  
**Individual Market**

**Rating Factors**

# QCC Insurance Company

## Confidential Actuarial Memorandum

### Individual Market

#### EXHIBIT 1: AGE RATING FACTORS

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	43	1.357
21	1.000	44	1.397
22	1.000	45	1.444
23	1.000	46	1.500
24	1.000	47	1.563
25	1.004	48	1.635
26	1.024	49	1.706
27	1.048	50	1.786
28	1.087	51	1.865
29	1.119	52	1.952
30	1.135	53	2.040
31	1.159	54	2.135
32	1.183	55	2.230
33	1.198	56	2.333
34	1.214	57	2.437
35	1.222	58	2.548
36	1.230	59	2.603
37	1.238	60	2.714
38	1.246	61	2.810
39	1.262	62	2.873
40	1.278	63	2.952
41	1.302	64	3.000
42	1.325	65 and Older	3.000

\*\*The Age Rating Factors follow the federal default standard age curve as provided in the Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting memorandum from HHS dated February 25, 2013.

## 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 QCC Insurance Company ("QCC") 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:** QCC Insurance Company ("QCC")

**State:** Pennsylvania

**HIOS Issuer ID (5-digit):** 31609

**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 31609, and Standard Component IDs 31609PA0140001 and 31609PA0140002.

#### 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 PRODUCTS**

No 2015 QCC Individual products are being terminated.

### **WARNING ALERTS**

There are no warning alerts in URRT part 1.

SERFF Tracking #:

INAC-129938930

State Tracking #:

INAC-129938930

Company Tracking #:

QCC INDIV PPO 1Q16

State:

Pennsylvania

Filing Company:

QCC Insurance Company

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

QCC Individual PPO effective 1-1-2016

Project Name/Number:

/

## Correspondence Summary

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Cherri Sanders-Jones (AH)	06/11/2015	06/11/2015

#### Response Letters

Responded By	Created On	Date Submitted
--------------	------------	----------------

**State:** Pennsylvania  
**TOI/Sub-TOI:** H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)  
**Product Name:** QCC Individual PPO effective 1-1-2016  
**Project Name/Number:** /

**Filing Company:** QCC Insurance Company

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/11/2015
Submitted Date	06/11/2015
Respond By Date	06/25/2015

Dear Hugh Lakshman,

### Introduction:

June 11, 2015

Hugh Lakshman  
Director and Actuary - Commercial Markets  
QCC Insurance Company  
1901 Market Street  
Philadelphia, PA 19103

RE: QCC Insurance Company - Individual – PPO - On/Off Exchange  
Received: May 11, 2015 SERFF ID# INAC-129938930

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 4.42% for a PPO Product and a 1.92% increase for the HMO product. Should the threshold product rate increase for the PPO be 4.42% 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 the average (or the revised average per question #2 above) 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 an exhibit showing the rate increase by plan and how the weighted average increase corresponds to the proposed aggregate increase of 2.8% (or the revised average per question #2 above). Please also identify the new plans.

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

6. The actuarial memorandum indicates that Form Number 08537 REV 1.16 reflects closed panel plans. Please provide an exhibit that shows the network/panel names and rating factors for each closed panel/network. What is the basis for the closed panel/network factors?

7. The actuarial memorandum indicates that, "Off-exchange plans are the same as on-exchange plans except that off-exchange plans include some coverage for elective abortions and PPO Bronze Basic is offered on exchange only." Regarding the PPO Bronze Basic

**State:** Pennsylvania **Filing Company:** QCC Insurance Company  
**TOI/Sub-TOI:** H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)  
**Product Name:** QCC Individual PPO effective 1-1-2016  
**Project Name/Number:** /

plan offered on exchange only, it is my understanding that on exchange plans must also be offered off exchange and at the same premium. Please discuss.

8. 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.

9. Please provide further discussion and show the development of the rates in the Base Rate Schedule.

10. 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.

11. 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.

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

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

14. 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.

15. 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.

16. 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)

**SERFF Tracking #:**

INAC-129938930

**State Tracking #:**

INAC-129938930

**Company Tracking #:**

QCC INDIV PPO 1Q16

**State:**

Pennsylvania

**Filing Company:**

QCC Insurance Company

**TOI/Sub-TOI:**

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

**Product Name:**

QCC Individual PPO effective 1-1-2016

**Project Name/Number:**

/

## Supporting Document Schedules

<b>Satisfied - Item:</b>	REDACTED Response to Objection Letter Dated June 11, 2015
<b>Comments:</b>	Attached are redacted versions of the response sent on June 23 from the June 11 objection letter. Exhibits that have been redacted are renamed beginning with "R-".
<b>Attachment(s):</b>	R-Breakdown of 2016 Consumer Rate Increase.pdf R-Comparison To URRT Instructions.pdf R-Exhibit A - 2016 Projected Index Rate Calculation.pdf R-Exhibit B - 2016 Market Index Rate Calculation.pdf R-Exhibit C - 2016 Plan Adjusted Index Rate Calculation.pdf R-Calibration.pdf R-Trend Basis.pdf R-Weighted Average of Rate Increases.pdf HPC Letter to HHS King v Burwell 022415.pdf R-qcc ind 2016 response to obj letter dated june-11-15.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

**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>	
<b>Total</b>	

**2016 Consumer Base Premium**

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

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			Administrative Expense Load
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	Plan Adjusted Index Rate Plan Adjusted Index Rate Plan Adjusted Index Rate Plan Adjusted Index Rate
4.6.6	Consumer Adjusted Premium Rate Development	Geographic Factor List all geographic factors Provide the geographic calibration if one is necessary Describe how allowable consumer level adjustments are applied to Plan Adjusted Index Rate SG - Consumer Adjusted should reflect appropriate quarter, trend	Calibration Calibration Calibration Calibration Calibration Calibration
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	Terminated Plans
	List terminated plans, products not in experience period but available later	
	Provide cross-walks for terminated plans mapped to new plans	
4.7.6	Warning Alerts	Warning Alerts
	Explain	
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	Actuarial Certification
	List of Elements	

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 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]	[REDACTED]
Projected Allowed PMPM QCC	[REDACTED]	[REDACTED]
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]	

# 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
Blue Cross Gold, a Multi-State Plan	31609PA0140001		
Blue Cross Silver, a Multi-State Plan	31609PA0140002		
Personal Choice PPO Platinum	31609PA0070001		
Personal Choice PPO Gold	31609PA0070002		
Personal Choice PPO Silver	31609PA0070003		
Personal Choice PPO Bronze	31609PA0070004		
Personal Choice PPO Bronze Reserve	31609PA0070006		
Personal Choice Catastrophic	31609PA0070007		
Personal Choice PPO Platinum Complete	31609PA0070009		
Personal Choice Bronze Basic	31609PA0070010		
Personal Choice PPO Platinum	31609PA0070020		
Personal Choice PPO Gold	31609PA0070021		
Personal Choice PPO Silver	31609PA0070022		
Personal Choice PPO Bronze	31609PA0070023		
Personal Choice Catastrophic	31609PA0070024		
Personal Choice PPO Bronze Reserve	31609PA0070027		
Personal Choice PPO Platinum Complete	31609PA0070028		

KHPE		
Age	% of Members	Factor
<21		0.635
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
35		1.222
36		1.230
37		1.238
38		1.246
39		1.262
40		1.278
41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000

QCC		
Age	% of Members	Factor
<21		0.635
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
35		1.222
36		1.230
37		1.238
38		1.246
39		1.262
40		1.278
41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000

Total		
Age	% of Members	Factor
<21		0.635
22		1.000
23		1.000
24		1.000
25		1.004
26		1.024
27		1.048
28		1.087
29		1.119
30		1.135
31		1.159
32		1.183
33		1.198
34		1.214
35		1.222
36		1.230
37		1.238
38		1.246
39		1.262
40		1.278
41		1.302
42		1.325
43		1.357
44		1.397
45		1.444
46		1.500
47		1.563
48		1.635
49		1.706
50		1.786
51		1.865
52		1.952
53		2.040
54		2.135
55		2.230
56		2.333
57		2.437
58		2.548
59		2.603
60		2.714
61		2.810
62		2.873
63		2.952
64		3.000
65+		3.000

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



Projected Utilization



Projected Trend



## PA Consumer

### Confidential Actuarial Memorandum - Addendum Weighted Average of Rate Increases

**QCC**

Plan	Current Rate	Members	Before Change	% Change	After Change
31609PA0070001					
31609PA0070002					
31609PA0070003					
31609PA0070004					
31609PA0070006					
31609PA0070007					
31609PA0070009					
31609PA0070010					
31609PA0070020					
31609PA0070021					
31609PA0070022					
31609PA0070023					
31609PA0070024					
31609PA0070027					
31609PA0070028					
<b>Total</b>					

**KHPE**

Plan	Current Rate	Members	Before Change	% Change	After Change
33871PA0040001					
33871PA0040002					
33871PA0040003					
33871PA0040004					
33871PA0040005					
33871PA0040006					
33871PA0040020					
33871PA0040021					
33871PA0040022					
33871PA0040023					
33871PA0040024					
33871PA0040025					
<b>Total</b>					

**MSP**

Plan	Current Rate	Members	Before Change	% Change	After Change
31609PA0140001					
31609PA0140002					
<b>Total</b>					

<b>Grand Total</b>					
--------------------	--	--	--	--	--



AMERICAN ACADEMY of ACTUARIES

Objective. Independent. Effective.™

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<sup>1</sup> 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),<sup>2</sup> 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

---

<sup>1</sup> 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.

<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

### **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.<sup>5</sup> 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

---

<sup>3</sup> 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.

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

<sup>5</sup> Available from: [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016\\_Letter\\_to\\_Issuers\\_2\\_20\\_2015.pdf](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.

\* \* \* \* \*

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](mailto: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



June 23, 2015

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

**SUBMITTED VIA SERFF**

**RE: QCC Insurance Company  
Individual PPO Rate Filing effective 1/1/2016  
INAC-129938930**

**VIA SERFF**

Dear Mr. Camacci:

The following is our response to the Objection letter received (via SERFF) June 11, 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 11, 2015".

- 1. It is my understanding that Section 1 of worksheet 1 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 QCC. 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 4.42% for a PPO Product and a 1.92% increase for the HMO product. Should the threshold product rate increase for the PPO be 4.42% 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]  
[REDACTED]

3. *The filing indicates the weighted average increase across plans based on current ACA-compliant membership is 2.8%. Please show how the average (or the revised average per question #2 above) 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.*

- [REDACTED]
4. *Please provide an exhibit showing the rate increase by plan and how the weighted average increase corresponds to the proposed aggregate increase of 2.8% (or the revised average per question #2 above). Please also identify the new plans.*

The calculation of the weighted average increase is [REDACTED]  
[REDACTED]  
[REDACTED]

5. *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.

6. *The actuarial memorandum indicates that Form Number 08537 REV 1.16 reflects closed panel plans. Please provide an exhibit that shows the network/panel names and rating factors for each closed panel/network. What is the basis for the closed panel/network factors?*



7. *The actuarial memorandum indicates that, "Off-exchange plans are the same as on-exchange plans except that off-exchange plans include some coverage for elective abortions and PPO Bronze Basic is offered on exchange only." Regarding the PPO Bronze Basic plan offered on exchange only, it is my understanding that on exchange plans must also be offered off exchange and at the same premium. Please discuss.*



8. *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.*



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

[REDACTED]

10. 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.

[REDACTED]

11. 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.

[REDACTED]

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

The calculations that produce the calibration factors [REDACTED]  
[REDACTED]

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

[REDACTED]

14. 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 concurrent with this response.

15. *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.*

[REDACTED]

16. *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.

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