NovaRest
ACTUARIAL CONSULTING

MEMORANDUM

August 9, 2016

Commissioner Nick Gerhart
Iowa Insurance Division
330 Maple St
Des Moines, IA 50319

Re: **Rate Review Summary for Medica Insurance Company**
Individual 1/1/2017 Rate Filing

Binder:	**MEDI-IA17-125059163**
SERFF:	**MEDI-130517607**
Plan Filing Actuary:	**Jacob D. Dority**
Filing Actuary Email Address:	**jacob.dority@medica.com**
Filing Contact Info:	**tescia.veldhouse@medica.com**

Dear Mr. Gerhart:

We have completed our review of the individual filing for Medica Insurance Company (Medica) and offer, for your consideration, the following report summarizing our review and conclusions.

The summary information used herein was taken, for the most part, directly from the actuarial memorandum or subsequent documentation provided to us by Medica. We have summarized and paraphrased portions of the information to some extent, but have generally relied on Medica's specific language in order to avoid inadvertently changing the meaning of any of the statements made therein through rephrasing.

Appendix C: Analysis of this document includes our conclusions with regard to the appropriateness of the rate filing for the reviews required to conduct an effective rate review process, as well as some additional analysis of our own.

For the complete objections and Medica's responses, please see Appendix B: Objections below.

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OVERVIEW OF FILING AND RATE REVIEW

Rate Increase:

The proposed rate increase for Medica's individual business rates effective January 1, 2017 is 19.0% over rates effective January 1, 2016. This rate increase reflects an estimate of the average increase that will be offered to current members based on March 2016 in-force business absent of rate changes due to attained age.

Base Period Member Months:

Not Applicable. The proposed rates and corresponding factors are based on a manual rate development process.

RATE CHANGE HISTORY

Date	Average Statewide Impact
1/1/2016	New Product
1/1/2017	19.0%

PAST PROJECTIONS AND ASSUMPTIONS

	Effective January 1, 2017	Effective January 1, 2016	Difference ($)
Projected Risk Adjustments PMPM	-$0.13	-$0.15	0.02
Projected Reinsurance Recoveries PMPM	$0.00	$10.77	-10.77
Projected Administrative Expense PMPM	$49.37	$66.08	-16.71
Projected Profit PMPM	$4.11	$2.12	1.99
Projected Taxes PMPM	$36.03	$33.38	2.65

INDEX RATE DEVELOPMENT

Base Experience

Not Applicable. The proposed rates and corresponding factors are based on a manual rate development process.

Credibility

Not Applicable. Medica was a new entrant to the Iowa market in 2016. In the absence of experience period data, rates are based on a manual rate development process.

Manual Rate

The source data used in the development of the manual rate is Medica's nationwide individual market experience for ACA compliant policies.

Medica's nationwide individual market experience for the 2015 plan year includes approximately 346,521 member months of ACA compliant business and provides a credible basis for the determination of claim costs.

Paid to Allowed

Paid-to-Allowed Average Factor

Plan	Projected Member Months	Allowed Claims PMPM[1]	Paid Claims PMPM[1]	Paid / Allowed
Medica Insure Gold Copay	1,728	$734.82	$646.61	88.00%
Medica Insure Silver Copay	7,488	$700.34	$569.03	81.30%
Medica Insure Bronze Copay	660	$672.47	$509.74	75.80%
Medica Insure Gold HSA	372	$730.04	$635.57	87.10%
Medica Insure Silver HSA	1,884	$696.64	$560.98	80.50%
Medica Insure Bronze HSA	1,200	$663.86	$492.02	74.10%
Medica Insure Catastrophic	1,188	$483.32	$365.22	75.60%
Medica Insure Gold Copay Plus	432	$757.14	$699.29	92.40%
Total	14,952	$684.84	$557.41	81.40%

[1] Before risk adjustment and reinsurance

Trend

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 5.7%. 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.

Medica only provides a single trend factor and does not provide separate factors for utilization and unit cost trends.

Cost Sharing Changes

Not applicable.

Changes in Benefits

Not applicable.

Changes in Enrollee Risk Profile

Medica applied an adjustment of 8% to the underlying manual rate to account for the anticipated difference in population morbidity between the morbidity inherent in the manual rate and the projected morbidity of the Iowa market in 2017.

This adjustment was primarily developed from information in the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (CMS Report) (published by the Centers for Medicare and Medicaid Services (CMS) on September 17th, 2015) and further supported by publicly available rate filings and annual financial statements for the Iowa individual market. In developing this adjustment, Medica compared the Plan Liability Risk Scores (PLRS) of Iowa to that of Medica's nationwide experience underlying the manual rate. The risk score algorithm remained unchanged from 2014 to 2015 so Medica determined that it was justifiable to perform this determination. The resulting relativity was 1.24.

Significant transitional policy migration in the Iowa marketplace was assumed from the base period to the projection period so Medica anticipates the relative morbidity of the Iowa individual market to improve over time. In contrast, when considering the relative morbidity between the manual rate and the Iowa market in 2017 it is anticipated that the morbidity improvement would be offset due to the partial-year effect present in the PLRS values reported in the CMS Report. Medica believes that this partial-year phenomenon dampened the reported PLRS values for the 2014 plan year in the CMS Report. Medica considered this information, and a business decision was made to reduce the 1.24 relativity to 1.08.

Other

An adjustment of 11.8% was applied to account for Medica's expected demographic profile in 2017. This adjustment was determined by comparing Medica's enrollment mix by age and geography as of March 2016 to that of the Iowa market mix inherent in the CMS Report.

An adjustment REDACTED. This assumption was developed by comparing Medica's provider discounts in Iowa to benchmarks that reflect the average discounts in the market.

Lastly, an adjustment of -1% was included to account for anticipated pharmacy rebate changes from the manual rate's base period to the projection period

Risk Adjustment

Medica assumes that it will enroll the market average risk in 2017. Therefore a net risk adjustment transfer of $0 PMPM is projected. Any resulting risk adjustment transfer payments would be allocated proportionally across all plans in Medica's individual market single risk pool.

Non-Benefit Expenses

Administrative Expense Load

Summary of Administrative Expenses

Description	PMPM	% of Premium
General Administration	$38.37	5.93%
Broker Commissions	$9.25	1.43%
HCQI	$1.75	0.27%
Total	$49.37	7.63%

Medica's administrative expense load includes general administration, commissions paid to brokers and agents, and Health Care Quality Improvements (HCQI). Medica allocates administrative expenses by product, state and legal entity.

Base fees paid to third party administrators on a PMPM basis are charged directly to the appropriate product. With the exception of regulatory costs and Medica Health Management (MHM) costs, the remaining administrative expenses are allocated to the market business segments to determine a PMPM. Regulatory costs are charged directly to the appropriate entity. MHM costs are captured in specific cost centers which are charged directly to MHM. The support cost centers (Human Resources, Facilities and a portion of IT and General Administration) are allocated to each of the other cost centers. Medica's Corporate Finance staff meets periodically with a representative of each cost center to review the allocation method.

Contribution to Surplus and Risk Margin

The targeted risk margin after federal income taxes is 0.6% applied proportionally to all plans.

Taxes and Fees

Summary of Taxes and Fees

Description	PMPM	% of Premium
State Premium Tax	$12.94	2.00%
Health Insurer Fee	$0.00	0.00%
Exchange User Fee	$20.68	3.20%
Comparative Effectiveness Research	$0.19	0.03%
Federal Income Tax	$2.21	0.34%
Total	$36.02	5.57%

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. Medica assumes that 2017 on-exchange premiums will be 91% of total premium.

FINAL PLAN RATES

The average age factor used in the calibration process is 1.77 and was determined by applying the standard age curve established by HHS to the projected member distribution by age. The approximate age, rounded to a whole number, associated to the single risk pool average age factor is 50.

As Medica does not have experience in Iowa, the billed charge relativities were estimated using Milliman's HCGs for a commercial population in each area. Discount information was provided by Medica's provider network.

ACTUARIAL VALUES (AVS)

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

MEDICAL LOSS RATIO (MLR)

MLR

The projected MLR for Medica based on the federally-prescribed MLR methodology is 91.5%.

Projected MLR for 2017		
Incurred Claims	$557.41	A
Risk Adjustment	$0.00	B
HCQI	$1.75	C
MLR Numerator	$559.16	D = A + B + C
Earned Premium	$647.04	E
Exchange Fees	$20.68	F
Federal PCORI Fees	$0.19	G
Risk Adjustment Fees	$0.13	H
State Premium Tax	$12.94	I
Federal Income Tax	$2.21	J
MLR Denominator	$610.88	K = E - F - G - H - I - J
Projected MLR	91.5%	L = D / K

INITIAL CONCERNS AND RESOLUTION

1. Our primary objections to this filing were related to the development of the manual rate and further support for various adjustments included in this filing. Medica was able to adequately support all adjustments.

2. Medica originally use a $0.15 risk adjustment fee rather than the $0.13 fee.

3. The induced utilization was not normalized

CHANGES MADE TO FILING DURING REVIEW

1. An error was discovered in how the initial URRT was populated. Updated materials were provided.

2. The risk adjustment fee originally included was $0.15, but was corrected to $0.13.

3. The filing was refiled to normalize the induced utilization factors.

No changes were made due to CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year.

CONCLUSION

We have reviewed the Medica individual product filing and find that the methods and assumptions used in developing the rates are based on generally accepted actuarial standards and meet the HHS guidelines for MLR calculation.

The overall annual average rate change from 1/1/16 to 1/1/17 associated with this filing for Medica Insurance Company's (Medica's) individual business is 19.0%.

Medica included the applicable ACA fees including the appropriate fees for the reinsurance and risk adjustment programs. The development of the consumer adjusted index rate was according to the federal instructions and we feel the calibrations are supported and are not unreasonable.

Medica's projected medical loss ratio was calculated according to the federal instructions and achieves the federally prescribed rebate threshold of 80.0%.

We find the filing to be complete and included s details documenting the assumptions and methods used in setting the rates. Based on the methodologies and assumptions used, we do not believe that the rates are unreasonable.

RELIANCE AND QUALIFICATIONS

We are providing this letter to you solely to communicate our findings regarding the filing under consideration. Distribution of this letter to parties other than the Division by us or any other party does not constitute advice from or by us to those parties. The reliance of parties other than the Division on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our opinion, as presented above, we made use of information provided by the company without independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on the data provided by the company without independent investigation or verification, we have reviewed the information for consistency and reasonableness. Where we found the data to be inconsistent or unreasonable we have requested clarification.

The actuarial methodologies utilized in order to arrive at our opinion were those which were considered generally accepted within the industry.

I am a member of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion.

If you have any questions, do not hesitate to call me at 520-908-7246.

Sincerely,

Donna C. Novak, FCA, ASA, MAAA, MBA

CC: Klete Geren

APPENDIX A: RATE DEVELOPMENT

Description	Notes/Source	Factor
Allowed Claim PMPM	Nationwide ACA Experience	$464.29
Unleveraged Trend of 5.7%	CY 2015 to CY 2017	1.118
Morbidity Adjustment	CMS Report	1.080
Mix Adjustment	CMS Report, Internal Data	1.118
Network Adjustment	Internal Data	REDACTED
Change in Pharmacy Rebates	Internal Data	0.993
Projected Index Rate		$684.84

APPENDIX B: OBJECTIONS

Response Posted June 20, 2016

Objection #1:

Please provide in an Excel sheet the complete development of the manual projected allowed amount included in WS 1 of the URRT in a way that parallels the URRT development of allowed amounts. Please show all adjustments to the base manual data resulting in the allowed amount $684.84 PMPM. Please describe and provide quantitative support for all adjustments made to manual data to bring it in line with the projected population, State market, and provider contracts.

Response:

The credibility manual rate as described in Section 4.4 of the actuarial memorandum and corresponding quantitative support is summarized in the following table.

Description	Notes/Source	Factor
Allowed Claim PMPM	Nationwide ACA Experience	$464.29
Unleveraged Trend of 5.7%	CY 2015 to CY 2017	1.118
Morbidity Adjustment	CMS Report	1.080
Mix Adjustment	CMS Report, Internal Data	1.118
Network Adjustment	Internal Data	REDACTED
Change in Pharmacy Rebates	Internal Data	0.993
Projected Index Rate		$684.84

- Allowed claim PMPM: the starting allowed claim PMPM of $464.29 is the average allowed claims net of pharmacy rebates for Medica's nationwide ACA experience in the individual market for the 2015 plan year.
- Unleveraged trend: 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 5.7%. 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.

- Morbidity adjustment: the average HHS risk score (Individual and Catastrophic risk pools) weighted on member months from the CMS report published on September 17, 2015 for the Iowa market is 1.67 [1.67 = (1.680 * 681,420 + .185 * 6,219) / (681,420 + 6,219)]. Medica's HHS risk score associated to its nationwide experience for the 2015 plan year is 1.345. The morbidity adjustment applied in the development of the credibility manual rate is 1.24 (1.24 = 1.67 / 1.345).

- Mix adjustment: The mix adjustment represents the adjustment needed for Medica's projected demographic profile by age and area. The adjustment factor of 1.118 was determined by comparing Medica's enrollment in Iowa as of March 2016 to that of the Iowa market mix in the CMS report.

Description	**Factor**
Iowa Market Age Factor	1.5840
Iowa Market Area Factor	0.9987
Medica's Iowa Age Factor	1.7668
Medica's Iowa Area Factor	1.0013
Mix Adjustment	1.118

- Network adjustment: REDACTED. This assumption was developed by comparing Medica's provider discounts in Iowa to benchmarks that reflect the average discounts in the market.

- Change in pharmacy rebates: Medica has negotiated contracts with a different pharmacy benefit manager then what was administered during the credibility manual rate's base period. The base period's rebate PMPM was $2.34. The estimated pharmacy rebate projected for the 2017 plan year is $7.00 PMPM, or an increase of $4.66 PMPM ($4.66 = $7.00 - $2.34). The factor of 0.993 was determined calculating one minus the ratio of the change in pharmacy rebates of $4.66 over the adjusted credibility manual rate of $689.50 as described in the table included at the beginning of objection 1 (product of components A through E) [0.993 = 1 – ($4.66/$689.50)].

Objection #2:

Please explain the source of the data in Table 1.

Response:

Projected member months summarized in Table 1 represent the actual member distribution by plan (and including the corresponding plan mapping as described in Section 7.4 of the Actuarial Memorandum) as of March 2016. Both the allowed PMPM amounts and paid PMPM amounts are adjusted by components of the AV and Cost-Sharing Adjustment as described in Section 6.4 of the Actuarial Memorandum. The allowed amounts have been adjusted by the induced demand adjustment whereas the paid amounts have been adjusted by both the induced demand adjustment and the benefit factor adjustment.

Objection #3:

Per the warning message on Worksheet 2 of the URRT, total projected incurred claims on Worksheets 1 and 2 of the URRT to do not match. Please explain.

Response:

This was due to an error in how the initial URRT was populated. Please see the revised actuarial memorandums and URRT attached as part of the filing amendment dated June 2nd, 2016 in response to Klete Geren's objection dated May 27th, 2016. All revised supporting documents have been attached and made available in the SERFF correspondence.

Objection #4:

In Worksheet 2 of the URRT, please quantify in detail the impact of the CSR subsidies on incurred claims in order to explain why the total paid-to-allowed ratio is significantly different from the weighted average actuarial metal values.

Response:

The paid-to-allowed ratio is significantly different from the weighted average actuarial metal levels as it is anticipated that the inherent trend leveraging associated to the projected index rate is resulting in higher paid-to-allowed ratios than what is assumed in the federal actuarial value calculator.

Objection #5:

Per the benefit and payment parameters, the risk adjustment user fee is $0.13 PMPM. Please correct.

Response:

Please see the revised actuarial memorandums and URRT attached as part of the filing amendment dated June 2nd, 2016 in response to Klete Geren's objection dated May 27th, 2016. All revised supporting documents have been attached and made available in the SERFF correspondence.

Objection #6:

Please reconcile the AV and Cost Sharing Adjustment in Exhibit F with the Paid/Allowed in Table 1.

Response:

Please see the reconciled slopes between the AV and Cost Sharing Adjustment values and the Paid-to-Allowed values provided in the actuarial memorandum.

Benefit Plan	**Projected MMs**	**AV and Cost Sharing Adjustment**	**Paid/Allowed**	**Reconciliation**
Medica Insure Gold Copay	1,728	0.908	88.0%	0.908
Medica Insure Silver Copay	7,488	0.838	81.3%	0.838
Medica Insure Bronze Copay	660	0.782	75.8%	0.782
Medica Insure Gold HSA	372	0.898	87.1%	0.898
Medica Insure Silver HSA	1,884	0.831	80.5%	0.831
Medica Insure Bronze HSA	1,200	0.764	74.1%	0.764
Medica Insure Catastrophic	1,188	0.779	75.6%	0.779
Medica Insure Gold Copay Plus	432	0.953	92.4%	0.953
Total	14,952	0.837	81.1%	83.7%

Objection #7:

Please provide your induced utilization before and after normalization and explain how they were developed.

Response:

Please see the normalized induced utilization factors provided in Objection 10. The induced utilization factors are a function of the net-to-allowed ratios determined from Medica's internal benefit factor model.

Objection #8:

Please explain what services are included in the "Other" service category on the URRT, including the measurements used.

Response:

The "Other Medical" category primarily includes the following services and associated measurements:

- Private Duty Nursing/Home Health – units measured as the number of visits
- Ambulance – units measured as the number of visits
- DME – units measured as the number of cases
- Prosthetics – units measured as the number of procedures

Objection #9:

Please provide quantitative support for the projected risk adjustment amounts.

Response:

It is assumed that Medica will enroll the market average risk in 2017; therefore, a net risk adjustment of $0 is projected.

Objection #10:

Based on Exhibit F and member months from worksheet 2 of the URRT, the weighted average of induced utilization factors is 0.982. We believe the induced utilization factors should be normalized to a weighted average of 1.0. Please correct.

Response:

Please see the modified version of Exhibit F, below. Medica will follow-up in SERFF with a filing amendment to including the corresponding actuarial memorandum.

	AV and Cost Sharing Adjustment	Benefit Induced Utilization	Provider Network	EHB Adjustment	Catastrophic Specific Eligibility	Administrative Costs	AV Pricing Value
Medica Insure Gold Copay	0.892	1.050	1.000	1.000	1.000	1.119	1.048
Medica Insure Silver Copay	0.823	1.001	1.000	1.000	1.000	1.119	0.922
Medica Insure Bronze Copay	0.768	0.961	1.000	1.000	1.000	1.119	0.826
Medica Insure Gold HSA	0.882	1.043	1.000	1.000	1.000	1.119	1.030
Medica Insure Silver HSA	0.816	0.996	1.000	1.000	1.000	1.119	0.909
Medica Insure Bronze HSA	0.751	0.949	1.000	1.000	1.000	1.119	0.797
Medica Insure Catastrophic	0.766	0.959	1.000	1.000	0.720	1.119	0.592
Medica Insure Gold Copay Plus	0.936	1.082	1.000	1.000	1.000	1.119	1.133

Objection #11:

Please provide the Actuarial Value and Cost Sharing adjustment separated between all factors that make it up.

Response:

Benefit Plan	Projected MMs	Benefit Factor	Benefit Induced Utilization	AV and Cost Sharing Adjustment
Medica Insure Gold Copay	1,728	1.000	1.050	0.892
Medica Insure Silver Copay	7,488	0.880	1.001	0.823
Medica Insure Bronze Copay	660	0.788	0.961	0.768
Medica Insure Gold HSA	372	0.983	1.043	0.882
Medica Insure Silver HSA	1,884	0.868	0.996	0.816
Medica Insure Bronze HSA	1,200	0.761	0.949	0.751
Medica Insure Catastrophic	1,188	0.565	0.959	0.766
Medica Insure Gold Copay Plus	432	1.082	1.082	0.936
Total	14,952	0.862	1.000	0.822
Average Benefit Factor/Average Net-to-Allowed			1.059	
Average Tobacco Factor			1.009	

Please note that the catastrophic plan is additionally adjusted for the eligibility adjustment of 0.72.

Objection #12:

Please provide documentation of the development of your administrative cost factor in Exhibit F (1.119).

Response:

The quantitative support describing the administrative cost factor is detailed in the following table.

Description	Value
Projected Premium PMPM	$647.04
Market-Adjusted Index Rate	$710.41
Projected Paid-to-Allowed Ratio	0.814

Administrative Costs (as a Percentage)	10.64%
Administrative Costs (as a Factor)	1.119

APPENDIX C: ANALYSIS

General Information

1) What are the main drivers of the rate change?

   - Anticipated medical trend, in both utilization and cost of services.
   - Discontinuance of the federal transitional reinsurance program effective starting with the 2017 plan year.
   - Market morbidity that is more adverse than what was assumed in the current rates.

2) Are variations in rate increases by product or plan explained?

   The proposed benefit factor changes will result in rate changes that vary across plan designs.

3) Were past rate increase assumptions (e.g. trends, projected allowed claims PMPM, etc.) consistent with actual experience?

   Because the plans were first effective in January 2016, there are no past rate increases.

Experience Period Allowed Claims to Projected Index Rate

1) Experience Period Premium and Claims

   a) Was the paid through date provided for the base period data?

      Not provided. The credibility manual rate utilization and unit costs are based on adjusted experience for the 2015 plan year, with no indication of paid-through date.

   b) Were the services in the "Other Medical" category explained including the measurement units used?

      The "Other Medical" category primarily includes the following services and associated measurements:
      - Private Duty Nursing/Home Health – units measured as the number of visits
      - Ambulance – units measured as the number of visits
      - DME – units measured as the number of cases
      - Prosthetics – units measured as the number of procedures

2) Projection Factors

a) Is the magnitude of the adjustments consistent with the URRT?

Not applicable. No projection factors are included in the URRT since there is no base period experience.

b) Were the data, assumptions, and magnitude of the morbidity adjustment explained?

For the population morbidity adjustment, Medica compared the Plan Liability Risk Scores (PLRS) of Iowa to that of Medica's nationwide experience underlying the manual rate. The risk score algorithm remained unchanged from 2014 to 2015 so Medica determined that it was justifiable to perform this determination. The resulting relativity was 1.24. After considering transitional policy migration in the Iowa marketplace and partial-year effects, Medica made a business decision to reduce the 1.24 relativity to 1.08. We believe this is well-supported and is not unreasonable.

c) Were all of the changes in the "Other" category described including the magnitude, data used, assumptions used and methodology used?

Medica included a REDACTED. Both of these adjustments were supported in an objection response and we believe they are not unreasonable.

i) Were changes due to age, gender, or region (included in the "Other" category) documented and reasonable?

The demographic adjustment was determined by comparing Medica's enrollment mix by age and geography as of March 2016 to that of the Iowa market mix inherent in the CMS report. Quantitative support was provided in an objection response and we believe it is not unreasonable.

ii) Were the changes in cost for changes in benefits reasonable (i.e., benefits from base period that are not an essential health benefit (EHB) and benefits that are EHBs that were not in the base period)?

Medica's plans continue to only include benefits that are EHBs. Therefore, there is no plan-level adjustment for benefits in addition to EHBs.

iii) Were changes in utilization use to cost-sharing adjustments reasonable when considering the direction of the difference between the base period paid-to-allowed factor and the projection period paid-to-allowed factor?

Not applicable, an adjustment for changes in cost sharing was not included.

d) Were medical cost trend changes by major service categories reasonable;

i) Compared to past history and prior estimates?

N/A, Medica does not have historic trends.

ii) Considering changes in provider contracting?

Medica did consider changes in provider contracting.

iii) Compared to other carrier filings for the same period?

Medica included an unleveraged total trend of 5.7%, which is not unreasonable when compared to other carriers.

iv) Compared to industry publications?

Medica included an unleveraged total trend of 5.7%, which is not unreasonable when compared to industry publications.

v) When comparing resulting cost per service compared to other carrier filings for the same period?

The resulting cost per service is not unreasonable when compared to other carriers.

e) Were changes in utilization of services by major service categories reasonable;

i) Compared to past history and prior estimates?

N/A, Medica does not have historic trends.

ii) Compared to other carrier filings for the same period?

Medica did not separate trends, see above for discussion on total trend.

iii) Compared to industry publications?

Medica did not separate trends, see above for discussion on total trend.

iv) Compared to other carrier filings when comparing resulting utilization per 1,000 for the same period?

The resulting utilization per 1,000 is not unreasonable.

f) How were trends adjusted due to fluctuation in large claim amounts?

Not applicable, since no experience claims were used in the rate development.

3) Credibility Manual Rate Development

a) Was the development of the manual rate reasonable and well documented including:

i) Source of manual data;

Yes, the source is Medica's national individual market experience for ACA compliant policies in the 2015 plan year.

ii) Adjustments to manual data to ensure it is consistent with the population being rated;

See 2) Projection Factors above.

iii) Projections of manual data for trend and other adjustments.

See 2) Projection Factors above.

b) If there were capitation payments, how were they accounted for?

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

c) Is the experience included on worksheet 1 of the URRT specific to the company? (i.e. confirm that the experience for the manual rate should be included in the manual rate section and not the experience section).

No experience basis, but the manual rates are based on nationwide company experience of ACA individual plans.

d) What credibility methodology was used?

Not applicable, Medica has no base experience.

e) What is the resulting credibility?

0% credibility is assigned to the base experience. 100% credibility is assigned to the manual rate experience.

f) Is the methodology reasonable when considering ASOP #25?

The methodology is not unreasonable.

4) Paid to Allowed Ratio

a) Was the paid to allowed ratio;

i) Reasonable compared to the base period data?

Not applicable, Medica has no base experience.

ii) Developed using carrier data from the appropriate block of policies?

Paid-to-allowed ratios were developed using nationwide manual rate data.

iii) Reasonably close to the weighted average actuarial values from the actuarial value calculator?

The paid-to-allowed ratio of 81.4% is significantly different from the weighted average actuarial metal values (70.4%). Medica anticipates that the inherent trend leveraging associated to the projected index rate is resulting in higher paid-to-allowed than assumed in the federal AVC. We believe this explanation is not unreasonable.

5) Risk Adjustments

a) What did the actuary base the relative risk of the carrier's block and the market on?

Medica assumes that it will enroll the market average risk in 2017.

b) Is the carrier's market share large enough that it represents the market?

No, Medica's market share is not large enough that it represents the market.

c) Were projected risk adjustment transfer amounts appropriate considering the size of the carrier and the source of the carrier's population?

Medica assumed they will enroll the market average risk in 2017, so they projected $0 for risk adjustment, which is not unreasonable.

d) Were projected risk adjustment fees appropriate (as a PMPM) and entered correctly in the URRT?

The risk adjustment fee incorrectly appeared as $0.15 PMPM instead of $0.13 PMPM, but was corrected in an objection response.

e) Are risk adjustment, and risk corridor included as adjustments to incurred claims in the MLR development?

Risk adjustment fees were appropriately made as an adjustment to premiums.

f) Are the net risk adjustment values consistent between the memorandum, URRT, and MLR development?

Yes.

g) Are the reinsurance and health insurer fees appropriate? For Small Group policies, carriers can assume a health insurer fee for months in 2018.

Not applicable, these fees are not applicable to the Individual market.

6) Non-Benefit Expenses

a) Are administrative cost and profit margins (PMPM and as a percentage of premium) reasonable compared to other carriers?

Administrative cost (7.63%) and profit margin (0.64%) appear reasonable

b) If administrative costs are not reasonable considering other carriers, are they consistent with historic actual administrative costs?

We did not request administrative expenses.

c) Are sales and marketing expenses reasonable?

Yes (1.43% of premium).

d) Are administrative costs related to programs that improve health care quality reasonable and comparable to other carrier filings?

Yes (0.27% of premium).

e) Are applicable taxes and licensing or regulatory fees appropriate?

All appropriate ACA taxes and fees are included and the amounts are not unreasonable.

f) Are taxes and fees consistent with adjustments made to premium in the development of the federal MLR?

Yes. The exchange user fee (3.2%) is calculated as 3.5% of anticipated on-exchange premiums, and then spread across the entire single risk pool as required by regulation. Medica assumes that 2017 on-exchange premiums will be 91% of total premiums.

g) Are the insurer's profit margins appropriate considering its Risk-based Capital (RBC) level?

Yes, 2015 RBC was REDACTED and Medica included a margin after federal income of 0.6%.

h) Are non-benefit expense values consistent with those included on the URRT? (Profit values on URRT are pre-tax)

Yes, the values are consistent across all materials.

7) Projected Loss Ratio

a) Are projected MLRs appropriate and determined according to ACA?

The federal MLR calculation is according to the federal instructions and the resulting MLR is above the minimum threshold for this market.

b) Are state MLR requirements fulfilled?

Not applicable.

Projected Index Rate to Consumer Adjusted Premium Rates

1) Index Rate

a) Was a market wide risk pool used including on exchange and off-exchange non-grandfathered plans in the market used?

Not applicable; Medica was new to the market in 2016 and has no base experience.

b) Were transitional plans included in the base experience?

Not applicable; Medica was new to the market in 2016.

c) Were transitional plans included in the projection period to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period?

Not applicable; Medica was new to the market in 2016.

d) Does the index rate only include the EHBs?

Yes.

e) For the small group market, is the index rate equal to the member weighted average of the quarterly index rates (if quarterly rates are used)?

Not applicable to the Individual market.

2) Market Adjusted Index Rate

a) Was the Market Adjusted Index Rate developed with consideration of adjustments for AV and cost sharing, after adjusting for the risk adjustment and exchange user fee?

The Market Adjusted Index Rate did not consider AV and cost sharing, which is not unreasonable.

b) Were the adjustments made considering the ratio of allowed to paid, which is factored in later?

The risk adjustment user fee was grossed up for allowed-to-paid of 0.814 from $0.13 to $0.16. The Exchange user Fee adjustment has also been grossed up appropriately from $20.68 to $25.41.

3) Plan Adjusted Index Rates

a) Were the following adjustments the only ones made to the Market Adjusted Index Rate:

i) Actuarial value and cost sharing;

ii) Provider network;

iii) Benefits in addition to EHBs;

iv) Non-Tobacco User

v) Impact for catastrophic plan eligibility; and

vi) Adjustment for distribution and administrative costs.

Only the allowable adjustments were made.

4) Are AV, cost sharing, and induced utilization factors provided separately and are they reasonable?

The AV/cost sharing was provided separately in an objection response. The range of induced utilization factors (0.932 – 1.063) is somewhat wider than the standard CMS range for bronze to gold (1.07 – 1.15). However, the AV and Cost Sharing Range is relatively slightly narrower (0.764 – 0.953) then the metal AV range (0.618 – 0.796). The induced utilization factors are close to the HHS factors for risk adjustment, and we believe they are not unreasonable.

5) If an adjustment was made for induced utilization, are cost sharing factors normalized to a weighted average of 1.0?

The actuarial memorandum was corrected to normalize the induced utilization.

There is an adjustment to account for the expected impact of the plan's cost sharing amounts on the member's utilization of services.

6) Was an adjustment made for non-tobacco user status and is it reasonable?

There is no specific adjustment for tobacco at this step because it is included in the AV and Cost Sharing Adjustment.

7) Were the rating factors for networks and medical management appropriate and supported by the documentation?

Not applicable.

8) Are differences between plans based on benefit richness (AV) appropriate and done in a way that the morbidity of those selecting lower cost sharing plans is ignored?

The induced demand factors do not seem to consider morbidity.

9) Are differences between plan administrative costs explained and appropriate?

Medica assumes a uniform 1.119 factor for all plans. A reconciliation was provided in an objection response, and we believe it is not unreasonable.

10) Are adjustments for catastrophic plan only applied to the catastrophic plan?

Yes

11) Calibration

a) Was the age calibration based on prior or projected age distributions and was it appropriate considering and adjustment to the base data for age? That is, if there was an adjustment for aging, the projected age distribution should be used in the age calibration.

Calibration was based on the projected age distribution.

b) Was normalization of the URRT premium rate to the base rate reasonable considering the changes in age curves and geographic rating?

Yes

c) Was the calibration uniform for all plans?

Yes

12) Consumer Adjusted Premium Rate

a) Was the appropriate age curve used?

Yes

b) Are the tobacco factors with in the required 1.5:1 range?

Yes. The tobacco load is 9%.

c) Were the appropriate geographic regions used?

The appropriate geographic regions were included.

d) Were the rating factors for geographic regions supported and appropriate?

As Medica does not have experience in Iowa, factors were estimated using Milliman's HCG for a commercial population in each area. Factors do not appear unreasonable.

e) Did the geographic factors only consider differences in cost and utilization by geographic are due to differences in practice patterns and cost and not consider differences in morbidity?

Yes, page 7 of the Actuarial Memorandum states that the factors do not include differences in demographic or morbidity.

f) Are the final rates appropriate when compared to each other?

Medica's rates do not appear unreasonable when compared to each other.

g) Are the final rates appropriate compared to other carriers in the same region and metal level?

Medica's final rates are not unreasonable compared to other carriers in the market.

Actuarial Value

1) Was the URRT AV close to the one in the Plans and Benefits template?

Yes

2) Was the AV for each metal plan in fact within the appropriate range?

Yes

3) If the plan was a unique plan design:

Medica does not believe any of the plans requires an alternative methodology. Not applicable.

a) Was the plan design in fact unique?

b) Were adjustments to the AV from the AVC or the AVC input made appropriately?

c) Was the actuarial certification and documentation appropriate? If an alternative method was used, was this indicated in the filing, and is the alternative method appropriate?

4) For sample plans can the AV be duplicated using the actuarial value calculator (AVC)?

Sample plan AVs can be duplicated using the federal AVC.

Membership

1) Were large projected shifts in membership adequately explained?

   Not applicable.

Solvency

1) Is the incurred but not paid reserve reasonable compared to the run out period?

   Not applicable.

2) Are there other reserves? If so, were changes in those reserves considered in the rating process?

   The Actuarial Memorandum did not discuss reserves.

3) To verify the issuer's capital and surplus is appropriate, we reviewed the historic risk-based capital.

   For confidentiality reasons this detailed information is not provided in our report.

Warning Alerts

1) Is the filing actuary's explanation for the warning alerts valid?

   An error was discovered in how the initial URRT was populated. Updated materials were provided.