WPS Health Plan, Inc.

Actuarial Memorandum

Individual Point of Service (POS Form 26535-085-1701)
Health Maintenance Organization (HMO Form 26534-085-1701)

Proposed for CY 2017 Single Risk Pool

1. General Information

Company Identifying Information

Company Legal Name:	WPS Health Plan, Incorporated
State:	Wisconsin
HIOS Issuer ID:	84670
Market:	Individual
Effective Date:	January 1, 2017
SERFF ID(s):	ARHP-130613075, ARHP-130613079

Company Contact Information

Primary Contact Name: Matt Streiff
Primary Contact Telephone Number: (608) 223-5790
Primary Contact E-mail Address: Matt.Streiff@wpsic.com

Description of Benefits

A summary of cost sharing features and range of options available are listed below.

Metal Options:	Bronze, Catastrophic
Plan Type Options:	HMO, HMO HDHP, POS, POS HDHP
Employee Deductible Range:	$5,500 to $7,150
Family Deductible Range:	2x employee deductible
Coinsurance Range:	100%, 80%
Employee Out-of-Pocket Maximum Range:	$6,550 to $7,150
Family Out-of-Pocket Maximum Range:	2x employee out-of-pocket
Office Visit Copay Range:	Benefits go to Ded/Coins. 3 Free PCP visit options on Catastrophic
Prescription Drug Options:	$0 Preventive then Ded/Coins.

For 2017, WPS Health Plan does not have any benefits, including wellness benefits, which exceed the Essential Health Benefits.

2. Scope and Purpose, Proposed Rate Increase(s)

Scope and Purpose:

- This is a Rate Change Filing and applies to WPS Health Plan, Inc. ACA plans sold on and off the exchange and is effective 1/1/2017.
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- Arise is narrowing our benefit offering to offer only Off Exchange Bronze and Catastrophic plans as of 1/1/2017.

- Arise is also eliminating product offerings in counties: Iron, Vilas, Price, Oneida, Florence, Forest, Langlade, Lincoln, Taylor, Clark, Marathon, Wood, Portage, Adams, Juneau, Milwaukee, Racine, Walworth, Kenosha, and the western half of Shawano County.

- The remaining 1/1/2017 Arise service area will be limited to Marinette, Oconto, Door, Brown, Kewaunee, Manitowoc, Outagamie, Waupaca, Waushara, Winnebago, Calumet, Fond du Lac, Sheboygan, Green Lake, Marquette, Dodge, Washington, Ozaukee, Waukesha, and the eastern half of Shawano county. We are exiting 19.5 counties and remaining in 19.5 counties. Therefore, given we are continuing product offerings in more than 50% of the service area.

- The average HMO and POS base plan change are 5.79% and 8.37% respectively.
- HMO Minimum Impact: -29.45%, HMO Maximum Impact: 53.76%
  POS Minimum Impact: -7.90 POS Maximum Impact: 47.00%
- Due to different benefit adjustments and cost sharing at the plan level, not the product, members in the same HMO or POS product will see different increases depending on which plan they renew in.

Reason for Rate Increases:

Medical Inflation:	3.00%
Increased Utilization:	3.00%
Changes in the Reinsurance Program:	6.00%
Plan Mapping Reduction*	-5.48%

* This is the reduction in premium due to plan mappings from discontinued plans into renewing plans.

The overall rate change for the entire filing is 6.29%. This varies by region. We found that based on our initial pricing the actual 2015 loss experience varied by region, so adjustments were made to bring our region rating more in line with our pricing targets.

3. Experience Period Premium and Claims

Paid Through Date

The data listed in Worksheet 1, Section I of the Part I Unified Rate Review Template (URRT) is incurred January 1, 2015 through December 31, 2015, paid through June 30, 2016.

Premiums (net of MLR Rebate) in Experience Period

WPS Health Plan did not owe any MLR rebates for the time period reported. The premium was not reduced for taxes or assessments. Therefore, total premium net of MLR Rebate in the experience period is $88,992,856.

Allowed and Incurred Claims Incurred During the Experience Period

1) All Medical claims were processed by our claim system. Prescription drug claims were processed by Express Scripts Incorporated (ESI). All claims are housed in the WPS systems and were pulled directly from our claim records.

2) Given six months of run-out, the claims are nearly 100% complete, but yet not fully complete. WPS Health Plan standard reserving methods suggest a small 0.2% completion factor to achieve full completion. That factor was applied to both paid and allowed numbers. The IBNR claims are in line with what we have historically experienced.

3) All adjustments have been made at an aggregate level.

4. Benefit Categories

Hospital facility claims on our system are categorized as such by being billed on a UB04 form. A place-of-service code further categorizes these claims into inpatient and outpatient Prescription drug claims are processed through our PBM. Professional and Other claims are billed on a CMS1500 form and are further categorized by their CPT and HCPCS codes.

The Other benefit category was the only one where "Other" was used to describe the utilization. This benefit category includes various subcategories with differing measurements of utilization, such as ambulance hospital runs, non-oral drug units administered, vision exams, dental procedures, and DME and prosthetics purchases. The utilization and cost-per-unit numbers reported for the "Other" benefit category are an aggregation of these subcategories.

5. Projection Factors

Changes in Morbidity of the Population Insured

WPS has studied the impact of the ACA on the individual market, including the impact of guarantee issue, the individual mandate, utilization changes, Medicaid changes, transitional policy and the elimination of the high risk pool in the state of Wisconsin. We compared our ACA experience to our base period experience. In comparing these numbers, we believe the base period experience is significantly better than our average ACA experience expected in 2017. In estimating that value, we estimated a population risk morbidity factor off 24.4% and included that in the projection model on worksheet 1. The population risk morbidity assumption is entirely due to these factors.

Changes in Benefits

We have not adjusted allowed claims from the base period to the projection period for any benefit changes. We do not see any material changes positive or negative to the essential health benefit package, or as a result of any other mandated benefit changes. Nor have we made any adjustments for changes in average utilization due to new or different cost sharing requirements.

Changes in Demographics

We are exiting the Silver market in 2017, and we expect to see some member turn over. At the same time, we expect to see a similar age mix in 2017 as what was seen in the base period.

6. Credibility of Experience

WPS Health Plan considers our experience to be fully credible.

7. Paid to Allowed Ratio

The average paid to allowed ratio for this block of business is 0.653.

8. Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM

2015 Risk Adjustment and Reinsurance results were made available on June 30, 2015.

WPS was notified of $10.67 PMPM in Risk Adjustment receipts for 2015 and $73.76 PMPM in Reinsurance receivables as part of the final settlement.

9. Non-Benefit Expenses and Profit and Risk

Methodology:

Each department on the general ledger has a unique methodology to allocate the costs between the various supported lines of business (including Arise and WPS individual ACA) depending on the function of the department. Costs used in the pricing projection only include costs allocated to the WPS and Arise Individual ACA lines of business using these various methodologies.

Development:

Expense projections were developed using base period expense experience and making adjustments for known changes. Known changes include enrollment factors, direct labor changes, inflation in labor payroll and benefits, historical trending, business unit initiatives, etc. Final projections were then compared to historical experience to assure that expenses were in an acceptable range of a reality.

10. Index Rate

The Experience period index rate equals $617.01. We do not cover any benefits beyond the EHB requirements so therefore the index rate equals our total allowed claims.

The Projection period index rate is $864.04. We aren't covering any benefits in addition to EHBs, so therefore, the index rate is equal to our projected allowed experience PMPM. This is simply the result of the trending and adjustment made in section II, Page 1 of the URRT. This rate reflects the anticipated claim level of the projection period with respect to trend, benefits and demographics. It reflects the experience of all policies expected to be policies enrolled on fully compliant ACA plans during the projection period.

11. Market-Adjusted Index Rate

The Market Adjusted Index Rate is equal to $741.50. To adjust from the Index Rate to the Market Adjusted Index Rate, we took the Risk Adjustment PMPM from the URRT, and then grossed it up by the paid to allowed ratio, resulting in a $122.54 adjustment for Risk Adjustment. The respective user/participation fees are already included in the numbers above.

12. Plan-Adjusted Index Rate(s)

We then took the Market Adjusted Index Rate and adjusted it to determine the various Plan Adjusted Index Rates. The first adjustment was the Actuarial Value and cost sharing adjustment. Then while we considered provider service area factors and adjustments for benefits in excess of EHB, no additional adjustments for those pieces were ultimately required.

Administrative costs excluding exchange fees were then loaded into the rates, as well as provider network adjustments.

WPS applies tobacco rates. This was considered in the actuarial value and cost sharing adjustments.

Regarding the Catastrophic plan, at the point of the initial pricing, we developed a claims distribution consisting of people typically eligible for catastrophic-type plans, and used that to price those benefit offerings. We compared the cost of our single risk pool costs to the expected catastrophic pool costs. The difference was calculated at 14% and is reflected in our pricing factors. We recognize there are a few hardship cases where older individuals may become eligible for these plans, but given the small expected population falling into that category we did not adjust for any hardship eligibility situations.

13. Calibration

Calibration was performed on age and geography. In each instance, the weighted average factor was calculated using our expected distribution by age and region. The membership was weighted based on the standard ACA rating curve and our region rating factors respectively.

to get the Plan Base Rate.

14. Consumer-Adjusted Premium Rate Development

This filing is for the Individual Market and therefore, no quarterly trend rates apply.

Sample Calculation

Effective Date:	1/1/2017	Plan Base Rate:	$310.67
Plan Choice:	HMO Bronze 7150	Age Factor:	1.786
Member Age:	50	Tobacco Factor:	1.175
Tobacco:	Yes	Region 16 Factor:	1.134
County:	Brown		
		Final Rate:	$739.32

15. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based primarily on the AV Calculator. For 2016, we modified the generic drug tier of our prescription drug plan to split it into two separate tiers, a preferred generic and an other generic, with different copays. Since this prescription drug plan structure is not available on the AV Calculator, we determined the final AV with an alternative calculation as allowed under 45 CFR Part 156, §156.135(b)(3). Our methodology is in accordance with generally accepted actuarial principles and methodologies.

For the Catastrophic Plan, we are following the general out of pocket benefit requirements. Since the government AV calculator does not handle special populations, we have calculated our values using a distribution of claims from members of a catastrophic plan-like population, and calculated values based on that. This approach will more accurately reflect the true actuarial values of a catastrophic plan population. The resulting Actuarial Value is 0.517, and clearly falls outside of the standard metal tier AV ranges. This value was developed using generally accepted actuarial principles and methodologies.

16. AV Pricing Values

The AV Pricing Value for all of our plans are attributable to different combinations of the following allowed plan-specific factors as described in 45 CFR Part 156, §156.80(d)(2). The factors applicable to our plans are:

(i) The actuarial value and cost-sharing design of the plan.
(ii) The plan's provider network, delivery system characteristics, and utilization management practices.
(iv) Administrative costs, excluding Exchange user fees.

A benefit utilization factor is applied in the pricing of our benefit factors to account for the level of discretionary use of benefits at different cost-sharing plans. These factors were determined based on factors published in Milliman's Health Cost Guidelines, as well as internal studies of our own data. Our internal analysis includes a review of billed claim PMPMs across our benefit plan offerings. Our results show a strong pattern of higher PMPMs at the richest plans grading down as cost-sharing increases and were in line with Milliman.

17. Plan Type

The plan types listed in Worksheet 2, Section I of the Unified Rate Review Template are described exactly by the plan types selected from the drop-down box.

18. Actuarial Certification

This certification includes:

✓ Prescribed Wording Only
__ Prescribed Wording with Additional Wording
__ Revised Wording

PRESCRIBED WORDING:
I, Matt Streiff , am a member of the American Academy of Actuaries (Academy) and I meet the Academy qualification standards for rendering this opinion.
I certify that, to the best of my knowledge and judgment:

- The entire rate filing is in compliance with the applicable laws of the state of Wisconsin and with the rules of the Office of the Commissioner of Insurance,
- The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations,
- The index rate and allowable modifiers as described in 45 CFR § 156.80 (d)(1) and 45 CFR § 156.80(d)(2) are used in the development of plan-specific premium rates,
- The essential health benefit portion of premium, upon which advanced payment of premium tax credits (APTCs) are based, is appropriate and was developed in accordance with Actuarial Standards of Practice,
- The methodology used to calculate the AV Metal Value for each plan complies with federal regulations,
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area,
- The entire rate filing, including development of the projected index rate and all rating factors, complies with all applicable Actuarial Standards of Practice,
- The projected index rate and rating factors are reasonable in relation to the benefits provided and the population anticipated to be covered, and
- The premium schedule, including the projected index

Signature of Actuary	Title	Organization	Date
Matt Streiff	Director Actuarial Svc	CVPS HealthPlan LLC	9-27-16