

# Actuarial Memorandum

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## 1. Purpose and Limitations

The purpose of this document, which is submitted in conjunction with the Part I Unified Rate Review Template (URRT), is to comply with the requirements of the Part III Actuarial Memorandum and to support the premium rates developed for Medica Insurance Company's (Medica's) individual Affordable Care Act (ACA) products, with an effective date of January 1<sup>st</sup>, 2018. [REDACTED]

[REDACTED] This rate filing is not intended to be used for other purposes.

This memorandum reflects Medica's current assumptions and working knowledge of the ACA's regulatory framework as of August 10<sup>th</sup>, 2017 which includes assumed defunding of the cost sharing reduction (CSR) program. If further information is shared that puts this assumption at risk, Medica reserves the right to modify components of the rate filing submission.

Medica designates the information submitted by Medica through HIOS as exempt from disclosure under Exemption 4 of the HHS's Freedom of Information Act (FOIA). Additionally, Medica designates the information submitted by Medica through SERFF as trade secret.

## 2. General Information

### Company Identifying Information

- Company Legal Name: Medica Insurance Company
- State: KS
- HIOS Issuer ID: 39520
- Market: Individual
- Effective Date: January 1, 2018

### Company Contact Information

- Primary Contact Name: Jacob Dority
- Primary Contact Telephone Number: (952) 992-3629
- Primary Contact Email Address: [jacob.dority@medica.com](mailto:jacob.dority@medica.com)

### Policy Form Numbers

[REDACTED]

## 3. Proposed Rate Increase

The proposed rate increase for Medica's individual business rates effective January 1, 2018 is 29.0% over rates effective January 1, 2017. This rate increase reflects an estimate of the average increase that will be offered to current members based on April 2017 in-force business absent of rate changes due to attained age.

The proposed annual rate changes by plan in this filing range from 7.1% to 35.4%.

### Reason for Rate Increase(s)

The significant factors driving the proposed rate increase primarily include:

- Anticipated medical trend, in both utilization and the cost of services.
- Market morbidity that is more adverse than what was assumed in the current rates.

- Reinstatement of the ACA health insurer fee.
- Unprecedented amount of uncertainty and risk inherent in the marketplace.
- Assumed impact of defunding the CSR payment program.

#### Additional Information

- The proposed benefit factor changes will result in rate changes that vary across plan designs.
- Medica's rate change history is documented in Exhibit B.
- Certain plans include cost sharing modifications due to actuarial value compliance.

█ [REDACTED] The corresponding plan mapping is summarized in Section 7.4.

### 4. Market Experience

#### 4.1 Experience Period Premium and Claims

Not Applicable. The proposed rates and corresponding factors are based on a manual rate development process, as described in Section 4.4.

#### 4.2 Benefit Categories

##### *Experience*

Not Applicable. All Medica policies in Kansas were new, effective January 1, 2017.

##### *Credibility Manual*

Utilization and cost information are categorized by benefit using Milliman's *Health Cost Guidelines*<sup>™</sup> (HCGs) categories. Milliman's categories are assigned based on place and type of service using a detailed claims mapping algorithm summarized as follows:

- Inpatient Hospital (facility charges with an overnight stay)
- Outpatient Hospital (facility charges without an overnight stay)
- Professional (with units measured as a mix of visits, cases, procedures, etc.)
- Other Medical (with units measured as a mix of visits, cases, procedures, etc.)
- Capitation (not applicable)
- Prescription Drug (prescriptions not billed by a facility or professional)

#### 4.3 Projection Factors

Not Applicable. The proposed rates and corresponding factors are based on a manual rate development process, as described in Section 4.4.

#### 4.4 Credibility Manual Rate Development

In the absence of fully credible experience period data, the rate projection considered a manual rate development process.

##### *Source and Appropriateness of Experience Data Used*

The source data used in the development of the manual rate is Medica's nationwide individual market experience for ACA compliant policies. The credibility manual rate utilization and unit costs displayed in Worksheet 1, Section II of the URRT are based on adjusted experience for the 2016 plan year.

Medica's nationwide individual market experience for the 2016 plan year includes approximately 852,940 member months of ACA compliant business and provides a credible basis for the determination of claim costs.

### ***Adjustments Made to the Data***

The trend applied to the manual rate to get from the base period to the projection period is based on an un-leveraged prospective annual trend of [REDACTED]. The trend assumptions used in the projection are based on Medica's standard trend projection process. Due to historical individual market experience not being credible to set an accurate trend forecast, all trends are currently based on a review of claim experience from Medica's group medical lines of business. The trend assumptions do not include the impact of changes in demographics, benefit design, or morbidity.



An additional adjustment of [REDACTED] was applied reflecting the anticipated change in claim costs outside the underlying demographics of the covered population. This adjustment corresponds to projected market membership attrition from the 2016 plan year to the 2018 plan year.

An adjustment of [REDACTED] was applied to account for Medica's expected demographic profile in 2018. This adjustment was determined by comparing Medica's enrollment mix in Kansas by age and geography as of April 2017 to that of Medica's nationwide experience underlying the manual rate.

An adjustment of [REDACTED] was included to account for Medica's provider network in Kansas. This assumption was developed by comparing Medica's provider discounts in Kansas to benchmarks that reflect the average discounts in the nationwide experience.

Lastly, an adjustment of [REDACTED] was included to account for anticipated pharmacy rebate changes from the manual rate's base period to the projection period.

### ***Inclusion of Capitation Payments***

Not applicable. There are no capitation payments assumed in the projection period.

### **4.5 Credibility of Experience**

Not Applicable. All Medica policies in Kansas were new, effective January 1, 2017. Worksheet 1, Section III of the URRT reflects a credibility assumption of 0%.

### **4.6 Paid to Allowed Ratio**

Table 1 details the paid-to-allowed ratio by plan design and is consistent with the membership projections by plan in Worksheet 2, Section IV of the URRT.



**Contribution to Surplus and Risk Margin**

The targeted risk margin after federal income taxes is [REDACTED] applied proportionally to all plans. The silver metal level plans include additional margin to account for the expected defunding of the CSR program.

**Taxes and Fees**

Table 3 summarizes the components of the taxes and fees shown in Worksheet 1, Section III of the URRT.

Table 3 Summary of Taxes and Fees		
Description	PMPM	% of Premium
[REDACTED]	[REDACTED]	[REDACTED]

The exchange user fee is calculated as 3.5% of anticipated on-exchange premiums, and then spread across the entire single risk pool as required by regulation. [REDACTED]

The risk adjustment user fee and reinsurance contributions are not reflected here, as documented in Section 4.7.

**5. Projected Loss Ratio**

The projected MLR for Medica based on the federally-prescribed methodology is [REDACTED]. The numerator of the projected MLR contains projected claim costs and HCQI expenses net of receipts from the risk adjustment program. The denominator consists of total premiums net of premium taxes and regulatory fees. Please note that the MLR presented here does not capture all adjustments, including multi-year averaging, credibility, deductible, and defunding of the CSR program.

Exhibit C provides a summary of the components included in the MLR projection.

**6. Application of Market Reform Rating Rules**

**6.1 Single Risk Pool**

This filing, including the URRT, complies with the single risk pool requirements documented in 45 CFR Part 156, §156.80(d). There is no base rate experience as Medica entered the Kansas market effective January 1<sup>st</sup>, 2017. The projection period reflects all projected 2018 covered lives for every non-grandfathered product/plan combination for Medica in the Kansas individual market.

**6.2 Index Rate**

**Experience Period**

Not Applicable. All Medica policies in Kansas were new, effective January 1, 2017.

**Projection Period**

The index rate for the projection period is developed on the anticipated claim level of all policies in the single risk pool as described in the manual rate development process detailed in Section 4.4. The index rate defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives is \$641.03.

**6.3 Market Adjusted Index Rate**

The market-adjusted index rate is calculated as the sum of the projection period index rate, the net impact of the risk adjustment program, and the exchange user fees. Table 4 details the projection period index rate, allowable market-wide modifiers as defined in 45 CFR Part 156, §156.80(d)(1), and the resulting market-adjusted index rate.

Table 4 Market-Adjusted Index Rate	
Description	PMPM
[REDACTED]	[REDACTED]

The adjustments in Table 4 reflect all of the market-wide modifiers allowed in federal regulation and the average demographic characteristics of the single risk pool. Please note the allowable market-wide modifiers were adjusted to an allowed basis in the development of the market adjusted index rate which is consistent with the basis of the projected index rate.

**6.4 Plan Adjusted Index Rates**

Exhibit D summarizes the plan adjusted index rates determined as the market adjusted index rate further adjusted for all the allowable plan-level modifiers defined in 45 CFR Part 156, §156.80(d)(2).

The allowable modifiers as described in 45 CFR Part 156, §156.80(d)(2) are the following:

- Actuarial value and cost-sharing design of the plan,
- Plan’s provider network and delivery system characteristics, as well as utilization management practices,
- Plan benefits in addition to the EHBs,
- Administrative costs, excluding Exchange user fees, and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

**AV and Cost-Sharing Adjustment**

The impact of each plan’s AV and cost-sharing adjustment includes a benefit factor adjustment and an adjustment to account for the expected impact of the plan’s cost sharing amounts on the member’s utilization of services. Medica’s internal benefit factor model, which uses a single continuance table for all plans, was used to estimate how members purchase services differently based on the amount of plan-specific cost sharing. By utilizing a single continuance table, the model’s adjustments assume the same demographic and risk characteristics for each plan priced and therefore exclude expected differences in the health status of members assumed to select the plan.

**Plan’s Provider Network and Delivery System Characteristics**

Network adjustments are developed based on an analysis of variation in cost by provider network. The adjustments are developed by analyzing the cost variation among providers in the care system networks against the open access network as a whole. Additionally, network-specific discounts were applied to the cost relativities, where applicable.

Exhibit E provides a summary of the proposed provider network adjustments applied to the plan-adjusted index rates.

***Adjustment for Benefits in Addition to the EHBs***

Medica's plans do not include any benefits other than EHBs (neither supplemental benefits nor state mandates eligible for state reimbursement), so the plan adjusted index rates do not include a plan-level adjustment for benefits in addition to the EHBs.

***Impact of the Specific Eligibility Categories for the Catastrophic Plan***

A specific eligibility adjustment reflects the difference in expected demographics between the catastrophic plan and the non-catastrophic plans due to the unique eligibility requirements of the catastrophic plans (i.e. that only individuals under the age of 30 or eligible by reason of financial hardship can enroll). This adjustment reflects that costs vary by age, and that the cost of the population expected to enroll in this plan is anticipated to be lower than the non-catastrophic plans.

**6.5 Calibration**

A single calibration adjustment is applied uniformly to all plans. The market-wide calibration factor is 1.719. Detailed support of the calibration factor is provided in Exhibit F.

***Age Curve Calibration***

The average age factor used in the calibration process is [REDACTED] and was determined by applying the standard age curve established by HHS to the projected member distribution by age. The approximate average age, rounded to a whole number, associated to the single risk pool average age factor is [REDACTED].

***Geographic Factor Calibration***

The average geographic factor used in the calibration process is [REDACTED].

The geographic rating factors represent the relativity of estimated average allowed claim costs in each rating area, for a fixed population so as not to include differences in demographics or morbidity. The allowed costs reflect differences in billed charge levels and differences in discount levels for Medica's 2018 provider network. As Medica does not have experience in Kansas, the billed charge relativities were estimated using Milliman's *Health Cost Guidelines (HCGs)* for a commercial population in each area. Discount information was provided by Medica's 2018 provider network.

Exhibit G provides a summary of the proposed geographic rating factors applied to the plan-adjusted index rates. Please note the scaling of the factors result in changes; however, the relativities between the rating regions are identical to the previously approved factors.

***Tobacco Factor Calibration***

The average tobacco rating factor used in the calibration process [REDACTED].

A tobacco load of [REDACTED] will be applied to adult tobacco users age 18 and older. In developing this factor, Medica relied on a 2009 Milliman research report regarding the impact of smoking on medical claim costs, since data on tobacco users in Medica's current populations was limited in volume. It was assumed that the more general under age 65 population in the Milliman study would provide a better proxy for the population in the individual market. The Milliman study was based on Medical Expenditure Panel Survey (MEPS) data.

**Consumer Adjusted Premium Rate Development**

Medica derives consumer adjusted premium rates by calibrating the plan-adjusted index rate and applying the rating factors specified by 45 CFR Part 147, §147.102. See Exhibit A for the proposed rate manual and sample rate calculation.

**7. Plan Product Info**

**7.1 AV Metal Values**

The AV metal levels were developed using only the federal AV calculator. Medica does not believe any of the plans requires an alternative methodology.

**7.2 AV Pricing Values**

Exhibit H provides a summary of the AV pricing values by plan as displayed in Worksheet 2, Section I of the URRT and a breakdown of the components attributable to each of the allowable modifiers to the index rate as described in 45 CFR Part 156, §156.80(d)(2).

**7.3 Membership Projections**

Medica projected membership as displayed in Worksheet 2, Section IV of the URRT by considering the size of the projected Kansas individual market and an assumed penetration rate of this market.

For silver level plans in the individual market, an estimate was made for the portion of projected enrollment that will be eligible for cost sharing reduction (CSR) subsidies at each subsidy level. Table 5 displays the distribution and projected members for all the silver plans, including the alternative silver plans which CSR eligibles can purchase.

Table 5 Distribution of Membership Across Silver Metal Tier		
Silver Metal Tier	Membership Distribution	Membership
Standard	28.8%	1,175
94% AV Level Silver Plan	35.3%	1,439
87% AV Level Silver Plan	22.2%	904
73% AV Level Silver Plan	13.4%	548
Limited Cost Sharing	0.0%	0
Zero Cost Sharing	0.3%	14
Total	100.0%	4,080

**7.4 Terminated Products**

Medica is modifying its plan portfolio for the 2018 plan year. Table 6 summarizes both the terminated plans that were included in the single risk pool during the experience period or made available thereafter and the corresponding mapped plans.

Table 6 Terminated Plan Cross-Walk			
Terminated Plan Name	Terminated HIOS ID	Mapped Plan Name	Mapped HIOS ID
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

**7.5 Plan Type**

Not Applicable. The plan types listed in Worksheet 2, Section I of the URRT appropriately describe Medica’s plans.

## 7.6 Warning Alerts

Not applicable. No warning alerts appear in Worksheet 2, Sections III and IV of the URRT.

## 8. Miscellaneous Instructions

### 8.1 Effective Rate Review Information

Medica believes all other information specific to the Kansas Insurance Department's (KID's) filing requirements are reflected elsewhere in this filing.

### 8.2 Reliance

In developing this rate filing, I have relied on several internal departments for information. This information includes Corporate Actuarial providing rating factors, projections of claim trend and Corporate Finance providing non-benefit expenses. I have performed a limited review of this information, and have deemed it to be reasonable.

### 8.3 Actuarial Certification

I, Jacob Dority, am the Manager of Actuarial Services for Medica. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice,
- Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- Neither excessive nor deficient.

I further certify that:

- 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 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 geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area, and
- The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



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August 10<sup>th</sup>, 2017











## Exhibit G Geographic Rating Factors

Rating Area	Current Adjustment	Proposed Adjustment

## Exhibit H AV Pricing Values

Plan Name	AV and Cost Sharing Adjustment	Benefit Induced Utilization	Provider Network	EHB Adjustment	Catastrophic Specific Eligibility	Administrative Costs	AV Pricing Value
	A	B	C	D	E	F	