NATIONAL FOUNDATION LIFE INSURANCE

300 Burnett Street, Suite 200 • Fort Worth, Texas 76102 • (800) 221-9039

May 6, 2015

Commissioner Michael F. Consedine
Pennsylvania Department of Insurance
1326 Strawberry Square
Harrisburg, PA 17120

RE: National Foundation Life Insurance
Individual Rate Filing for:
Essential Health Benefits Plan EHB-2016-IP-PA-NFL with EHB-2016-SCH-PA-NFL
SERFF# USHG-130034220
NAIC # 98205
FEIN # 73-1187572

Dear Commissioner Consedine:

We are submitting the initial rate filing for our new Essential Health Benefits Plan, policy form EHB-2016-IP-PA-NFL. This is a new form with no existing rates or policyholders. This Individual Major Medical product covers the Essential Health Benefits (EHB) as required under the Patient Protection and Affordable Care Act (PPACA). At this time we are filing only the Bronze Metal Level. The new plan is to be offered in 2016 Off Exchange only.

The rates for the new plan were based on our previously approved ACA compliant plan EHB-2015-IP-PA-NFL. The proposed rates for 2016 are 9.9% higher than the currently approved rates for 2015. Enclosed please find an actuarial memorandum and exhibits in support of this modification.

The new form has been submitted separately for review under SERFF Tracking # USHG-129973102, as requested in the PA General Instructions.

<u>The following plan will be discontinued effective 1/1/2016:</u>
EHB-2015-IP-PA-NFL 37352PA0100001

Your review of this filing is appreciated. If you have any questions or need additional information, please contact me at the following number or email address.

Sincerely,

Diana Ivie
Actuarial Assistant
Telephone: (800) 387-9027 ext. 635
Email: Ivied@ushealthgroup.com

National Foundation Life Insurance Company
Actuarial Memorandum for Policy Form
EHB-2016-IP-PA-NFL with EHB-2016-SCH-PA-NFL

I. GENERAL INFORMATION

Insurance Company Name	National Foundation Life Insurance Company
State	Pennsylvania
HIOS Issuer ID	37352
Market	Individual Major Medical
Effective Date	January 1, 2016
Primary Contact Name	Tom Kennedy
Primary Contact Phone #	[redacted]
Primary Contact E-mail Address	[redacted]

The rates included in this filing are for non-grandfathered individual major medical plans which cover the Essential Health Benefits (EHB) as required under the Affordable Care Act (ACA). These plans are guaranteed issue and guaranteed renewable as defined under the ACA and HIPAA. These plans are marketed through licensed agents operating through a variety of distribution channels. In 2016, our insurance company will only sell plans outside of the public health exchanges in this state. Coverage beyond age 65 will be secondary to Medicare. Premiums are on an attained age basis and will increase with age. Premiums also vary by plan design, tobacco status and geographic area. In 2016, only the oldest three dependents under age 21 will be charged a premium rate for a given policy. This actuarial memorandum has been prepared for the purpose of demonstrating compliance with the applicable requirements in your state, assuring that premium rates are reasonable in relation to benefits provided. This rate filing is not intended to be used for other purposes.

National Foundation Life Insurance Company has a previous product approved for plan year 2015 under the product name EHB-2015-IP-PA-NFL. Changes in the product necessitated the filing of a new form EHB-2016-IP-PA-NFL. This filing proposes new rates for the new form EHB-2016-IP-PA-NFL. The new rates between the 2015 form and 2016 form constitute a [redacted] increase. We believe we are in compliance with the Uniform Modification of Coverage exceptions under sections 2702 and 2703 of the Public Health Service Act as defined by 45 CFR 146.152, 147.106 and 148.122.

II. PROPOSED RATE INCREASE

The net total premium increase proposed for these policy forms is [redacted]. This increase reflects a trend increase of [redacted], an increase of [redacted] to account for the new 2016 Federal Transitional Reinsurance Program and associated fees and a [redacted] decrease to account for the tobacco normalization factor. The development of these factors is detailed in later Sections. The proposed increase does not vary for ACA compliant products.

In 2016 we are changing the deductibles for each metal tier due to the new HHS AV Calculator and due to our desire to provide a cost sharing level that is approximately equivalent to the originally approved plan design. The new HHS AV Calculator has been updated to include medical cost and utilization trend as well as an updated out of pocket maximum. We have increased the deductibles so that the calculated 2016 Actuarial Value based on the 2016 Actuarial Value Calculator is approximately equal to the 2015 Actuarial Value as calculated using the 2015 Actuarial Value Calculator. There will be no change in rates because of this change. The annual trend of [redacted] does not include deductible leveraging. The deductible leveraging increase that would normally be included in the annual trend is offset by the increase in deductibles. This change is covered under the uniform modification of coverage exception under sections 2702 and 2703 of the Public Health Service Act as defined by 45 CFR 146.152, 147.106 and 148.122.

III. EXPERIENCE PERIOD PREMIUM AND CLAIMS

The Unified Rate Review Template was completed using state and legal entity specific non-grandfathered experience in order to comply with the Department of Health and Human Services (HHS) requirements. For the purpose of estimating the average risk of the 2016 market, experience of our non-grandfathered major medical plans for all of our affiliate companies Freedom Life Insurance Company of America, National Foundation Life Insurance Company, and Enterprise Life Insurance Company was reviewed together. This combined experience was used in order to develop an actuarially appropriate prediction of the market wide per member per month risk and standardized claim cost in 2016.

Experience Period: The experience period is from January 1, 2014 through December 31, 2014.

Paid Through Date: The paid through date for which payments have been made on claims incurred during the experience period is December 31, 2014

Premiums (Net of MLR Rebate) in Experience Period: In the Unified Rate Review Template, the Earned Premium net of Medical Loss Ratio (MLR) rebates for the Calendar Year 2014 experience period was [redacted] for your state. Earned Premium was not adjusted for any reductions prescribed when calculating the MLR, such as taxes and assessments. There were no estimated MLR rebates for the experience period in your State. Our accounting department estimates accrued premium refunds required under Federal Minimum Loss Ratio regulations for our Individual Medical insurance business by projecting Incurred Claims, Earned Premiums, and other elements and applying adjustments as outlined in Federal laws and regulations. These projections are performed on a state and market level basis and recent claims experience is adjusted for estimated claims reserves on a state level basis.

Allowed and Incurred Claims During the Experience Period: For the Unified Rate Review Template (URRT), the amount of Incurred Claims processed through our claim system for the experience period 2014 was [redacted] for your state. The best estimate of experience period claims incurred but not reported was [redacted] for your state. The amount of allowed claims processed through our claim system for the experience period 2014 was [redacted] for your state. The best estimate of experience period allowed claims incurred but not paid as of the paid through date shown above was [redacted] for your state. Allowed claims are developed by subtracting ineligible charges and discounts from the total provider billed amount. We have no capitation agreements. All state experience provided in the URRT is based on our entity specific non-grandfathered block of business. See the Credibility Manual Rate Development section below for details on how the Credibility Manual section of Worksheet 1 of the URRT was determined.

Our accounting department develops lag triangles for our nationwide individual medical experience. Historical averages are used in order to calculate our monthly completion factors. Specific large claims are also analyzed and additional reserves may be set up based on anticipated PPO savings and run-out for those claims.

IV. BENEFIT CATEGORIES

Inpatient services are those received during a patient's hospital stay and are included in the Inpatient Hospital Category. Outpatient services (e.g. lab tests, X-rays, and some surgical services) are those rendered by a facility within an outpatient setting. Professional services include primary care, specialist, therapy and other professional charges that are not included in facility fees. Other Medical services include charges for items that do not fall into the categories above, such as ambulance and durable medical equipment. The Other category is measured based upon distinct services or items provided. Retail and mail order pharmacy claims are included in the Prescription Drug category.

V. PROJECTION FACTORS

Changes in the Morbidity of the Insured Population: There are no changes in the morbidity assumption used in the approved 2015 rates. However, the application of the assumption has changed as the 2014 experience includes ACA compliant products. The morbidity assumption is applied to the transitional non-grandfathered portion of the 2014 experience and the factor shown in the URRT reflects this change. The ACA will cause significant changes in average risk of the population insured in the Individual Market (IM). Some drivers of the population change will be guaranteed issue, the individual mandate, underwriting and rating changes and the availability of premium subsidies for lower income consumers. In addition, average morbidity will increase because issuers are no longer allowed to exclude coverage for pre-existing conditions. The insured population will also be changing due to uninsured individuals moving into the market because of subsidies, currently insured individuals in the group market whose employers are directing them to the individual exchange, individuals forgoing coverage until mandate becomes more punitive, and individuals moving over from high risk pools and conversion markets. We estimated the impact of these changes on the morbidity of the insured population in your state to be [redacted]. We utilized the data within the "Cost of the Future Newly Insured under the Affordable Care Act (ACA)" study prepared by Optum Health and commissioned by the Society of Actuaries and internal risk studies in order to assess possible scenarios and develop our assumption. In addition, we compared our estimates against various industry studies in order to validate the reasonableness of our results. Data is still unavailable to analyze this assumption, this morbidity load reflects our best estimate at this time.

Changes in Benefits: There are no changes in the benefits factor assumption used in the approved 2015 rates. However, the application of the assumption has changed as the 2014 experience includes ACA compliant products. The change in benefits factor assumption is applied to the transitional non-grandfathered portion of the 2014 experience and the factor shown in the URRT reflects this change. The adjustment in the URRT of [redacted] within our pricing and claim projection is used to include new and expanded benefits in accordance with the EHB requirements of the ACA. These are differences in benefits between the new EHB plan and our non-grandfathered major medical plans that were utilized for our allowed claims estimates. The table below lists the estimated additional cost associated with each new benefit. These estimates are based upon purchased data and experience of a standard population. The estimated additional benefit costs below represent the percentage increase applied to the transitional non-grandfathered policies only:

Benefit Estimated Additional Cost

Benefit	Percentage
Maternity	[redacted]
Prescription Drug	[redacted]
Mental Health & Substance Abuse	[redacted]
Dental	[redacted]
Doctor's Office Visits	[redacted]
Vision	[redacted]
All Other	[redacted]
Total	[redacted]

Changes in Demographics: No changes in demographics were made from the assumption used in the approved 2015 rates. Differences in expected average area of the population are also applied to the base period claims experience to project 2016 experience. An average area factor was derived by applying 2012 annualized premium to the existing area factors. The experience period allowed claims were adjusted by the relativity of the state average area factor to the nationwide average area factor to reflect differences in overall average expected claim costs for your state.

Trend Factors (cost/utilization): Our trend assumption utilized in our projections and proposed increase is [redacted] and was estimated based on current trend analysis studies. The estimated portion of this assumption due to increases in medical cost is [redacted], and the estimated portion due to increased utilization is [redacted] (These portions are multiplicative).

VI. CREDIBILITY MANUAL RATE DEVELOPMENT

The Credibility Manual Rate reflects the nationwide experience of our non-grandfathered major medical plans for our affiliate companies. Allowed claims per member per month (PMPM) were calculated from this experience and adjusted to reflect the 2016 projected allowed claims. The Changes in Demographics factor described in Section V is applied to the Credibility Manual in order to reflect your states expected morbidity. All pricing components, including the base experience period data, are applied consistently across the single risk pool in the state and market for 2016.

VII. CREDIBILITY OF EXPERIENCE

Our standard for fully credible data is 2,000 life years, with less than 500 life years having no credibility. For life years between 500 and 2,000 life years, credibility is linearly interpolated from 0% at 500 life years to 100% at 2,000 life years. Credibility in your state is equal to [redacted].

VIII. PAID TO ALLOWED RATIO

Our paid to allowed ratio was estimated using our internal continuance tables for the plan benefits for each metal tier. The estimated paid to allowed ratio was [redacted] for Bronze. We projected 2016 enrollment given only one plan option, and assumed a [redacted] shock lapse on existing business for 2016 based upon the higher rates due to new essential health benefits and guaranteed issue requirements.

IX. RISK ADJUSTMENT AND REINSURANCE

Risk Adjustment: We have developed manual rates for a 1.0 average statewide risk and assumed that our company would enroll average risk individuals. Therefore, no risk adjustment PMPM payment is assumed in 2016. The Risk Adjustment Admin fee is $1.75 per member per year and we assumed this amount to be negligible and therefore did not account for it in our pricing but still included a [redacted] PMPM charge in the URRT.

Reinsurance Recoveries: In 2016, the ACA has a Reinsurance Program that will reimburse carriers 50% of claim costs between $90,000 and $250,000 per member. We have made a [redacted] adjustment to our expected claim costs within our pricing in order to account for expected reinsurance recoveries. This adjustment is consistently applied across all plans within the state. Our reinsurance recovery assumption was developed using analysis on our internal claims. The exposure and claim data was limited to members that had complete data and were on a non-capitated basis. In addition, the claim data for each member was trended to 2016. The reinsurance formula was applied by member, and the result was divided by total paid claims on the same adjusted basis. This process was done to estimate a reinsurance recovery factor for each plan metal level. The final composite factor was developed based upon our expected mix of metal level business.

Reinsurance Contributions: The Reinsurance Program is funded by a fee of $2.25 per member per month. We have increased our expected claim costs within our pricing development by [redacted] in order to cover this fee. In order to maintain compliance with the required relativity of prices by age, we have applied the adjustment on a multiplicative basis. Our adjustment factor was developed by dividing $2.25 by the expected total per member per month claim costs in the state. The reinsurance factor of [redacted] is multiplied by the [redacted] load for the $2.25 reinsurance fee resulting in a net reinsurance factor of [redacted]

Total Reinsurance Factor Increase: The total Reinsurance factor change from 2015 rates to 2016 rates is [redacted]. The 2015 rates were priced for the parameters of the Federal Transitional Reinsurance Program for 2015 which will reimburse carriers 50% of claim costs between $70,000 and $250,000 per member. The Reinsurance Program for 2015 is funded by a fee of $3.67 per member per month. Together our 2015 Reinsurance factor was [redacted].

The increase is therefore equal to [redacted]

Tobacco Normalization Factor: In order to use a tobacco load for smokers we have adjusted the projected index by [redacted]. Based on current Non-Grandfathered Major Medical experience, we estimated only [redacted] of projected members would be smokers. The calibration would be [redacted]. The normalization factor is equal to [redacted].

X. NON-BENEFIT EXPENSES AND PROFIT & RISK

Expenses are estimated based off of current costs, adjusted for any anticipated changes in 2016. The pricing load to cover these expenses is applied consistently across all plans.

Category	Percent of Premium
Customer Service, Claims Administration, & Information Systems	[redacted]
Marketing Expenses	[redacted]
General Overhead	[redacted]
Cost Containment	[redacted]
Commissions and Sales Bonus	[redacted]
Quality Improvement	[redacted]
Taxes, Fees, and State Assessments	[redacted]
Profit and Contingency Margin	[redacted]
Total	[redacted]

XI. PROJECTED LOSS RATIO

The projected loss ratio on a traditional Incurred Claims to Earned Premium basis is [redacted]. We project the loss ratio for these products based on the new MLR formula will meet or exceed 80%, after the allowed adjustments for quality improvement expenses, premium taxes & fees, credibility, and average deductible in your state.

XII. SINGLE RISK POOL

The Single Risk Pool for the individual major medical market in your state reflects experience for all covered lives for every non-grandfathered product/plan combination for all of our affiliate companies Freedom Life Insurance Company of America, National Foundation Life Insurance Company, and Enterprise Life Insurance Company.

XIII. INDEX RATE

The Index Rate of [redacted] is shown in cell V44 of worksheet 1 of the Unified Rate Review Template (URRT) and in the attachment "Index Rate Example PA". This index rate reflects our expected allowed claims from our pricing assumptions.

XIV. MARKET ADJUSTED INDEX RATE

Our Market Adjusted Index Rate used in pricing is shown in the attachment "Index Rate Example PA". Using the Risk Adjustment and Reinsurance Factor described in Section IX, the pricing Market Adjusted Index Rate as shown in "Index Rate Example PA" is calculated as follows:

[redacted]

XV. PLAN ADJUSTED INDEX RATE

The Plan Adjusted Index Rates are developed by adjusting the Market Adjusted Index Rate to account for the Actuarial Value and Cost Sharing adjustments for each plan and adjustments for distribution and administrative costs. Using the Actuarial Value and Cost Sharing Factors and the expenses described in Section X, the Plan Adjusted Index Rates are the following:

Bronze = [redacted]

XVI. CALIBRATION

An age curve calibration factor of [redacted] is used to adjust the Plan Adjusted Index Rates in order to calculate the Consumer Adjusted Premium Rates. There is no calibration needed to adjust for geography.

XVII. CONSUMER ADJUSTED PREMIUM RATE DEVELOPMENT

The Consumer Adjusted Premium Rate is the final premium rate for each plan that is charged to an individual after applying the calibration factors and the rating adjustments of age, area, and tobacco status. Please see the attached document "Index Rate Example PA".

XVIII. AV METAL VALUES

The HHS Actuarial Value Calculator (AVC) was used to generate the AV metal values for the plans in our portfolio. These plans represent the standardized plans promulgated by your state. We have attached the HHS AV calculator pages showing the calculated values for each metal plan.

XIX. AV PRICING VALUES

The AV pricing values were determined by studying our own internal continuance tables, in addition to an adjustment for utilization differences we expect due to plan cost sharing design. In the Actuarial Value Calculator Methodology document released by HHS, HHS states that spending is affected by plan design through induced demand, and they in turn have explicitly differentiated and estimated the impact of induced utilization by metal level. The HHS defined induced utilization factor for the Bronze metal level is 1.00. Since we don't have enough credible experience to determine separate induced utilization factors for each metal level, we are applying the prescribed HHS induced utilization factors used in the HHS risk score to our plans. These values are then divided by the projected loss ratio in order to account for the administrative expenses.

XX. MEMBERSHIP PROJECTIONS

We projected 2016 enrollment from the existing business by assuming a [redacted] shock lapse because of the higher rates due to new essential health benefits and guaranteed issue requirements. For new business, we analyzed current sales levels and projected anticipated sales of the new metal tier plans in 2016.

XXI. TERMINATED PRODUCTS

We have not made a final decision as to whether Non-Compliant Non-Grandfathered forms will be allowed to renew for 2016. For filing purposes we have grouped the transitional policies in the URRT and labeled them "Terminated Products". Non-grandfathered product USHG-2009-C-PA-FLIC may be discontinued as of 12/31/2015. This product is included in the experience period data.

The following Single Risk Pool ACA compliant products will be terminated:
EHB-2015-IP-PA-NFL, 37352PA010

XXII. PLAN TYPE

All 2016 individual medical plans will be PPO plans.

XXIII. WARNING ALERTS

Warning alerts from the unified rate review template are explained below:

1. Worksheet 1 Cell H30 has a warning because of rounding of values.
2. Worksheet 2 Cells A54 and A56 have warnings because the premiums on Worksheet 1 include terminated plans while the premiums in Worksheet 2 do not. The URRT instructions for Worksheet 2 Plan Adjusted Index Rates say the following, "For terminated non-single risk pool compliant plans, enter zero in the template."

XXIV. EFFECTIVE RATE REVIEW INFORMATION

See the attachments for additional rating information.

XXV. RELIANCE

In developing this rate filing I relied upon information provided by others within my department, as well as on information provided by other departments within the organization, and public information available including but not limited to the "Cost of the Future Newly Insured under the Affordable Care Act (ACA)" study prepared by Optum Health, external trend studies, various HHS publications, and other sources. I have reviewed this information for reasonableness, and I consider it to be reliable.

XXVI. ACTUARIAL CERTIFICATION

I am a member of the American Academy of Actuaries. To the best of my knowledge and judgment,

1. This rate filing is in compliance with the applicable laws and regulations concerning premium rate development in this state and the benefits are reasonable in relation to premiums.
2. The projected index rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations.
    b. Developed in compliance with Actuarial Standards of Practice.
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered.
    d. Neither excessive nor deficient.
3. 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.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections 3 and 4 were calculated in accordance with actuarial standards of practice.
5. The HHS AV Calculator was used to determine the AV Metal Values for all plans shown in Worksheet 2 of the Part I Unified Rate Review Template.
6. The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

This opinion is qualified, in that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Tom P. Kennedy

Tom P. Kennedy, A.S.A., M.A.A.A.
Vice President and Actuary

May 6, 2015
Date

National Foundation Life Insurance Company
Exhibit A
Rate Formula and Example

Rating Variables:
Bronze
Age 45
Non-Tobacco User
Rating Area 1
1/1/2016 Effective Date
Monthly Mode

Formula	Value
Monthly Base Rate	[redacted]
x Age Factor	[redacted]
x Tobacco Factor	[redacted]
x Actuarial Value Pricing Factor	[redacted]
x Area Factor	[redacted]
x Trend Factor	[redacted]
x Reinsurance Factor	[redacted]
x Modal Factor	[redacted]
Final Rate	[redacted]

A rate is calculated for each individual on the policy. However, only the oldest three child dependents under age 21 will be charged a premium rate. Tobacco User Factor may only be applied to ages 21 and above.

Actual final rate may vary due to rounding.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$6,850.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,850.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑				
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑				
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.02%
Metal Tier:	Bronze

State: Pennsylvania **Filing Company:** National Foundation Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHB Plan
Project Name/Number: 2016 EHB Rates/

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Additional Information Needed	Cherri Sanders-Jones (AH)	06/03/2015	06/03/2015

Response Letters

Responded By	Created On	Date Submitted

State: Pennsylvania **Filing Company:** National Foundation Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHB Plan
Project Name/Number: 2016 EHB Rates/

Objection Letter

Objection Letter Status	Additional Information Needed
Objection Letter Date	06/03/2015
Submitted Date	06/03/2015
Respond By Date	06/17/2015

Dear Diana Ivie,

Introduction:

June 3, 2015

Tom Kennedy, ASA, MAAA
Vice President and Actuary
3100 Burnett Plaza
801 Cherry Street, Unit 33
Fort Worth, TX 76102

RE: National Foundation Life Insurance Company
Individual - Preferred Provider (PPO) - EHB-2016-IP-PA-NFL
Received: May 6, 2015 SERFF ID# USHG-130034220

Dear Mr. Kennedy:

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.The filing indicates the weighted average increase across plans based on current ACA-compliant membership, inclusive of the impact of benefit and cost sharing changes is 9.9%. 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.

2.Please provide the rates template in the Rate/Rule Schedule tab. Also, complete the Company Rate Information required in this tab.
3.The Actuarial Memorandum indicates that, "We believe we are in compliance with the Uniform Modification of Coverage exceptions under sections 2702 and 2703 of the Public Health Service Act as defined by 45 CFR 146.152, 147.106 and 148.122." Please discuss why you believe you are in compliance with the Uniform Modification of Coverage exceptions. Is the cumulative impact of the benefit change 2% or greater?
4.Please discuss the plan design changes (benefit and cost sharing) and why these changes have been proposed? What is the net cost change to benefits? Please provide the mapping illustration that shows the development of the 9.9% rate increase.
5.Please explain why there was no run-out for the experience period data. Please provide an exhibit showing the completion factors by month.
6.The actuarial memorandum indicates there are no changes in the benefit factor assumption from the 2015 URRT – Section II projection period; however the 2016 URRT shows a factor of 25.9%, while the 2015 URRT shows a factor of 27.7%. Please review and revise as necessary.
7.Please provide a numeric illustration, in Excel, of the Changes in Demographics as discussed on page 5 of the actuarial

memorandum.
8.Please provide an Excel exhibit that shows the development of the age calibration of 1.444.
9.What is the basis for the trend selection of 9.6% (6.3% cost and 3.1% utilization)? Please provide support.
10.What is the basis for the monthly base rate in Exhibit A.1? Please provide a discussion and show the development.
11.In the Credibility Manual Rate Development section VI you indicate that nationwide experience of the non-grandfathered major medical plans for affiliate companies is used. How was this data adjusted to be Pennsylvania specific?
12.Regarding the Credibility Manual Rate Development section VI, please provide narrative that explains the rate development and an Excel exhibit that shows the nationwide experience and all adjustments used in the development of the Index Rate of $558.82. What was the total number of member months for the experience period?
13.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.
14.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.
15.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)

State: Pennsylvania **Filing Company:** National Foundation Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHB Plan
Project Name/Number: 2016 EHB Rates/

Supporting Document Schedules

Satisfied - Item:	Public Viewing Objection Response Documents
Comments:	
Attachment(s):	20150602 PA EHB Objection Response - NFL_Redacted.pdf PA 2016 Rating Exhibits NFL no subsidies_Redacted.pdf 20160101_EHB-2016-IP-PA-NFL_Rate_Pages_Redacted.pdf Trend Anaylsis All Major Med_Redacted.pdf 2015 Segal Health Plan Cost Trend Survey.pdf
Item Status:	
Status Date:	

20150602 PA EHB Objection Response

1. The filing indicates the weighted average increase across plans based on current ACA-compliant membership, inclusive of the impact of benefit and cost sharing changes is 9.9%. 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.

The 9.9% increase reflects a trend increase of [redacted], an increase of [redacted] to account for the new 2016 Federal Transitional Reinsurance Program and associated fees and a [redacted] decrease to account for the tobacco normalization factor. No other changes were made and all changes are applied evenly across all proposed plans. We discovered an error in the percentage for the reinsurance adjustment and the tobacco normalization factor formula which were typos and did not affect the rates. We have corrected these in the attached revised Actuarial Memorandum.

2. Please provide the rates template in the Rate/Rule Schedule tab. Also, complete the Company Rate Information required in this tab.

We have attached the rate pages (the pdf of the rates template was already attached) and completed the Company Rate Information via a PSU. Since this is a new form we have entered zeroes in the fields.

3. The Actuarial Memorandum indicates that, "We believe we are in compliance with the Uniform Modification of Coverage exceptions under sections 2702 and 2703 of the Public Health Service Act as defined by 45 CFR 146.152, 147.106 and 148.122." Please discuss why you believe you are in compliance with the Uniform Modification of Coverage exceptions. Is the cumulative impact of the benefit change 2% or greater?

Please see Exhibit Q3 of the attachment. The following criteria in blue must be kept to meet the Uniform Modification of Coverage requirements:

1. The product is offered by the same health insurance issuer: This product will be offered by National Foundation Life Insurance Company.
2. The product is offered as the same product type: This product will be offered as a preferred provider organization (PPO).
3. The product covers a majority of the same counties in its service area: The product covers the same counties in its service area as the previous product.
4. The product has the same cost sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act (e.g., bronze, silver, gold, platinum or catastrophic): We have changed the cost sharing structures to maintain the same level of coverage and approximately the same Actuarial Value as previous years. This was needed because there was a change in the Actuarial Value calculator.
5. The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not

including changes required by applicable Federal or State law): The product provides the same covered benefits.

4. Please discuss the plan design changes (benefit and cost sharing) and why these changes have been proposed? What is the net cost change to benefits? Please provide the mapping illustration that shows the development of the 9.9% rate increase.

As noted in 3. above, we have changed the cost sharing structures to maintain the same level of coverage and approximately the same Actuarial Value as previous years. This was needed because there was a change in the Actuarial Value calculator. There are no changes to the benefits.

The 9.9% increase reflects a trend increase of [redacted], an increase of [redacted] to account for the new 2016 Federal Transitional Reinsurance Program and associated fees and a [redacted] decrease to account for the tobacco normalization factor.

5. Please explain why there was [redacted] the experience period data. Please provide an exhibit showing the completion factors by month.

Due to the accelerated timeline of EHB filings this year, the most recent experience available and validated when the filing process began was [redacted] See attached exhibit Q5 for the completion factors by month.

6. The actuarial memorandum indicates there are no changes in the benefit factor assumption from the 2015 URRT – Section II projection period; however the 2016 URRT shows a factor of [redacted], while the 2015 URRT shows a factor of [redacted]. Please review and revise as necessary.

It appears that you are looking at a previous version of the URRT in SERFF from last year's filing, not the most recent version submitted on 8/12/2014. The final approved version of the URRT from last year has the [redacted] factor that is the same as this year's filing.

7. Please provide a numeric illustration, in Excel, of the Changes in Demographics as discussed on page 5 of the actuarial memorandum.

See attached exhibit Q7.

8. Please provide an Excel exhibit that shows the development of the age calibration of 1.444.

See attached exhibit Q8.

9. What is the basis for the trend selection of [redacted])? Please provide support.

Trend for your state was calculated as a blend of our internal trend study and the 2015 Segal Health Care Cost Trend Study (see page 5). We weighted the Segal study with [redacted] and our internal study with [redacted] The resulting trend calculation was [redacted]. We have attached both studies for your convenience.

10. What is the basis for the monthly base rate in Exhibit A.1? Please provide a discussion and show the development.

The monthly base rate is the approved 2015 monthly base rate adjusted for the tobacco adjustment factor. Please see the attached Exhibit Q10 (taken from the formerly labeled Exhibit A in the previous year's filing).

11. In the Credibility Manual Rate Development section VI you indicate that nationwide experience of the non-grandfathered major medical plans for affiliate companies is used. How was this data adjusted to be Pennsylvania specific?

The Pennsylvania specific factors, PA Morbidity Load, PA Benefit Adjustment, PA Average Area Factor were applied to the Credibility Manual. In addition, please see the full development of the Credibility Manual in the answer to question 12.

12. Regarding the Credibility Manual Rate Development section VI, please provide an Excel exhibit that shows the nationwide experience and all adjustments used in the development of the Index Rate of [redacted]. What was the total number of member months for the experience period?

The Pennsylvania rates were originally priced for plan year 2015 using 2013 Non-Grandfathered data. The adjusted 2013 Non-Grandfathered data represented our best estimate of the average risk of the ACA compliant EHB marketplace for plan year 2015. Non-Grandfathered experience for year 2014 is now available. [redacted].

[redacted] This Index Rate development is shown in Exhibit Q12.1. Since the plans will potentially be offered to our current Non-Grandfathered business, we decided to base the expected demographics on the most current distributions along with the benefit category splits shown in the URRT. The credibility manual reflects our 2014 nationwide experience of our Non-Grandfathered major medical plans for all of our affiliate companies adjusted to the 2016 Index Rate as described in our pricing considerations above and shown in Exhibit Q12.1. Please see Exhibit Q12.2 for the development of the values in the Credibility Manual. The "Pop'l Risk Morbidity" and "Additional Benefits" adjustments use the Pennsylvania specific rating assumptions of [redacted] and [redacted] respectively. They differ to the extent of how much 2014 ACA Compliant EHB experience is represented in the experience period. The total number of member months for the experience period was [redacted]

13. 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 this requirement and certify that we are currently in compliance.

14. 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.

No, we do not offer transitional policies in your state.

15. 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.

We are selling off exchange only and will not be directly affected by the ruling. However, if subsidies are no longer allowed for the on-exchange plans, it is anticipated that only the sicker insureds will maintain coverage, while the healthier will lapse. Given that the ACA's permanent risk adjustment program spreads exchange morbidity risk across the entire single risk pool, an insurer that remains only off-exchange would, in theory, end up with a healthier population and end up having to pay into the risk-adjustment pool to compensate for those health plans that remained on exchange and enrolled less healthy members. We have developed rates with a [redacted] load to account for this potential impact. Attached please find rate pages and rating exhibits detailing this second set of rates.

National Foundation Life Insurance Company
EHB-2016-IP-PA-NFL
Pricing Exhibit

Item	Description	Factors	
A	Pooled 2013 Per Member Per Month Allowed Claims - State	[redacted]	
B	Pooled 2013 Per Member Per Month Allowed Claims - Manual	[redacted]	
C	Credibility of State (approximately 777 life years in experience year 2013)	[redacted]	
D	Credibility Adjusted Allowed Claims PMPM	[redacted]	D = A x C + (B x (1-C))
E	Annual Trend on Allowed Claims Basis	[redacted]	
F	24 Months of Trend from Midpoint of 2013 to Midpoint of 2015	[redacted]	F = (1 + E)^2
G	Underwriting Wear Off in Experience	[redacted]	
H	Adjust Experience to 2015 Market Risk	[redacted]	
I	Cost of Essential Benefits Not covered within Experience Data	[redacted]	
J	Adjust Experience to Utilization Level of Bronze Plan	[redacted]	Note: Historical experience is at approximately a Bronze level.
K	Adjusted to 2015 Bronze Plan PMPM Allowed Claims	[redacted]	K = D x F x G x H x I x J
L	Average Area Factor Adjustment	[redacted]	Adjusting Allowed Claims to Expected State Level
M	Adjusted to State Level PMPM Allowed Claims	[redacted]	M = K x L
N	2015 projected Average Age Rating Factor	[redacted]	
O	**Final 2015 Index Rate**	[redacted]	O = M
P	Plan Year 2016 Proposed Trend	[redacted]	
Q	2015 projected Average Age Rating Factor	[redacted]	
R	**Final 2016 Index Rate**	[redacted]	R = O x P x Q / N
S	Potential Impact of No Subsidies due to King vs. Burwell	[redacted]	
T	**Proposed 2016 Index Rate with no subsidies**	[redacted]	

Premium Rate Development

Index Rate for Projected Period PMPM	[redacted]
Risk Adjustment PMPM	[redacted]
Net Reinsurance Contributions PMPM	[redacted]
Exchange User Fees PMPM	[redacted]
Market Adjusted Index Rate PMPM	[redacted]

Metal Tier	Bronze
Metal AV Value	[redacted]
Market Adjusted Index Rate PMPM	[redacted]
<u>Plan Adjustments (in multiplicative format)</u>	
Actuarial value and cost-sharing design of the plan	[redacted]
Tobacco Adjustment	[redacted]
Plan benefits in addition to EHB	[redacted]
Expected impact of special eligibility categories (only for catastrophic plans)	[redacted]
<u>Plan Adjustments (in % format)</u>	
Distribution and administration costs	[redacted]%
Plan Adjusted Index Rate	[redacted]
Age Calibration Factor	[redacted]
Geography Calibration Factor	[redacted]
Aggregate Calibration Factor	[redacted]
Consumer Adjusted Premium Rate PMPM	[redacted]

Age 45 Factor	[redacted]
Geographic Rating Area #1	[redacted]
Geographic Rating Area #2	[redacted]
Geographic Rating Area #3	[redacted]
Geographic Rating Area #4	[redacted]
Geographic Rating Area #5	[redacted]
Geographic Rating Area #6	[redacted]
Geographic Rating Area #7	[redacted]
Geographic Rating Area #8	[redacted]
Geographic Rating Area #9	[redacted]

Final Premium Rate (Age 45, Area 1)	**$** [redacted]
Final Premium Rate (Age 45, Area 2)	**$** [redacted]
Final Premium Rate (Age 45, Area 3)	**$** [redacted]
Final Premium Rate (Age 45, Area 4)	**$** [redacted]
Final Premium Rate (Age 45, Area 5)	**$** [redacted]
Final Premium Rate (Age 45, Area 6)	**$** [redacted]
Final Premium Rate (Age 45, Area 7)	**$** [redacted]
Final Premium Rate (Age 45, Area 8)	**$** [redacted]
Final Premium Rate (Age 45, Area 9)	**$** [redacted]

National Foundation Life Insurance Company
Exhibit A
Rate Formula and Example

Rating Variables:
Bronze
Age 45
Non-Tobacco User
Rating Area 1
1/1/2016 Effective Date
Monthly Mode

Formula	Value
Monthly Base Rate	[redacted]
x Age Factor	[redacted]
x Tobacco Factor	[redacted]
x Actuarial Value Pricing Factor	[redacted]
x Area Factor	[redacted]
x Trend Factor	[redacted]
x Reinsurance Factor	[redacted]
x Modal Factor	[redacted]
Final Rate	[redacted]

A rate is calculated for each individual on the policy. However, only the oldest three child dependents under age 21 will be charged a premium rate.

Actual final rate may vary due to rounding.

National Foundation Life Insurance Company
Rating Factors for Forms EHB-2016-IP-PA-NFL with EHB-2016-SCH-PA-NFL

Attained Age	Factor
0 - 20	0.635
21	1.000
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

Monthly Base Rate	$[redacted]
Trend Factor	[redacted]
2016 Reinsurance Factor	[redacted]
Tobacco User Factor	[redacted]
Non-Tobacco User Factor	1.00

Actuarial Value and Cost Sharing Factors	
Bronze	[redacted]

Modal Factors	
Quarterly	3
Semi-Annual	6
Annual	12

A rate is calculated for each individual on the policy. However, only the oldest three child dependents under age 21 will be charged a premium rate. Tobacco User Factor May only be applied to ages 21 and above

National Foundation Life Insurance Company
Area Factors for Forms EHB-2016-IP-PA-NFL with EHB-2016-SCH-PA-NFL

State Rating Area	Area Factor
1	[redacted]
2	
3	
4	
5	
6	
7	
8	
9	

STATE	COUNTY/ZIP	RATING AREA	AREA FACTOR	COMMENTS
PA	Clarion	1	0.937	
PA	Crawford	1	0.937	
PA	Erie	1	0.937	
PA	Forest	1	N/A	No GW-CIGNA coverage
PA	McKean	1	N/A	No GW-CIGNA coverage
PA	Mercer	1	0.937	
PA	Venango	1	0.937	
PA	Warren	1	N/A	No GW-CIGNA coverage
PA	Cameron	2	N/A	No GW-CIGNA coverage
PA	Elk	2	N/A	No GW-CIGNA coverage
PA	Potter	2	N/A	No GW-CIGNA coverage
PA	Bradford	3	N/A	No GW-CIGNA coverage
PA	Carbon	3	0.963	
PA	Clinton	3	0.963	
PA	Lackawanna	3	0.963	
PA	Luzerne	3	0.963	
PA	Lycoming	3	0.963	
PA	Monroe	3	0.963	
PA	Pike	3	N/A	No GW-CIGNA coverage
PA	Sullivan	3	0.963	
PA	Susquehanna	3	N/A	No GW-CIGNA coverage
PA	Tioga	3	N/A	No GW-CIGNA coverage
PA	Wayne	3	N/A	No GW-CIGNA coverage
PA	Wyoming	3	0.963	
PA	Allegheny	4	0.893	
PA	Armstrong	4	0.893	
PA	Beaver	4	0.893	
PA	Butler	4	0.893	
PA	Fayette	4	0.893	
PA	Greene	4	0.893	
PA	Indiana	4	0.893	
PA	Lawrence	4	0.893	
PA	Washington	4	0.893	
PA	Westmoreland	4	0.893	
PA	Bedford	5	0.899	
PA	Blair	5	0.899	
PA	Cambria	5	0.899	
PA	Clearfield	5	N/A	No GW-CIGNA coverage
PA	Huntingdon	5	0.899	
PA	Jefferson	5	0.899	
PA	Somerset	5	0.899	
PA	Centre	6	1.083	
PA	Columbia	6	1.083	
PA	Lehigh	6	1.083	
PA	Mifflin	6	1.083	
PA	Montour	6	1.083	
PA	Northampton	6	1.083	
PA	Northumberland	6	1.083	
PA	Schuylkill	6	1.083	
PA	Snyder	6	1.083	
PA	Union	6	1.083	
PA	Adams	7	1.027	
PA	Berks	7	1.027	
PA	Lancaster	7	1.027	
PA	York	7	1.027	
PA	Bucks	8	1.042	
PA	Chester	8	1.042	
PA	Delaware	8	1.042	
PA	Montgomery	8	1.042	
PA	Philadelphia	8	1.042	
PA	Cumberland	9	0.943	
PA	Dauphin	9	0.943	
PA	Franklin	9	0.943	
PA	Fulton	9	0.943	
PA	Juniata	9	0.943	
PA	Lebanon	9	0.943	
PA	Perry	9	0.943	

2012-2014 Trend Exhibit: Major Medical

Incurred Year	Allowed Claims by Incurred Year	Number of Claims	Average Cost per Claim	Annual Increase in Average Claim Amount	Average Annual Increase in Average Claim Amount Over 3 Years	Exposed Member Months	Number of Claims per Member Month	Annual Increase in Number of Claims per Member Month	Average Annual Increase in Number of Claims per Member Month Over 3 Years	Expected Loss Ratio	Annual Expected Increase due to Underwriting Wear-off	Annual Allowed Claim Cost per Member Month	Average Annual Increase in Allowed Claim Cost per Member Month Over 3 Years
2012	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2013	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2014	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Segal Group

Segal Consulting • Sibson Consulting
Segal Rogerscasey • Segal Select Insurance

2015 Segal Health Plan Cost Trend Survey

Expect More Variation in Health Benefit Cost Trends for 2015

Health benefit plan cost trend rates for 2015 are forecast to drop slightly for some coverage, but to increase substantially for prescription drug coverage, according to data compiled in the 2015 *Segal Health Plan Cost Trend Survey*, Segal's eighteenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs). Trend is the forecast of annual gross per capita claims cost increases.[1] The survey captured data on trend projections for the following types of medical coverage for active participants and retirees under age 65: fee-for-service (FFS)/indemnity plans, high-deductible health plans (HDHPs), open-access preferred provider organizations (PPOs)/point-of-service (POS) plans, PPOs/POS Plans (with PCP gatekeepers) and health maintenance organizations (HMOs). In addition, the survey compiled data on trend projections for various types of medical coverage for Medicare-eligible retirees, prescription drug carve-out, dental and vision.

This report presents the survey results, including components of trend, in graphs and tables with observations on key findings. To assess the accuracy of projections, trend projections are compared to actual data. Actual trends for 2013 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years for managed care plans (HMOs and PPOs/POS plans). The report also compares trend data to increases in the consumer price index for all urban consumers (CPI-U) and wages. It concludes with Segal's commentary on top health care cost-management strategies.

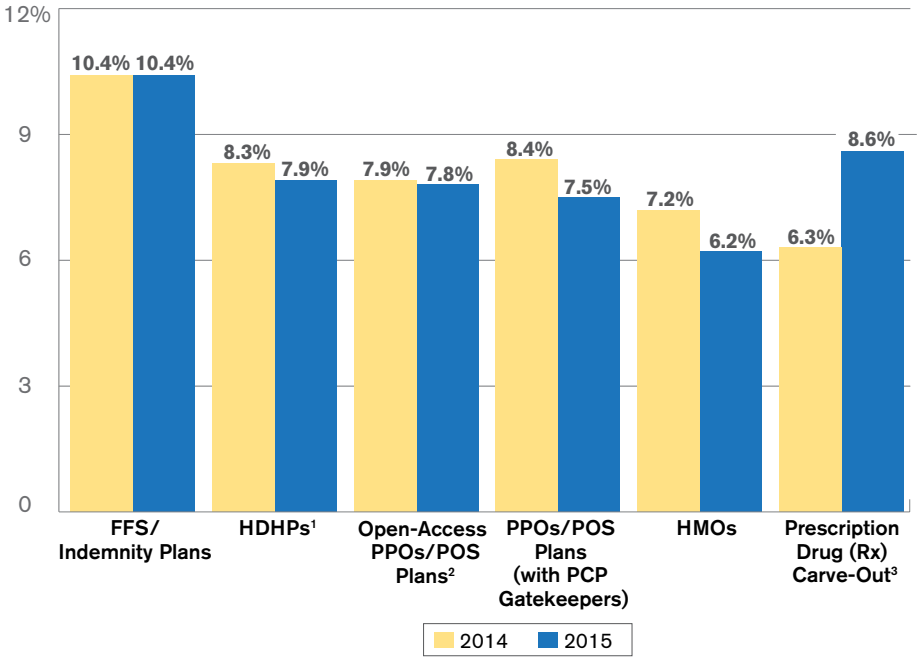
Benefit Trend Projections for 2015

Health benefit trends for actives and retirees under age 65 are forecast to vary widely by type of coverage for 2015, as shown in Graph 1, which compares those projections to 2014 projections:

- Medical trends are projected to range from a low of 6.2 percent for HMOs to a high of 10.4 percent for fee-for-service coverage.
- More closely managed medical plans, like HMOs and PPOs/POS plans with primary care gatekeeper models, are forecast to see a 1 percentage-point drop from 2014 projections.
- The increase in the cost of prescription drug carve-out coverage is expected to jump to nearly 9 percent.

New specialty drugs coming to market and price increases of brand-name drugs are the main driving forces of prescription drug plan cost trends.

Graph 1: Projected Medical and Prescription Drug Trends for Actives and Retirees Under Age 65: 2014 and 2015



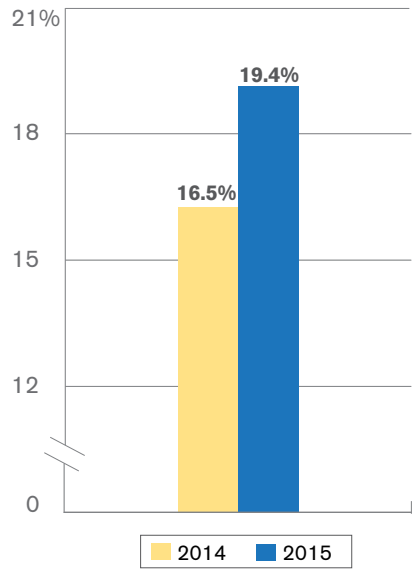
[1] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services.

[2] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[3] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

[1] For a more detailed description of trend, see the following online supplement: http://www.segalco.com/publications/surveysandstudies/2015TSsupp1.pdf. For information about the survey participants, see another online supplement: http://www.segalco.com/publications/surveysandstudies/2015TSsupp2.pdf.

Graph 2: Projected Specialty Drug/ Biotech Trend: 2014 and 2015



Typically, less than 1 percent of all prescriptions are specialty drug medications,[2] yet survey respondents noted these drugs now account for more than 25 percent of total prescription drug cost trends. The projected specialty drug/biotech trend rate for 2015 is an exceptionally high 19.4 percent. See Graph 2 above.

Graph 3 compares 2015 projections for Medicare-eligible retiree coverage to 2014 projections. Notable findings follow:

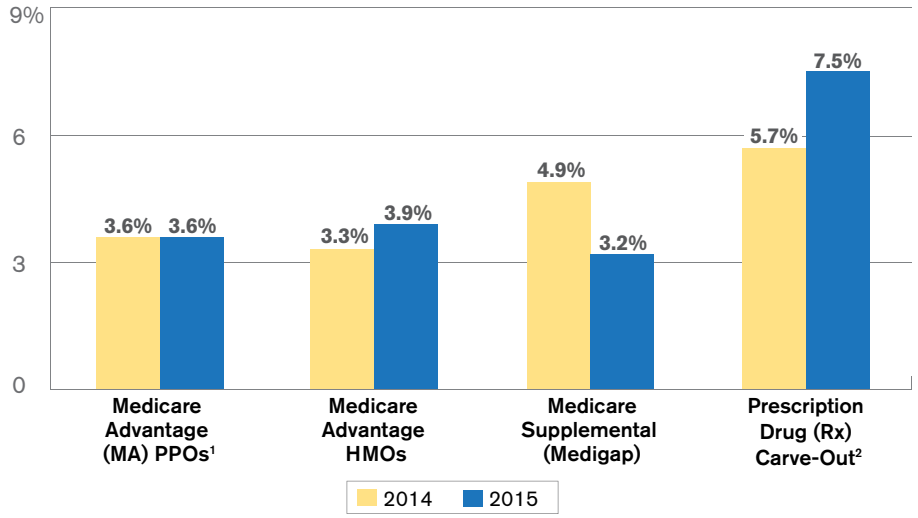
- The trend for Medicare supplemental (Medigap) plans is expected to decline, while the trend for Medicare Advantage (MA) PPO plans will remain the same and the trend for Medicare Advantage HMOs is forecast to be higher.
- Prescription drug trend for retirees age 65 and older is expected to rise to 7.5 percent, more than twice the rate of retiree medical cost trends.

As shown in Graph 4, trends for dental coverage are expected to be either flat or higher for 2015 compared to 2014 projections, whereas trends for vision coverage are forecast to be lower. Notably:

- Dental plan trends are projected to increase to 4.7 percent for dental provider organizations (DPOs).
- Vision plan cost trend rates are projected to decline to just below 3 percent.

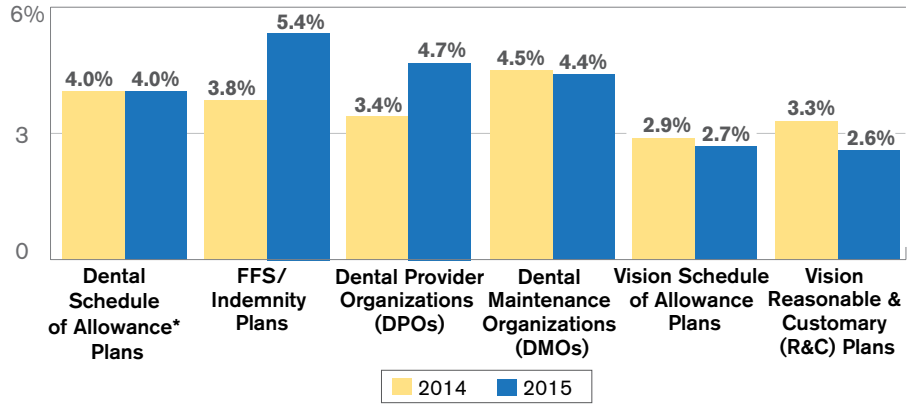
The survey looked for regional variations in trend rates. Projected 2015 trend rates for PPOs and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South

Graph 3: Projected Medical and Prescription Drug Trends for Retirees Age 65 and Older: 2014 and 2015



[1] The 2014 survey combined PPOs with FFS plans. The 2015 survey only captured data about PPOs, not FFS plans.
[2] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

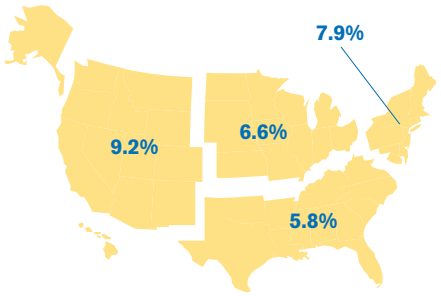
Graph 4: Projected Dental and Vision Trends: 2014 and 2015



* A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

[2] *2013 Express Scripts Drug Trend Report*: http://lab.express-scripts.com/~/media/7f14884da6ef434dbf30abd82dd7e655.ashx

Graph 5: Projected 2015 Medical Trends for PPOs/POS Plans for Actives and Retirees Under Age 65 by Region



and highest rate of 9.2 percent in the West, as shown in Graph 5 above.

For plans that offer narrow networks,[3] survey participants were asked the average cost impact on 2015 plan trend relative to standard broad networks. Most reported no difference, as shown in Table 1. However, 38 percent indicated narrow network cost trends would average 3.8 percentage points lower than standard networks.

Affordable Care Act Mandates Adding to Health Plan Cost Trends

The Affordable Care Act imposes new mandates and taxes on most health plan sponsors and charges new fees to them, all of which are adding to cost trends. Segal asked the survey respondents specifically about what the expected cost increase would be to comply with the Affordable Care Act's out-of-pocket maximum requirement for 2015, which applies to non-grandfathered plans. That requirement is expected to add an average cost increase of about 1 percent to medical plans and 1.5 percent to prescription drug carve-out plans.

Components of 2015 Medical Trends

The survey also examined 2015 projected medical trends by service type. Similar to prior-year projections, price inflation remains the largest component for hospital services and brand-name medications.

The survey respondents predict a nearly 3.5 percent increase in utilization of hospital and physician services, up slightly from prior projections. Prescription drug utilization rates (the number of prescriptions filled per enrollee) are forecast to increase by 2.5 percent. However, for many "mature" groups (those with stable enrollment), Segal continues to see relatively unchanged inpatient admission and prescription drug utilization rates.

Accuracy of Trend Projections

To assess the accuracy of trend projections, Segal compared the average 2013 trend forecasts by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the actual average trend rates experienced by the health plans covered by those organizations for the same 12-month period (the most recent full year for which actual data is available), as reported by the survey respondents. Consistent with previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that trend projections have been generally higher than actual experience in most years.

> "Trend projections have been generally higher than actual experience in most years."

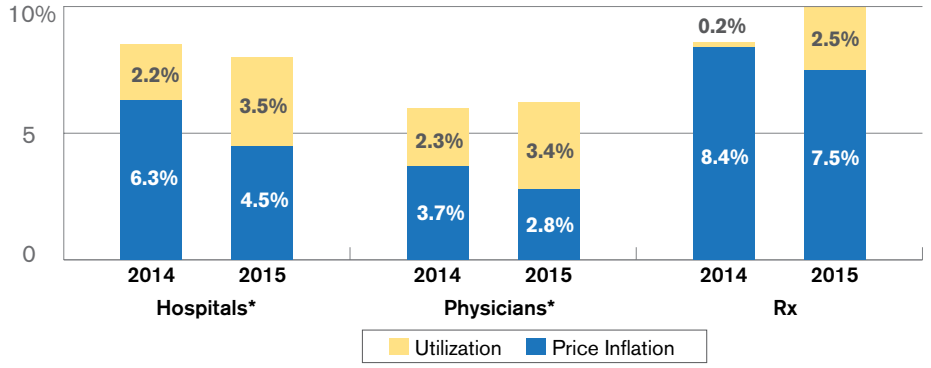
It should be noted that the accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections

[3] Narrow networks typically offer less than half of available providers in the network area.

Table 1: Average Cost Impact on 2015 Plan Trend for Narrow Networks Relative to Standard Broad Networks

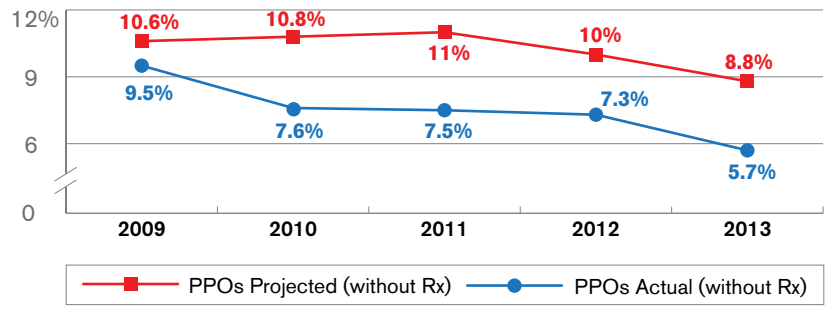
Rank	Percent of Responses	Trend Rate Impact
No Difference	63%	0.0%
Lower	38%	3.8%
Higher	0%	Not Applicable

Graph 6: Components of 2014 and 2015 Projected Trends for Hospital Services, Physician Services and Prescription Drugs for Actives and Retirees Under Age 65

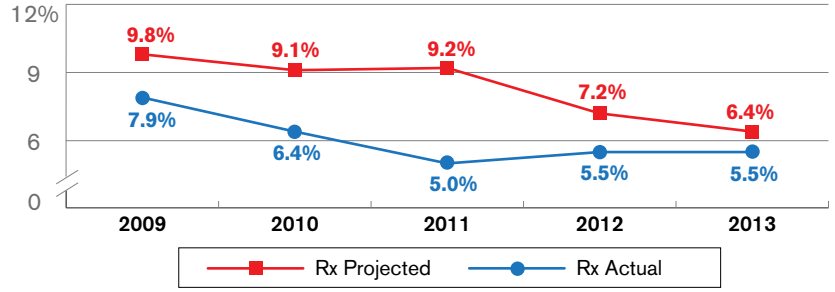


* Hospital and physician trends are for open-access PPOs. The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component.

Graph 7: Comparison of Projected to Actual Trends for Open-Access PPOs/ POS Plans for Actives and Retirees under Age 65: 2009–2013

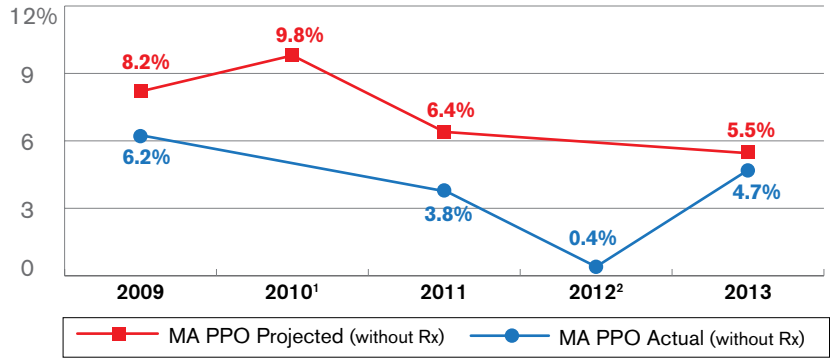


Graph 8: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2009–2013



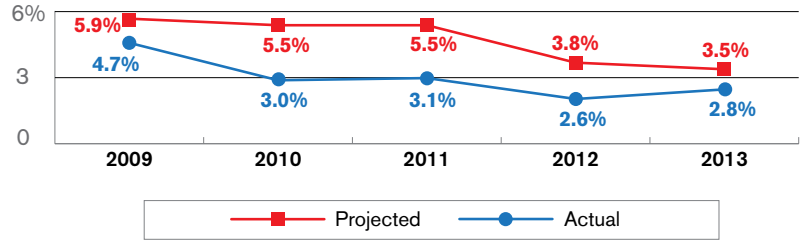
* This data reflects retail and mail-order delivery channels combined.

Graph 9: Comparison of Projected to Actual Trends for MA PPOs: 2009–2013



[1]Actual data for 2010 is not available. [2]Projected data for 2012 is not available.

Graph 10: Comparison of Projected to Actual Trends for Dental PPOs: 2009–2013



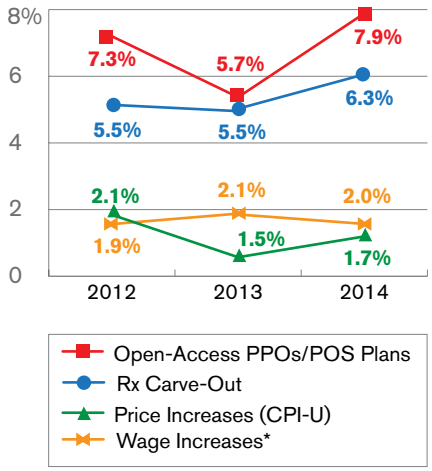
will generally be underestimated for a period. Also, actual historic results may reflect changes to plan design taken by plan sponsors year to year, while forecasted trends are based on the same level of benefits. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 7–10 compare projected trends to actual trends for five years.

Table 2 on the next page shows selected trends for 13 years (actual trends for 2003–2013 and projected trends for 2014 and 2015). Actual trends for 2013 for managed care plans were the lowest reported in more than 12 years.

Trend Rates Compared to Increases in Prices and Wages

Medical health plan cost trends continue to outpace the CPI-U and wage growth by a margin of at least three to one. See Graph 11. For many plan sponsors, the increase in medical plan cost trends can be more than four times the rate of increase in wages.

Graph 11: Comparison of Selected Trend Rates (2012–2013 Actual and 2014 Projected) to Price and Wage Increases



* Bureau of Labor Statistics (BLS) – Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted: http://www.bls.gov/news.release/empsit.t19.htm

Cost-Management Strategies

Survey participants were asked to indicate the top cost-management strategies implemented in 2014. The text box at the bottom of this page lists the common strategies implemented for medical and prescription drug plans, respectively.

Commentary & Outlook

The improving economy continues to play a significant role in the spending and utilization of health care. Additionally, the impact of the Affordable Care Act is also beginning to take effect. Not only has the law failed to provide significant cost relief for plan sponsors, it has had the opposite effect as a result of new mandates, taxes and fees. Several studies estimate the increase in health costs to range between 1 and 4 percent, depending on the year.[4]

Sponsors of large group plans must stay focused on exploring health plan strategies that produce high-value medical benefits with stable cost trends, even as the health benefits landscape changes around them due to the Affordable Care Act. Some of these strategies include:

- ***Setting Appropriate Cost Sharing***
  The level of cost sharing influences plan utilization and overall costs. The relative relationship between treatment copayments for different treatment options and settings is a critical element of creating a highly efficient plan design. For example, the right copayment differences for lower-cost settings, such as telemedicine, walk-in clinics and urgent care, can play a role in reducing

[4] See *2014 Employer-Sponsored Health Care: ACA Impact* (https://www.ifebp.org/pdf/research/ACASurvey_2014.PDF); *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans* (http://www.ahipcoverage.com/wp-content/uploads/2011/11/Insurer-Fees-report-final.pdf); *Impact of the Health Insurance "Annual Fee" Tax* (http://americanactionforum.org/uploads/files/research/Impact_of_the_Health_Insurance_Tax.pdf); and *The Cost of the Affordable Care Act to Large Employers* (http://www.americanhealthpolicy.org/content/documents/resources/2014_ACA_Cost_Study.pdf).

Table 2: Selected Medical,[1] Rx Carve-Out and Dental Trends: 2003–2013 Actual and 2014 and 2015 Projected[2]

Year	PPOs	POS Plans	HMOs	MA HMOs	Rx	DPOs
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Actual	5.7%	6.7%	6.1%	3.1%	5.5%	2.8%
2014 Projected	**7.9%**	**8.4%**	**7.2%**	**3.3%**	**6.3%**	**3.4%**
2015 Projected	**7.8%**	**7.5%**	**6.2%**	**3.9%**	**8.6%**	**4.7%**

[1] Medical trends exclude prescription drug coverage.
[2] All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2014 and 2015 projected trends to actual trends for 2003 through 2013 — is available on the following webpage: http://www.segalco.com/publications/surveysandstudies/2015TSsupp3.pdf).

Top Medical Plan and Prescription Drug Plan Cost-Management Strategies Implemented in 2014

Medical Plan Strategies

- Expand Use of Low-Cost Primary-Care Access (Telehealth, Walk-In Clinics, Worksite Clinics)
- Reference-Based Pricing[1]
- Follow the Medicare Hospital Readmissions Reduction Program to Reduce Hospital Readmissions
- Value-Based Contracting, including:
  - Accountable Care Organizations (ACOs)[2]
  - Patient-Centered Medical Homes (PCMHs)[3]
  - Use of Narrow/Tiered Networks[4]
- Defined Contribution Approaches with or without the Use of Private Exchanges
- Continued Focus on Wellness

Prescription Drug Plan Strategies

- Medication Therapy Management Program
- RetroDUR Program[5]
- EGWP[6] Implementation
- Formulary Management
- Prior Authorization
- Step Therapy
- Physician Dispensing and Pharmacy Network Management
- Specialty Pharmaceutical Management

[1] Reference-based pricing involves designs where a plan sets a maximum price for covering the cost of a particular service to steer patients away from higher-priced providers who have no evidence of providing higher-quality services.
[2] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.
[3] PCMHs focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions.
[4] Tiered networks require lower cost sharing if participants use high-quality, preferred providers within a network.
[5] RetroDUR stands for retrospective drug utilization review.
[6] EGWP is an abbreviation of Employer Group Waiver Plan.

emergency department visits for minor illnesses. Reintroducing percentage copayments for some services (*e.g.*, prescription drugs, rehabilitative services and elective surgery) can encourage participants to be thoughtful health care consumers. Having an incentive to reduce out-of-pocket costs, where treatment options exist, will create more engaged plan participants and will reduce non-essential treatments and increase the use of lower-cost alternatives.

- ***Selecting the "Right" Network Providers*** Managed care networks have competitive advantages (deep discounts) in different regions. Some plan sponsors are evaluating the potential savings associated with narrow network strategies that steer patients to higher-quality, lower cost providers. Substantial migration to shared-savings provider reimbursements shows promise with respect to long-term cost savings.

- ***Emphasizing Prevention, Wellness, Early Detection and Improved Health Consumer Literacy*** The amount of excess health care spending that is the result of preventable behaviors and lifestyle has been well-documented in the consulting and academic community. Smoking, obesity, stress, lack of physical activity, and poor eating habits contribute to a significant percentage of our national health spending. When plan sponsors design, incent and support the proper wellness and health literacy programs, they experience long-term reductions in hospitalization, emergency room visits, advanced complications of disease and rates of chronic diseases with comorbidities.

- ***Considering a Reference-Based Allowance Approach*** Many plan designs are reviewing the feasibility of implementing reference-based pricing for particular procedures (*e.g.*, a knee replacement). The goal is to negotiate cost-effective arrangements with high-quality providers.

- ***Considering a Defined Contribution (DC) Approach*** The elimination of pre-existing exclusions and guaranteed issue underwriting and the maturation of private health Exchanges has created new coverage opportunities for plan sponsors to consider. While a DC approach is sometimes used as a way to simply cut benefits, in some situations, employers and plan sponsors can create more economically sustainable health benefit strategies by converting to a defined contribution funding strategy and outsourcing medical coverage to the private health Exchanges.[5] This approach may be even more compelling for covered retirees and has become more widely adopted for sponsors of plans with large retiree populations.

- ***Resetting Eligibility Rules*** In light of individual coverage available through the public Marketplaces, some plan sponsors are considering eliminating coverage for working spouses or charging for each covered dependent. This approach may most attractive in industries where incomes tend to be lower because spouses may be able to obtain heavily subsidized coverage through the public Marketplaces.

The Affordable Care Act's pay-or-play design for providing health coverage to full-time employees creates a complicated set of new options for plan sponsors. Segal expects large self-funded health plan sponsors to continue to provide higher-value, responsive health care benefits to participants as they can provide these benefits at lower long-term costs than will be found in the public Marketplaces and private Exchanges over the long term. Removing or avoiding the cost of commissions, taxes and insurer profits is one obvious advantage that these larger plans will continue to enjoy. The ability to understand what their unique participant population demands in terms of coverage, choice and service will allow these plan sponsors to focus on strategies that are most appropriate. Plan sponsors can take steps to remove excess waste and fees in vendor contracts; to identify providers that produce the best value; and to choose levers and incentives to help promote healthy participant behavior. The combination of these strategies will produce meaningful dividends to plan sponsors and allow them to maintain control over providing high-value medical benefits that are well received by current and future employees.

For assistance with health care cost management strategies, contact your Segal or Sibson consultant or the nearest office from the lists on the websites accessible from the hyperlinks at the bottom of the box below.

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To receive survey reports and other publications as soon as they are available online, register your e-mail address via Segal Consulting's website (www.segalco.com/register/) or Sibson Consulting's website (www.sibson.com/register/).

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[5] According to a study by the National Business Group on Health, while 3 percent of employers will move workers into the private health Exchanges next year, 35 percent say they are considering doing so for 2016. See the press release, "U.S. Employers Changing Health Benefit Plans to Control Rising Costs, Comply with ACA, National Business Group on Health Survey Finds": https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234

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