# Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

**Commonwealth of Virginia**

## 2017 Rate Filing

**Kaiser Permanente Individual and Family ("KPIF")**

### Actuarial Memorandum

I, James Sabater, 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 the Mid-Atlantic States, Inc. ("KFHP") to comply with the CMS requirements as well as the Rules and Regulations of the Bureau of Insurance of Virginia under 14 VAC 5-130-60 B and 14 VAC 5-130-70 B Sections specific to Virginia will be in italics. This memorandum relates to KPIF Individual ("Kaiser Permanente Individual and Family") 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, 2017.

*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 KPMA-130005320.*

Kaiser Foundation Health Plan is a Health Maintenance Organization ("HMO") and offers traditional HMO copayment plans covering medical and pharmacy claims expenses, and Deductible and High Deductible plans, some of which are HSA qualified. Benefits include all Virginia 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 (301) 816-7420 and my email address is james.j.sabater@kp.org . Please also include Ky Le on correspondence related to this submission. Ky's email is ky.t.le@kp.org.

**State**: **Virginia**

**HIOS Issuer ID**: **95185**

**NAIC # 95639**

**Forms:** VA-DP-HMO-BASE(01-17)HIX, et al.
(See Health Insurance Rate Increase Summary Part 1 for complete list.)

**SERFF Tracking Number Forms** KPMA-130005320

## Proposed Rate Increases

The percent increase in the Market Adjusted Index rate from 2016 to 2017 is 21.34%. The drivers of that change are shown in Exhibit 1 which contains all the components of the Market Adjusted Index rate calculation. The numbers shown are the ratio of the 2017 to the 2016 factor, so a 1.000 indicates no impact on the rate change.

***(i)*** *These rates are an increase over prior rates*
***(ii)*** *The expected increase is 10.0%*
***(iii)*** *The number of members (policyholders) impacted is 17,343 as of January 2016*
**(iv)** *Reason for the increase is significant risk adjustment payments and inadequacy of prior year's premium.*

This filing is for new plans as well as updated rates for our 2016 block and is based on the experience of our existing Individual, conversion, dues subsidy and HIPAA Guarantee Issue business which is treated as a single risk pool under 45 CFR Part 156, §156.80. This is not to imply that all plans will receive this rate increase but rather that the increases weighted by current membership should balance to 10.0%.

## Market Experience

The development of Market 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 2017 rates by plan and age are developed by applying plan factors, non-EHB benefit costs and admin 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*

*14 VAC 5-130-81 A&B*

The assumptions for the experience period are detailed in Exhibit 3.

*Base Period Data*

The base period was January 1, 2015 to December 31, 2015.

*Paid Through Date*

Claims were incurred and paid through the end of January 2016.

*Capitation*

Kaiser Permanente has contracted with Dominion Dental to provide dental care to Kaiser's members. Kaiser pays Dominion Dental a fixed capitation of $1.18 to cover adult preventive. The $1.18 is part of the base period allowed amount, shown in Exhibit 2. It is then removed as a non-Essential Health benefit in Exhibit 4. Finally, this benefit is added back as part of the non-EHB adjustment in Exhibit 16.

*Earned Premiums during the Experience Period*

Earned premiums represent the dues paid by members for coverage during the experience period. No rebates were payable.

*Allowed Claims*

Allowed claims are calculated differently for internal versus external claims. Internal allocated costs are considered Allowed. These are our internal allocated costs for providing care through our internal delivery system. For external claims the actual paid claim plus the members cost sharing was used to develop the allowed amount. Allowed amounts are shown by plan in Exhibit 3.

*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 2015 and paid through January 2016 so a 12/13 completion factor is used.

I relied on the work of KFHP reserving actuaries, for the development of an IBNR estimate. These estimates are based on the numbers used for our financial reporting.

*Experience Paid and Incurred*

This is calculated as allowed amounts for internal claims less cost sharing plus external claims paid. The utilization column in the data for experience was adjusted to account for IBNR. The amount under Average Cost/Service is the actual average costs paid from our data based on the counts given in each category. The starting allowed amount is shown on Exhibit 2 line 1.

*Bad Debt*

The allowed amounts on Exhibit 3 were adjusted for bad debt. The amount can be shown as a separate column. This represents the amount that we paid on non-members.

*Deductible Suppression*

The total allowed amount was adjusted for the impact of deductibles during the experience. Since this represents a new block, member cost sharing is a higher proportion of the claims in the early part of the year than in the second half. Most of our new members joined in May the full impact of a calendar year of claims is not reflected in our experience.

**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 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 requirements. This amount is shown in Exhibit 4. This is also shown on line 2 of Exhibit 2.

**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 benefits between the historical period and the projection period because of induced utilization.

The impact of utilization as shown in the index build up represents the increased utilization if the plans had zero cost sharing plans. Each plan in our portfolio was priced using an independent consulting firm's pricing model. This model is calibrated to KFHP of MAS and has an assumption for decreased utilization based on the cost sharing of the plan being priced. This assumption is shown in Exhibit 5. It is also shown Exhibit 2 line 4

For the projection period the utilization adjustment is shown by plan in Exhibit 16 based on our projected membership. This adjustment is shown in Exhibit 2 line 5.

**Changes in Demographics**

Exhibit 6 shows the expected changes in demographics from the historical period to the projection period. The adjustment for the historical period is shown in line 6 of Exhibit 2.

## 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. Therefore, the projected cost that is included in our total revenue requirement is based on the expected costs in KFHP's Strategic Plan. For traditional carriers, projected claims trends are developed to project expected costs. However, given KFHP's fixed cost structure, KFHP's projected claims trends stem from the development of projected budgeted costs. We relied on our Finance Department for the majority of the relevant figures related to trend calculation. Exhibit 7 shows our expected trend assumption from the base period to the projection period.

The trend projection is shown in Exhibit 2 lines 8, 9 and 10.

## Changes in the Morbidity of the Expected Covered Population

Changes in the expected morbidity composition of the block are developed in Exhibit 8.

Considerations in the development of the morbidity were changes in our risk profile, changes in the expected morbidity of the Individuals ACA pool, the morbidity of the new members sold to Kaiser. This amount is shown in Exhibit 2 line 11.

## Projected Index Rate

Is the product of all the above adjustments and is shown on Exhibit 2 line 13.

## Market Level Index Rate

*14 VAC 5-130-81 C*

Four adjustments are allowed to the projected index rate to arrive at the market Level Index Rate. These are described below under the section for the URRT.

The Risk Adjustment factor can be found in Exhibit 8.

The exchange fee is 3.5% of premium. The amount on Exhibit 2 is the average based on expected membership on the exchange versus the total membership.

## Specific Plan Rate Development

The rates for an average aged member can be found in Exhibit 16. Rates for each plan are shown for someone age 45.

The exhibit starts with the Market Index Rate from Exhibit 2 line 20.

Line 3 of Exhibit 16 represents the adjustment to calibrate the rates to the nearest age and to remove the smoker load from the rates.

Those adjustments are found in Exhibit 6.

*14 VAC 5-130-50 E 1 & E3*

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) *Rating areas are regions 7, 10 and 12. However rates do not vary by region.*
c) *Rates are adjusted by the CMS curve in Exhibit 14.*
d) *Tobacco use is rated at a 20% load.*

*14 VAC 5-130-50 E 2 and 14 VAC 5-130-81 D*

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

*14 VAC 5-130-50 E 4*

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

**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.

**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 age factor will be multiplied by the tobacco factor. The adjustment to our experience is shown in Exhibit 6 and then applied in Exhibit 16.

**Catastrophic Plan Adjustment**

The catastrophic plan adjustment was made to remove the subsidy that is on the younger ages in the CMS age factor curve. Kaiser specific experience by age is looked at and then difference between the CMS average factor with and without the catastrophic members is used as an adjustment. This adjustment table can be found in Exhibit 12 and is used in Exhibit 16 in line 4.

## Non-EHB Benefits

Non-EHB Benefits are added back in to the specific plan rates on line 5 of Exhibit 16. These come from Exhibit 4.

## Actuarial Pricing Value Development

The rates for specific plans are calculated by multiplying plan factors times the index rate. The plan factors use industry standard data in a model from a national actuarial consulting firm, calibrated to Kaiser 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 reflects both member cost shares and the resulting dampening of expected utilization due to those cost shares.

Exhibit 16 contains the Actuarial Pricing Value factors on line 6.

## Contract limit of 3 Children factor

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

## Retention

Retention includes broker commissions, administrative expenses and capital contribution. Commissions are paid to Brokers of Record. The capital contribution is an amount to maintain and expand medical center facilities where members receive the majority of health care in the Kaiser Foundation Health Plan. As a group model HMO, Kaiser owns a significant portion of the health care delivery system. In other health care delivery models, capital contributions are included in fee for service payments, whereas for KFHP, these are funded through premium rates. Our current administrative expenses are shown in Exhibit 10.

## Contribution to Capital

The contribution to capital is -10.0%.

## Patient-Centered Outcomes Research Institute Fee (PCORI)

This fee is imposed on health plans under provision of the ACA. The percentage shown represents the taxes paid in 2015.

## Projected Loss Ratio

*The expected loss ratio is expected to be 79.9%. Since all administrative expenses are calculated as a percentage of premium, this is calculated as 100% less the total administrative expenses including the exchange fee.*

## Plan Adjusted Index Rate

Line 8 of Exhibit 16 is therefore the rates for each of our plans designs for someone at the calibrated average age.

Lines 11, 12, 13 and 14 are the calculated AV, metal level and HIOS ID Numbers for each plan.

## Alternative AV Calculations

The AV calculator does not have an option for outpatient facility copay. To calculate the impact on the actuarial value of the plan for this benefit we used the alternate method described in 156.135 (b)(2). We requested from a major actuarial consulting firm the national average allowed amount for outpatient facility costs in 2015. To determine AVs for plans' outpatient facility copays, we propose an OP Copay Converter to be used with the AV calculator. To create this converter, we then compared the copay amount to the estimated average national OP facility allowed amount to calculate the implied coinsurance % for OP procedures. This coinsurance should only be applied to the OP facility cost and not the OP professional cost, which should be covered at 100%.

The value from the AV calculator was adjusted for our benefit of no copays for members under the age of 5.

## 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. For example:

| 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 | Other Services |
| Capitation | None |
| Prescription | Drug Pharmacy |

*Population Risk Morbidity*

This adjustment is consistent with our index rate build up.

*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. This includes our adjustments for deductible suppression and bad debt.

*Trend*

Adjustments for cost, utilization, and trend are included here. Cost and utilization trends are consistent with Kaiser Foundation Health Plan of Mid-Atlantic States's Strategic Plan.

We are including the annualized utilization impact of the benefit change from the experience to projection period.

*Credibility*

We assume our block is fully credible. Full credibility is defined at 75,000 life years in regards to 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 Period Index rate*

The index rate represents the allowed health benefits we expect to pay as a company during a contract period starting on January 1, 2017.

*Reinsurance Risk Adjustment*

The development of the risk adjustor PMPM takes the value from the "Projected Index Rate, before ACA Reinsurance & Risk Adjustment, PMPM" and multiplies by 1 - the value in line (16) Exhibit 2.

*Reinsurance Transitional Program*

The development of the PMPM for the transitional reinsurance program is developed by taking the value from the "Projected Index rate times the value in line (16) of Exhibit 2 and multiplying it by 1 minus the product of lines (17) and (18) in Exhibit 1.

*Market Level Index Rate*

Represents the net allowed health benefits we expect to pay as a company during a contract period starting on January 1, 2017 after reinsurance and risk adjustments.

*Administrative Expenses, Taxes, Fees and Contributions to Surplus*

Exhibit 10 shows the break out of our Administrative Expenses and Capital Contribution.

*Projected Membership*

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

**Other**

*14 VAC 5-130-70 B 3 & 14 VAC 5-130-65 B*

*The estimated average annual premium per member is $4,352.*

*The average annual premium as of January 2016 is $4,178, the maximum increase is 13.8% and the minimum change is 7.2% assuming no change in age. Resulting in a weighted increase of 10.0%. This increase was determined by looking at our in force membership as of January 2016 and assuming that they would move to the comparable benefit plan on January 2017 assuming no change in age.*

*14 VAC 5-130-70 B 6*

*Form 130-A is attached that shows the 2015 experience under ACA and expected projection.*

*The experience is specific to Virginia.*

*14 VAC 5-130-70 B 7*

*The forms are revision for 2016.*

*In 2015 we requested a 5.6% increase under SERFF number KPMA-129538579*

*14 VAC 5-130-70-B 11*

*The original loss ratio was expected to be 80%.*

**Exhibit Table of Contents:**

The following exhibits are included in this filing:

- Exhibit 1 – Proposed Rate Increase by Source of Change
- Exhibit 2 – Market Adjusted Index Rate Development - Summary
- Exhibit 3 – 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 10 – Administrative Expense Adjustment
- Exhibit 11 - Development of Anticipated Loss Ratio
- Exhibit 12 – Catastrophic Plan Adjustment
- Exhibit 13 – Embedded Pediatric Dental Adjustment Factor
- Exhibit 14 – Age and Smoker Factors
- Exhibit 15 – Child Dependent Cap Adjustment
- Exhibit 16 - Development of the Plan Adjusted Index Rate

**Warning Alerts**

There were no warning alerts.

**Reliance**

I relied on others within the company to provide experience data, administrative expenses, IBNR 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 Mid-Atlantic States
## 2017 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. *This filing is in compliance with laws and regulations of the Commonwealth of Virginia regarding the filing of rates. 14 VAC 5-130-60 B 8 and 14 VAC 5-130-70 B 14.*

3. 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 were 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.

4. *The rates filed are reasonable in relation to the benefits being provided.* The rates are not excessive, inadequate, or unfairly discriminatory.

5. I have relied on work completed by another actuary with regards to the Alternative AV Calculation. Based on that reliance, I certify the calculation to be actuarially sound. A separate actuarial certification is provided.

6. 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.

I am the primary contact person for this rate filing.

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