

Kaiser Foundation Health Plan of Georgia, Inc
2019 Rate Filing
Kaiser Permanente Individual and Family (“KPIF”)

Actuarial Memorandum

I, Melissa E. Belen, am a Member of the American Academy of Actuaries and meet its Qualification Standards for preparing rate filings for health maintenance organizations (“HMOs”). I am preparing this Actuarial Memorandum for Kaiser Foundation Health Plan of Georgia, Inc. (“KFHP”) to comply with the CMS requirements as well as the Rules and Regulations of the state of Georgia. This memorandum relates to Kaiser Permanente Individual and Family (“KPIF”) HMO products. The purpose of this rate filing is to obtain approval of rates for Individual KPIF products required under the health care reform law. The material presented in this filing was prepared for this specific purpose and may not be appropriate for other purposes. This filing is for effective dates beginning January 1, 2019.

This rate filing is a revision of existing rates. The forms are open to new sales and for renewals. This filing does not cover grandfathered products. The risk classification is guaranteed issue under the Affordable Care Act. Previous rates were filed under SERFF Binder KPGA-GA18-125072257.

This actuarial opinion is qualified such that the information contained within this filing reflect the state of Georgia and Federal statutes, rules, regulations, and guidance as of June 13, 2018. Changes to the applicable regulations could have a significant impact on rate development. Subsequent changes to these statutes, rules, and regulations may make these rates deficient and would necessitate revisions to this filing.

Kaiser Foundation Health Plan is a Health Maintenance Organization (“HMO”) and offers traditional HMO copayment plans covering medical and pharmacy claim expenses, and Deductible and High Deductible plans, some of which are HSA qualified. Benefits include all Georgia Essential Health Benefits as well as non-Essential Health Benefits including adult preventive dental, adult vision, and sleep lab and studies. A detailed list of all covered benefits is included in the submitted benefit form filing.

I am the primary contact for this submission. My telephone number is (404) 364-7208, and my email address is melissa.e.belen@kp.org.

State: Georgia

HIOS Issuer ID: 89942

NAIC # 96237

Forms:

SERFF Tracking Number Forms

GA19KPIF HMO;HDHP ON 05/18, KPFM-131506502
GA19KPIFNATIVEAME 05/18, KPFM-131506502
GA19KPIFCATEOC ON 05/18, KPFM-131506502
GA19KPIF HMO;HDHP OFF 05/18, KPFM-131506504
GA19KPIFCATEOC OFF 05/18, KPFM-131506504

Proposed Rate Increases

The projected rate increase is 14.7%. There are several reasons for the high rate increase.

- Historical claim experience has been unfavorable.
- CSR payments were not funded in 2018 and our 2018 rates were not adjusted to reflect this. We expect this to continue in 2019.
- Population morbidity is worsening due to antiselective lapsation. These lapses are the result of high increases, changes to the individual mandate, and changes to the treatment of short term and association plans.

This filing is for new plans as well as updated rates for some of our 2018 block. This filing is based on the experience of our 2017 ACA individual business which is treated as a single risk pool under 45 CFR Part 156, §156.80. Rate increases weighted by projected membership are 14.7%. If we were to weight 2019 increases based on 2018 membership, the composite increase would be 19%. Rate increases for the Silver 4700 plan and other Silver On Exchange plans are higher. We expect membership in these Silver plans to decline, lowering the effective increase in 2019.

Market Experience

The development of the Marketwide Adjusted Index Rate is shown in Exhibit 2. This exhibit shows the development of the Index Rate from the historical period Medical Cost Data. The final 2019 rates by plan and age are developed by applying plan factors, network factors, non-EHB benefit costs, and administrative expense to the index rate to get a plan specific rate for an average aged member. The plan specific rate is then multiplied by the calibrated age factors to generate specific rates for other ages. These age specific rates are multiplied by smoker rate up factors to generate tobacco rates.

Experience Period Claims under the Single Risk Pool

The summary of the experience period claims is detailed in Exhibit 3.

Base Period Data

The base period was January 1, 2017 to December 31, 2017.

Allowed claim experience includes all non-grandfathered business. Transitional products (KYP) were removed from all increase analyses. The KYP removal factor is applied in Exhibit 2 line 6, and the calculation is detailed in Exhibit 3.

Paid Through Date

Claims were incurred and paid through the end of February 2018.

Earned Premiums during the Experience Period

Earned premiums represent the dues paid by members as well as federal subsidies, with adjustments for bad debt and accounts receivable. No rebates were payable. Earned premiums include expected net risk adjustment transfers.

Allowed Claims

Allowed amounts are summarized in Exhibit 3. Allowed claims were calculated as net claims adjusted to add the assumed value of cost sharing.

Allowed claims are defined as services or goods consumed by a member at a facility, or at a physician office, including pharmaceutical goods or any such service or goods that are deemed a covered benefit by the member's contract with Kaiser. Some services would not be contractually covered and therefore are not allowed. In addition, other services that may be the responsibility of another party such as coordination of benefits would not be counted as allowable.

Estimate for Incurred and Unpaid Claims

A common reserve tool developed and maintained by KFHP Actuarial Services is used to set KFHP's IBNR reserves. Kaiser's common reserve tool uses historical claim lag averages to project anticipated future payments. IBNR levels are set for line of business and service line breakouts. The completion factors used to complete the base period external claims were developed using KFHP's overall commercial line of business by type of service. The claims are incurred in 2017 and paid through February 2018, so a 14/12 completion factor is used. The completion factor estimates for external claims are based on the numbers used for our financial reporting.

A separate reserve model was used to estimate completion factors for internal claims. These claims are not included in the unpaid claim liability established for the region. Commercial experience in aggregate was used to estimate the completion factors for the individual line of business.

Experience Incurred and Paid to Date

This is calculated as the sum of internal and external claims adjusted for the value of cost sharing. The starting allowed amount is shown on Exhibit 2 line 1.

Bad Debt

This represents the amount that we expect to pay for non-members and is an adjustment to our administrative expenses. This filing includes a \$0 adjustment for bad debt.

Projection Factors

Non-EHB

An adjustment has been made to the base period allowed amount to remove the Non-EHB benefits from the Index Rate. This multiplier was calculated by summing the allowed amount for Non-EHB benefits in the base period and dividing by total allowed. The same multiplier adjusted for new Non-EHB benefits effective after the experience period is used to add back Non-EHB benefits when calculating the final index rate.

Non-EHB benefits are removed from the experience as required by the index build up instructions. The adjustment is shown in Exhibit 4. This is also shown on line 2 of Exhibit 2. The new Non-EHB benefit adjustment is shown in Exhibit 9.

Utilization Adjustment in Historical Period

Exhibit 5 shows the adjustments by plan of the impact on induced utilization for co-pays and deductibles. This will reflect the difference in induced utilization due to benefit changes between the historical period and the projection period.

The utilization adjustments by plan represent the impact of induced utilization, as calculated using a pricing model developed by a national consulting firm. This model is calibrated to KFHP of Georgia's experience basis and trended to the projection period. The change in the composite utilization adjustment from the historical to the projected period reflects the impact of benefit changes and changes in member mix on utilization in aggregate for the ACA block. This assumption is shown in Exhibit 5. It is also shown in Exhibit 2 line 4.

For the projection period, the utilization adjustment is shown by plan in Exhibit 16 based on our projected membership.

Changes in Demographics

Exhibit 6 shows the expected change in demographics from the historical period to the projection period. The adjustment for the historical period is shown in line 5 of Exhibit 2. We do not expect any material changes in age or other demographic characteristics are projected.

Trend

As an integrated health care provider, a large portion of KFHP's expenses are the fixed costs associated with providing medical care through our facilities. To accurately project expenses, trends should recognize assumptions in KFHP-GA's strategic plan. Internal budgeted expenses are the most appropriate basis to estimate internal expenses. For external expenses, we accounted for contractual changes, benefit changes, cost initiatives, and changes in product mix when developing external trends. Exhibit 7 shows our expected trend assumption from the base period to the projection period.

The trend projection is shown in Exhibit 2 lines 7, 8 and 9.

Changes in the Morbidity of the Expected Covered Population

Changes in the expected morbidity composition of the block are developed in Exhibit 8. This amount is shown in Exhibit 2 line 10.

We are assuming that Blue Cross Blue Shield of Georgia's exit from Rating Area 3 will worsen KFHP-GA's morbidity by 6.9%. We are also assuming a 14.5% increase in statewide morbidity due to a projected 26% decrease in market size from 2017 to 2019. We relied on the market size estimates provided by KFHP's Market Strategy department.

Pediatric Dental

Adjustments for pediatric dental are developed based on expected claims, estimated administrative fee, and expected pediatric membership as a percentage of total membership.

Projected Index Rate

This is the product of all the above adjustments and is shown on Exhibit 2 line 11.

Marketwide Adjusted Index Rate

Two adjustments are allowed to the projected index rate to arrive at the Marketwide Adjusted Index Rate. These are described in more detail under the URRT section.

The Risk Adjustment factor can be found in Exhibit 8. The factor includes the risk adjustment user fee and the risk adjustment transfer.

The exchange fee is 3.5% of premium. The exchange fee adjustment in Exhibit 2 is based on expected membership on the exchange versus the total membership, calculated as a percentage of the final premium and converted to an allowed basis.

Plan Adjusted Index Rate

The rates for an average age member can be found in row 13 of Exhibit 16. Rates for each plan are developed for a 47 year old.

The exhibit starts with the Marketwide Adjusted Index Rate from Exhibit 2 line 14.

Plan Adjusted Index Rates are developed after adjusting for benefit design, network, Non-EHB benefits, pediatric dental, catastrophic plan adjustments, and retention.

Benefit Design

Pricing Value factors are calculated using pricing estimates from our national pricing model as the projected net cost by plan divided by the allowed claim cost expected for the projected book of business. The plan factors use industry standard data in a model from a national actuarial consulting firm, calibrated to KFHP-GA's experience to calculate the impact of the various cost share and plan elements for EHBs, including utilization copayment effect. The plan factors shown in Exhibit 16 reflect both member cost shares and the resulting dampening of expected utilization due to those cost shares. There are no adjustments for morbidity in calculating plan factors.

Exhibit 16 contains the Pricing Value factors on line 7.

Provider Network

Provider network adjustments are listed in Exhibit 18. Effective in 2018, there are two different networks in our individual line of business:

- 1) HMO network: KFHP's traditional HMO network with access to Permanente Medical Group's doctors and facilities, contracted providers outside of KP, and external pharmacies
- 2) Signature HMO network: A network that limits primary care physician access to Permanente Medical Group's doctors and facilities, narrows the available list of contracted providers outside of KP, and has no external pharmacy access

These factors are unchanged.

Catastrophic Plan Adjustment

The catastrophic plan adjustment reflects favorable morbidity for the catastrophic plan versus our book of business in aggregate.

Non-EHB Benefits

Non-EHB Benefits are added back in to the specific plan rates on line 9 of Exhibit 16. These come from Exhibit 4 and Exhibit 9 and reflect adjustments for projected Non-EHB benefits added after the experience period.

Retention

Retention includes broker commissions, administrative expenses, and capital contribution. Commissions are paid to Brokers of Record. Administrative expense trends used to develop our projected administrative expenses per member per month are consistent with our strategic plan, net of adjustments for mix changes, and include the HIP fee. Our current and projected administrative expenses are shown in Exhibit 10.

Capital Contribution

The contribution to capital is 5%.

CSR Load

The CSR load is applied to Silver On Exchange plans only. No other rating factors were changed. We are applying a 10.75% load despite calculating an 12% adjustment. Because of uncertainty in how risk adjustment impacts the required increase for Silver CSR plans and because of membership shifts, we chose to slightly lower the increase and allocate more of the total required increase elsewhere. Please see Exhibit 20 for calculation details.

Consumer Adjusted Rate

The Consumer Adjusted Rate reflects adjustments for demographic calibration, smoker rate calibrations, and the 3+ dependent calibration. The Consumer Adjusted Rate is in row 15 of Exhibit 16.

The smoker and age calibrations are found in Exhibit 6. The 3+ dependent calibration is found in Exhibit 15.

- a) Plan covers individuals and families, but rates are determined by individual with the exception that families covering more than 3 children under 21 will only be charged for the three oldest under 21.
- b) The rating area is Region 3.
- c) Rates are adjusted by the CMS curve in Exhibit 14.
- d) Tobacco use is rated at a 20% load, except for individuals under the age of 18.

Rates do not vary by any other factor besides plan design, age of the individual covered, and tobacco use.

These rates are only adjusted annually unless there is a change in the number of members covered or the member requests a change in coverage.

Tobacco Factors

We rate for tobacco use. The factors that modify our rates are shown in Exhibit 14. Tobacco use is associated with higher costs. These assertions are supported by KFHP - specific data and publicly available information. The adjustment to our experience is shown in Exhibit 6 and then applied in Exhibit 16.

Contract limit of 3 Children factor

This adjustment from Exhibit 15 represents the revenue amount lost because we will not bill for additional dependents under the age of 21 for families with more than 3 children under the age of 21.

Age Factors

The age factor table used to develop age specific rates is the standard table provided by CMS. Exhibit 14 then recalibrates the CMS factor to the closest average of age of the segment.

Patient-Centered Outcomes Research Institute Fee

Patient-Centered Outcomes Research Institute (PCORI) was a fee established by the Affordable Care Act to promote research in the health care industry.

PCORI will not be assessed for plan years ending after September 30, 2019. The fee is \$0.00 PMPY for calendar year 2019.

Health Insurance Provider Fee

The Health Insurance Provider Fee is a fee established by provision 9010 of the affordable care act payable to the IRS in order to support the regulation of the act. The IRS website defines who the covered entities are and how the fee is paid.

The Health Insurance Provider Fee has a moratorium in 2019 and is expected to be \$0.

Exchange Fee

As part of the federal exchanges there is a fee attributable to policies written on exchange. The adjustment to our rate development is based on our expected pro-rata portion between members on and off the exchanges.

Community Benefit

One of our responsibilities as a non-profit is to spend a certain percentage of our revenue on community benefits. Some of this is done by offering plans at reduced premiums where Kaiser pays the premium for the members, provides support for cost sharing and provides grants to local non-profit hospitals and other community services.

Actuarial Value Metal levels and Plan Design

Exhibit 19 shows the 2019 plan designs.

Projected Loss Ratio

The expected loss ratio is 88.6% as defined under the federally-prescribed MLR methodology.

Alternative Actuarial Value Calculations

The Actuarial Value Calculator does not handle a split generic drug benefit. We have lower cost sharing on preventive generic drugs compared to other generic drugs. For some plans, preventive generic drugs are not subject to deductibles and coinsurance as are the other drugs in this class. For these plans, an Actuarial Value was calculated with and without the deductible applying to generic, and we used an interpolated value between these two Actuarial Values to calculate the plan Actuarial Value.

Projected Membership

Our assumption for projected membership comes from our marketing strategy team. They provide the total expected membership broken down by month and product type. Actuarial splits the membership into specific plan designs based on existing membership enrollment.

Unified Rate Review Template

Benefit Categories:

The benefit categories in Section II of Worksheet 1 are mapped based on type of service and place of treatment codes. Service mappings are as follows:

Benefit Category	Services
Inpatient Hospital	Inpatient Facility, Inpatient Visits (Rounding), Inpatient Surgery - Non Maternity, Maternity
Outpatient Hospital	Outpatient Facility, Emergency/Urgent Care, Hospital Outpatient Other Professional, Outpatient Surgery

Professional	Diagnostic Services, Office Visits, Cardiovascular, Chemotherapy/Pharmacy, Dialysis, PT/OT/ST
Other Medical	Dental, Vision, Home Health, Residential Treatment, Hearing Aid, Ambulance, and DME
Capitation	Embedded Pediatric Dental
Prescription	Drug Pharmacy

Population Risk Morbidity

This adjustment is consistent with our index rate build up and reflects the impact of morbidity.

Other

Other represents the impact of adding EHB's which are not currently covered by our plan as well as changes to demographic mix. The demographic mix impact represents the change in expected cost versus the change in prescribed age gender as well as the expected change in county mix. This includes our adjustments for deductible suppression and bad debt. Other adjustments also included are the following: the impact of changes in utilization due to benefit and mix changes, the impact of removing KYP/POS membership from the base period, and **an adjustment for pediatric dental**.

Trend

Adjustments for cost, utilization, and trend are included here. Cost and utilization trend assumptions factored in Kaiser Foundation Health Plan of Georgia's Strategic Plan, adjusted to reflect the ACA population.

We are including the annualized utilization impact of benefit changes from the experience to projection period. Because of the integrated nature of our delivery system, trends consistent with our internal budgeted expenses are most appropriate for internal expenses. For external expenses, contractual changes, changes in benefits, initiatives, and changes in mix were considered to develop expected trends.

Credibility

We assume our block is fully credible. Full credibility is defined at 75,000 life years for rebate calculations, but for purposes of establishing experience, it is normally considered at 2,000 subscriber life years.

Paid-to-Allowed

The adjustment for paid-to-allowed is based on the ratio of our paid claims to those claims on an allowed basis.

Projected Allowed Claims Per Member Per Month

The index rate represents the allowed health benefits we expect to pay as a company during a contract period starting on January 1, 2019.

Risk Adjustment

The Projected Risk Adjustment per member per month is calculated as

$(-1) \times [2019 \text{ Risk Adjustment PMPM} + 2019 \text{ Risk Adjustment Fee PMPM}]$.

The following assumptions were used in projecting the 2019 risk adjustment transfer in Exhibit 8:

- 1) Market rate increase from 2017 to 2019
- 2) Administrative expense removal from the statewide average premium
- 3) Impact on KFHP-GA risk due to market exits and mix changes

Reinsurance Transitional Program

Not applicable.

Projected Incurred Claims

This represents the net allowed health benefits we expect to pay as a company during a contract period starting on January 1, 2019 after risk adjustment.

Administrative Expenses, Taxes, Fees, and Contributions to Surplus

Exhibit 10 shows the break out of our administrative expenses and capital contribution.

% Increase over Experience Period

Note that this increase is greater than the actual increase because historical premiums include all non-grandfathered business and because historical premiums included CHC, or charity business. Premiums are not charged to members with CHC coverage, although they are considered ACA members and are included in the single risk pool.

Projected Membership

The total projected membership was developed by our forecasting and planning department. Membership by plan was based on the latest enrollment numbers.

Terminated Plans and Products

The following plans were effective after the experience period and were terminated prior to the rating period:

<u>HIOS ID</u>	<u>Plan Name</u>	<u>Effective Date</u>	<u>End Date</u>
89942GA0050023	KP GA Signature Silver Std	1/1/2018	12/31/2018
89942GA0070023	KP GA Signature Silver Std	1/1/2018	12/31/2018

Other

The estimated 2019 average annual premium per member is \$7,208.66.

The 2018 average annual premium per member is \$6,285.17, the maximum increase is 25.5% and the minimum increase is 3.8%. The composite rate increase is 14.7% based on expected membership by plan.

The experience is specific to Georgia.

The experience shown in the experience section (section I of worksheet 1) is for all of our non-grandfathered individual business.

The forms are revisions for 2019.

In 2018 we requested an 30.6% increase under SERFF Binder number KPGA-GA18-125072257.

Exhibit Table of Contents:

The following exhibits are included in this filing:

- Exhibit 1 – Change in Marketwide Index Rate from 2018
- Exhibit 2 – Marketwide Adjusted Index Rate Development - Summary
- Exhibit 3 – Historical Allowed Claims Development
- Exhibit 4 – Non-EHB Adjustments
- Exhibit 5 –Utilization Copayment Effect Adjustments
- Exhibit 6 – Demographic Adjustment
- Exhibit 7 – Trend Calculation
- Exhibit 8 – Risk Adjustment and Morbidity Development
- Exhibit 9 – Projected Non-EHB
- Exhibit 10 – Administrative Expense Adjustment
- Exhibit 11 – Embedded Pediatric Dental Adjustment Factor
- Exhibit 12 – Catastrophic Plan Adjustment Due to Demographics
- Exhibit 13 – Development of Projected MLR Under Federal Methodology
- Exhibit 14 – Age Curve Factors
- Exhibit 15 – Contract Limit of 3 Children Factor
- Exhibit 16 – Development of Plan Adjusted Index Rate
- Exhibit 17 –Impact of ACA-Related Fees
- Exhibit 18 – Provider Network Adjustments
- Exhibit 19 – Plan Designs
- Exhibit 20 – CSR Load

Warning Alerts

There were no warning messages.

Reliance

I relied on others within the company to provide experience data, administrative expenses, IBNR, market size estimates, and membership projections. Steps were taken by me to ensure that the information provided are reasonable and reflect an adequate representation of the information necessary to complete this filing.

Kaiser Foundation Health Plan of Georgia
2019 Rate Filing
Kaiser Permanente Individual and Family (KPIF)

Actuarial Certification

To the best of my knowledge and judgment, the following are true with respect to this filing:

1. The assumptions used in developing the filed rates are reasonable and in accordance with generally accepted actuarial principles.
2. The development of the Index Rate complies with the applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1). The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice. The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The rating methodologies produce premiums that are reasonable in relation to benefits being provided and the populations being covered and are based on sound and commonly accepted actuarial principles and are neither excessive nor deficient.
3. The rates filed are reasonable in relation to the benefits being provided. The rates are not excessive, inadequate, or unfairly discriminatory.
4. I certify that the actuarial value (AV) for each plan was calculated based on the federal actuarial value calculator as allowed to be adjusted under 156.135(b)(2).
5. The adequacy of the rates will depend on the ability of management to achieve the utilization and cost targets assumed. Emerging experience will need to be monitored carefully and appropriate adjustments to the rates made on a timely basis.
6. The level of risk adjustments is unknown at this time. The values used in this rate filing are our best estimates.
7. The level of historical experience is questionable due to a large number of members that were retroactively termed in January because of their eligibility for subsidies.
8. The URRT does not demonstrate the process used by the issuer to develop rates. Rather it represents information required by the federal regulations to be provided in support of the review of rate increases, for certification of QHP for FFM, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.
9. This rate filing is in compliance with all applicable Actuarial Standards of Practice.

10. The percent of total premium that represents EHB included in worksheet 2, sections III and IV, were calculated in accordance with actuarial standards of practice.
11. This actuarial opinion is qualified such that the information contained within this filing reflect the state of Georgia and Federal statutes, rules, regulations, and guidance as of June 13, 2018. Changes to the applicable regulations, including but not limited to termination of the Cost Share Reduction Subsidies, Advanced Premium Tax Credits, Risk Stabilization programs, or the Individual Mandate could have a significant impact on rate development. Subsequent changes to these statutes, rules, and regulations may make these rates deficient and would necessitate revisions to this filing.

I am the primary contact person for this rate filing.



Melissa E. Belen, ASA, MAAA
Member, American Academy of Actuaries
(404) 364-7208
melissa.e.belen@kp.org