

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:)	
MAINE COMMUNITY HEALTH OPTIONS)	PRE-FILED TESTIMONY OF
INDIVIDUAL RATE HEARING)	WILLIAM THOMPSON
)	
)	
)	July 15, 2016
Docket No. INS-16-1002)	

1 **1. Please state your name and your position with Community Health Options.**

2 My name is William Thompson. I am a Principal & Consulting Actuary with Milliman, Inc. Community
3 Health Options has engaged Milliman to provide actuarial support to CHO. I am CHO's appointed actuary
4 and I signed the actuarial memorandum related to the 2017 Maine Individual marketplace premiums for
5 CHO.

6 **2. Please describe any relevant education or experience that qualifies you as a witness today.**

7 I am a Fellow of the Society of Actuaries and a Member of the American Academy. I have been in the
8 actuarial profession for over 46 years and have been pricing health products for much of that time.
9 Presently, I sign the pricing actuarial memorandum for CO-OPs in three states and I serve as a peer
10 reviewer of rate filings for CO-OPs and other health plans in several other states.

11 **3. Please state your reasons for testifying at this hearing.**

12 My role is to describe the components of the 2017 rate development, starting with the historical
13 experience that was used as the foundation for the rates, trends in health care costs, changes in provider
14 contracting and other arrangements, the effect of plan design changes on rates, and the way that
15 expenses, taxes, fees, and risk charges were incorporated into the 2017 individual rates.

16 **4. Please provide an overview of the key steps of the process used to develop the 2017 rates.**

17 The Affordable Care Act prescribes a process for presenting the development of rates. It is based on the
18 Uniform Rate Review Template (URRT) and the Part III Actuarial Memorandum, both of which are
19 components of CHO's rate filing. The following summarizes the major steps in the rate development
20 process:

- 21 A. Develop Experience Period Allowed Claims Per Member Per Month (PMPM)
- 22 B. Adjust for changes between the experience period and the rating period
 - 23 a. Demographics and area composition of the experience period population compared to
 - 24 the expected demographics during the rating period
 - 25 b. Benefit richness difference between the experience period population and the rating
 - 26 period population
 - 27 c. Projected morbidity difference between the 2015 experience period and the 2017 rating
 - 28 period
 - 29 d. Contractual arrangements and other one-time adjustments between the experience
 - 30 period and the rating period
- 31 C. Adjust for expected risk adjustments payable or receivable
- 32 D. Adjust for two years of utilization and unit cost trend
- 33 E. Produce the "Index Rate" for the rating period
- 34 F. Incorporate marketplace adjustments such as Exchange fee and risk adjustment to develop
- 35 single risk pool allowed costs PMPM for essential health benefits
- 36 G. Compute plan-adjusted index rate, reflecting the plan design features of each plan
- 37 H. Include all administrative expenses, taxes, fees, and risk charges into the plan-adjusted
- 38 index rates
- 39 I. Calibrate from the average member demographics and area to values of 1.000 for
- 40 demographics and area.

41 This process is used to develop the 2017 rates that are required based on the underlying experience and
42 assumptions used in the rate development process. Note that the rate increase is not explicitly
43 computed—it is solved for by comparing the 2017 rates developed using the approach above to the 2016
44 approved rates.

45 **5. Have you made changes to your proposed rate increase since the initial rate filing?**

46 Yes. The revised average rate increase is now 25.5% compared to 22.8% in the initial filing. My testimony
47 is focused on the underlying assumptions supporting the revised rate request.

48 The rates were revised to increase the morbidity level, and there were changes to the relative values of
49 some plans and to the area factor for area 4.

50 **6. Please describe the Single Risk Pool concept and how it impacts rates.**

51 The regulations related to the Affordable Care Act define the Single Risk Pool for an individual market as
52 follows:

53 **§156.80 Single risk pool.**

54 (a) *Individual market.* A health insurance issuer must consider the claims experience of all
55 enrollees in all health plans (other than grandfathered health plans) subject to section 2701
56 of the Public Health Service Act and offered by such issuer in the individual market in a state,
57 including those enrollees who do not enroll in such plans through the Exchange, to be
58 members of a single risk pool.

59 (d) *Index rate—(1) In general.* A health insurance issuer must establish an index rate that is
60 effective January 1 of each calendar year for a state market described in paragraphs (a)
61 through (c) of this section based on the total combined claims costs for providing essential
62 health benefits within the single risk pool of that state market. The index rate must be
63 adjusted on a market-wide basis for the state based on the total expected market-wide
64 payments and charges under the risk adjustment and reinsurance programs, and Exchange

65 user fees (expected to be remitted under §156.50(b) or §156.50(c) and (d) of this subchapter
66 as applicable plus the dollar amount under §156.50(d)(3)(i) and (ii) of this subchapter
67 expected to be credited against user fees payable for that state market). The premium rate
68 for all of the health insurance issuer's plans in the relevant state market must use the
69 applicable market-wide adjusted index rate, subject only to the plan-level adjustments
70 permitted in paragraph (d)(2) of this section.

71 *(2) Permitted plan-level adjustments to the index rate.* For plan years or policy years beginning
72 on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular
73 plan from its market-wide index rate for a relevant state market based only on the following
74 actuarially justified plan-specific factors:

75 (i) The actuarial value and cost-sharing design of the plan.

76 (ii) The plan's provider network, delivery system characteristics, and utilization management
77 practices.

78 (iii) The benefits provided under the plan that are in addition to the essential health benefits.
79 These additional benefits must be pooled with similar benefits within the single risk pool and
80 the claims experience from those benefits must be utilized to determine rate variations for
81 plans that offer those benefits in addition to essential health benefits.

82 (iv) Administrative costs, excluding Exchange user fees.

83 (v) With respect to catastrophic plans, the expected impact of the specific eligibility categories
84 for those plans

85 As indicated in the citation above, the Affordable Care Act dictates that each marketplace in each state
86 represents a Single Risk Pool. All insurance companies are required to set their rates to be representative
87 of the anticipated characteristics of that Single Risk Pool, including the health status of the population in
88 total, demographics, etc. This requires that the rates for each plan offered in the individual market are

89 based on the expected health characteristics of the average member of the single risk pool; no
90 adjustments can be made for an individual's health status and rates from plan to plan cannot be adjusted
91 to reflect differences in the expected health status by plan. (Please see the portion of the citation in
92 response to the question above that addresses permitted plan-level adjustments to the index rate.)

93 If a particular insurer's covered lives, on average, have a lower risk score than the average risk score across
94 all insurers in the state, that insurer must pay a portion of its premiums for the year to the insurers whose
95 covered lives have a higher risk score, on average, than the composite statewide Single Risk Pool. As a
96 result, insurers who enroll members with lower risk scores than the average must increase their rates to
97 be representative of the average risk score of the Single Risk Pool, and conversely for insurers that enroll
98 members with higher than average risk scores. CHO's 2015 risk adjustment calculation indicated that
99 CHO's membership had a slightly higher risk score than the Maine individual marketplace single risk pool,
100 resulting in a payment to CHO of just under 1% of CHO's 2015 individual marketplace total premiums.

101 **7. How do the benefit changes described by Mr. Lewis impact the requested rate increase?**

102 The changes described by Mr. Lewis affect the portion of the total medical costs that the plan will pay.
103 On average, the benefit changes made CHO's 2017 plans less rich than they were in 2016. On average, the
104 effect of the benefit changes resulted in a decrease in the rate of 7.6% compared to what the rates would
105 have been had no benefit plan changes been made.

106 **8. Are you familiar with the requirements of 24-A M.R.S.A. §2850-B?**

107 Yes, I am familiar with this requirement.

108 **9. Did you evaluate the impact of the benefit changes as they relate to the requirements of 24-A**

109 **M.R.S.A. §2850-B? If yes, please discuss the process used and the results of your analysis.**

110 I evaluated the impact of the benefit increases and benefit decreases separately for each of CHO's
111 individual marketplace plans. I used the Milliman Managed Care Rating Model (MCRM) as the foundation

112 for the analysis. (The MCRM is widely used by Milliman consultants and carriers to evaluate the cost of
113 healthcare benefits and the effect of changes in benefits on the expected average cost of a plan.) I
114 calibrated the MCRM to be representative of the provider contracting terms and care management
115 programs in place at CHO during 2017. I then determined the expected PMPM claim cost for each of the
116 2016 and 2017 benefit plan designs. Then, I separated all of the benefit changes into benefit
117 improvements or benefit reductions. I determined the value of the improvements as a percent of total
118 2016 plan costs and I did the same for the benefit reductions. These changes included elements such as
119 plan deductibles, coinsurance copayments and out of pocket limits. Because of the interaction of several
120 of these elements, the analysis is approximate at best.

121 Based on this analysis, none of CHO's individual marketplace plans had benefit improvements in excess
122 of 5% of the total 2016 cost; however, three had reductions of more than 5%. The catastrophic plan,
123 "Safe Harbor", had a reduction of 6.1%; the only change that had been made to that plan was an increase
124 in the deductible and out of pocket max to the 2017 ACA maximum; all covered services in excess of the
125 deductible are covered at 100% so the change is attributable solely to the deductible change. The "Edge"
126 plan had a reduction of 9.1%; this was the result of a combination of an increase in the deductible and out
127 of pocket maximum, emergency room copay changed to deductible/coinsurance, generic drug effective
128 copay increase, preferred drug change from copay to deductible/coinsurance, non-preferred and
129 specialty pharmacy increase in coinsurance. The "Value" plan increased the out of pocket maximum,
130 generic drug effective copay increased, and OT/ST/PT changed from copay to deductible/coinsurance.

131 **10. Mr. Lewis indicated three of the plans do not meet the requirements of 24-A M.R.S.A. §2850-B.**

132 **Should CHO's request for a waiver of the requirements of 24-A M.R.S.A. §2850-B be declined,**
133 **what will be the impact on the proposed rate increase?**

134 If the waiver is not granted, one option is for CHO to change the benefits under these plans to comply
135 with the 5% limit. Under the single risk pool concept, the overall average rate increase for the Maine

136 Individual business would increase if the affected plans need to be enriched to meet the subject
137 requirement. The rates for the three affected plans would increase more than the rates for other plans.

138 **11. Are you familiar with the requirements of 24-A M.R.S.A. §2677-A(2)?**

139 Yes, I am familiar with this requirement.

140 **12. Did you evaluate the impact of the proposed cost-sharing changes as they relate to the**
141 **requirements of 24-A M.R.S. §2677-A(2)? If yes, please discuss the process used and the results of**
142 **your analysis.**

143 I interpreted the requirement as a comparison of the expected average claim cost for the individual single
144 risk pool membership assuming that all services were provided in-network at in-network cost sharing
145 compared to all services being provided out-of-network at out-of-network cost sharing. Using this
146 interpretation, I used Milliman's Managed Care Rating Model to compute the claim costs and compare
147 the in- and out-of-network costs. The ratio of the out-of-network claim cost to the in-network claim cost
148 ranged from 74% to 105% from plan to plan, with a weighted average of 86% across all individual plans
149 combined. One plan fell outside of the 20% range with a value of 74%.

150 **13. Why are the increases more for some plans than others?**

151 As indicated in the response to an earlier question, the cost-sharing changes were not uniform across all
152 of CHO's plans. Some plans had more extensive changes than others, the result being that the rate
153 changes varied by plan.

154 **14. Please describe the premium stabilization programs available to the issuer under the Affordable**
155 **Care Act and how those impact the requested rates for 2017.**

156 The premium stabilization programs available under the Affordable Care Act that affected CHO's 2017
157 Individual marketplace rates are as follows:

- 158 • Transitional Reinsurance Program: The ACA established this program as a temporary measure
159 that required all insurers and self-insured health plans (e.g., individual, small group, large group,
160 self-insured employers) to pay into a reinsurance pool that provided benefits to the individual
161 insurance marketplace. This program was effective for 2014-2016 and terminates at the end of
162 2016. The elimination of this program resulted in an increase of 5.1% in CHO's individual
163 marketplace rates, compared to the rate levels had the 2016 reinsurance benefits remained in
164 place.
- 165 • Risk Adjustment Program: As described in the response to an earlier question, this program re-
166 distributes premium dollars among insurers in each Single Risk Pool, with insurers that cover the
167 healthier than average person paying a portion of their premium to those insurers that cover the
168 less healthy lives. For 2017 pricing, CHO assumed that it would neither receive nor pay money
169 related to the Risk Adjustment Program.
- 170 • Risk Corridors: The ACA established the risk corridor program to absorb excessive losses an
171 insurer may incur related to ACA products and to be funded by excessive gains an insurer may
172 reap related to ACA products. This temporary program ends after 2016. CHO's 2017 individual
173 rates did not incorporate any charge or credit related to the risk corridor program.

174 **15. Please describe the adjustments that were made to historical experience and the effect of those**
175 **adjustments on the 2017 rates.**

176 The calendar year 2015 experience under CHO's individual business was the foundation for the 2017
177 pricing. The 2015 experience that was used as the foundation for the pricing represents the amounts that
178 were covered by CHO under its benefit plan contracts, adjusted to reflect provider contracting

179 reimbursement terms then in effect, but before being reduced by member cost sharing, such as
180 deductible, coinsurance, or copays. This amount is called the allowed amount. The total allowed amount
181 in the 2015 individual Single Risk Pool was divided by the total number of months of coverage across all
182 members in that risk pool in 2015, known as member months, to produce an allowed amount per member
183 per month. As indicated in the response to question 4 B above, the 2015 experience was adjusted to
184 reflect differences between the 2015 single risk pool and the 2017 single risk pool.

185 The adjustments described herein represent one-time adjustments to the 2015 experience to reflect what
186 that experience would have been had these changes been in place in 2015.

187 The population that is expected to be covered by the individual Single Risk Pool in 2017 has a different
188 composition by age, gender and geographic area than the population covered in 2015. The expected
189 population has a higher expected cost than the 2015 population, so the 2015 experience period allowed
190 amount PMPM was increased by 4.4% to reflect this population change.

191 The 2017 morbidity experience is expected to differ slightly from the 2015 experience due to a reduction
192 in the proportion of members in Cost Sharing Reduction plans. This reduction results in a morbidity
193 experience adjustment of 99.0% of the 2015 experience morbidity. In 2017, grandfathered plans lose that
194 status and persons covered by such plans will enter the individual marketplace single risk pool. We have
195 increased the expected morbidity level of the single risk pool by 4% in anticipation of the morbidity change
196 due to the introduction of this membership. The morbidity assumptions are discussed in more detail in
197 the actuarial memorandum submitted with the rate filing.

198 CHO continues to re-negotiate its contracts with network providers. These contracts determine the
199 amount that CHO will pay for the services covered by its benefit plans. The effect of the contract changes
200 for 2017 represents a 1.9% reduction in the allowed amount PMPM compared to the terms in place in
201 2015.

202 CHO has entered into a new Pharmacy Benefit Manager (PBM) contract effective July 1, 2016. This
203 contract dictates the amount that CHO will need to pay for each prescription filled by a CHO member.
204 Because the terms of the new contract are more favorable than the terms in place in 2015, the 2015
205 allowed amount PMPM was reduced by 1.24% to reflect the anticipated costs under the 2017 contract
206 terms.

207 **16. Please describe the concept of trend and how it impacts the rates.**

208 Trend represents a forward-looking value that measures the annual rate of change in the allowed cost of
209 medical services for a member with the same age, benefit plan, and geographic area over the
210 measurement period. It is not a measurement of actual to expected experience; rather, it is a forecast of
211 the annual rate of change in the total cost of healthcare services for a given population.

212 There are two primary components to trend: utilization trend and unit cost trend. Utilization trend refers
213 to how many of each kind of service are expected to be utilized by a covered population of insured persons
214 in the future, compared to their utilization during a recent period. Unit cost trend refers to the cost for
215 providing those services; the unit cost is affected by the change in the negotiated price for each service
216 and the change in the intensity of the services provided. For example, if the future expected number of
217 services per person, including their intensity, is the same as the prior year, the utilization trend would be
218 zero. Likewise, if the unit cost to provide those services remains the same from one year to the next, the
219 unit cost trend would be zero.

220 Trend is incorporated into the rate development as described in item D of question 4 above. CHO's 2017
221 rates are based on its 2015 claims experience, the most recent complete calendar year for which data is
222 available. This 2015 experience needs to be adjusted by two years of annual trend to put it onto a 2017
223 basis. The cost of healthcare services has been going up annually (e.g. the cost of drugs, lab tests,

224 hospitalization, physician visits) and utilization of services also change over time. As a result, the annual
225 trend rate is greater than zero, resulting in an increase in rates due to the trend in healthcare costs.

226 **17. Please describe how you developed your trend assumptions.**

227 The development of the 2017 allowed charge annual trend rates is described in a December 15, 2015
228 report from Milliman to Ed Vozzo, Chief Financial Officer of CHO (see Exhibit 4). To summarize that report,
229 CHO's historical experience is limited to 2014 and 2015 years, a period when CHO was commencing
230 operations, such that the historical experience did not provide a stable base for comparing utilization and
231 costs of services from one year to the next. Instead, we used Milliman's Health Cost Guidelines Secular
232 Trend assumptions as the starting point for establishing the annual rate of trend to take CHO's 2015
233 experience into 2017. Secular trend implies the rate of change in the total cost for covered services
234 before adjusting for the portion of the services that are covered by a benefit plan and the portion covered
235 by the member in the form of copays, deductible or coinsurance. Milliman's secular trend assumptions
236 separate medical costs into inpatient facility, outpatient facility, professional services, pharmacy, and
237 other services. For each component, the annual rate of change in utilization of services by a population
238 of covered lives is shown along with the change in the cost per unit of service (e.g. office visit, script,
239 inpatient day). Using information that was known about CHO's provider contracting arrangements and
240 care management programs, the Milliman Secular Trend components were adjusted to be more
241 representative of CHO's characteristics that were expected to continue beyond 2015. Using those
242 adjusted unit cost and utilization trend factors for each type of medical service, along with CHO's actual
243 distribution of 2015 allowed amounts by service type, the annual trend assumptions were developed. The
244 annual weighted average shown in the December 15, 2015 report was 7.2%; the weighted average will
245 change over time as the distribution of costs across service type evolves.

246 **18. How often do you review and update your trend assumptions?**

247 Trend assumptions are reviewed and updated at least annually.

248 **19. How does CHO's assumed trend compare to other issuers in the market? Why would it differ?**

249 By referencing information publically available on the Bureau of Insurance's website, the following is an
250 estimate of the annual allowed amount trend rates underlying the 2017 rate filings for issuers in Maine.

251 Community Health Options: the annual trend rate applied to allowed amounts is 7.2%, based on CHO's
252 distribution of services across categories in 2015.

253 Aetna: Aetna's small group filing provided information about their utilization and unit cost trend rates by
254 categories of service. Weighting those values by CHO's distribution by type of service produces an annual
255 trend rate of 7.1% on an allowed charge basis.

256 Anthem: Anthem's individual rate filing uses a blend between actual experience and manual rates. The
257 trend rate for the actual experience is 9.6%; it is 7.7% for the manual rates. They used a blend of 60%
258 experience/40% manual in their rate development, which produces an average annual trend rate of 8.8%.
259 This rate is applied to plan benefits, not to allowed amounts.

260 Harvard-Pilgrim: their small group filing implies an annual trend rate of 8.6%, developed by looking at
261 their quarterly effective date adjustment factors. This trend rate also applies to plan benefits, not to
262 allowed amounts.

263 United Healthcare: their small group filing indicates a utilization trend of 1.2%, a unit cost trend of 4.8%
264 and a leveraging trend of 1.1%. The trend rate that would compare to CHO's 7.2% trend in allowed
265 charges is the product of the first two values, an annual rate of 6.1%; their benefit trend, applied to the
266 plan's portion of the allowed costs, would include all three components, resulting in an annual trend rate
267 of 7.2%.

268 Trend rates will vary by issuer for a number of reasons. Each issuer has different care management
269 programs that will affect their utilization rates and each issuer has different contracts and types of
270 contracts with providers that will affect their unit costs. A single composite annual trend rate is also

271 affected by an issuer's distribution of costs by type of service (e.g. hospital inpatient, hospital outpatient,
272 professional, pharmacy). Differences will also arise if the trend rate is applied to allowed costs or to
273 benefit plan costs.

274 Related to the difference between allowed charge trend rates and benefit trend rates, if we were to use
275 United's 1.1% leveraging factor to adjust the benefit plan trend rates provided by Anthem and Harvard-
276 Pilgrim, their allowed trend rates would be approximately 7.6% and 7.4% respectively. These can be
277 compared to the allowed trend rates of 7.1% for Aetna, 6.1% for United Healthcare, and 7.2% for CHO.

278 **20. Given CHO's 2015 losses and emerging 2016 experience, what makes you confident in the trend**
279 **assumptions used for 2017?**

280 As indicated earlier, the annual trend assumption is the expected change in the utilization of services and
281 the cost per service from one period to another. The trend rate developed for CHO's 2017 pricing is
282 generally consistent with the allowed trend rates for other issuers in Maine and they were developed with
283 reference to programs that CHO has in place to manage utilization of services and the provider contracting
284 terms that CHO has in place.

285 Note that the base claims cost underlying the 2017 rating already reflects 2015 experience adjusted for
286 emerging 2016 experience and related factors (demographics, contracting, etc.) Hence the trend
287 assumption need not reflect these items.

288 As such, the trend assumptions used in the 2017 individual pricing for CHO are reasonable and
289 appropriate.

290 **21. How did you arrive at a required revenue amount after you have accounted for the claim portion**
291 **of the rate?**

292 Item "H" of question 4 above addresses the non-claims component of the 2017 individual premiums.
293 Expenses were derived from CHO's forecast of 2017 expenses, allocating fixed costs across all lines of

294 business and both Maine and New Hampshire. Those expenses came out to 12.6% of premium and were
295 applied across all plans as a percent of premiums.

296 In addition, the fee for the Maine marketplace (exchange) and the Comparative Effectiveness Research
297 fee add another 3.2% of premium to the costs.

298 CHO has included 4.0% of premium as its risk charge. This charge is intended to provide a cushion against
299 experience emerging less favorable than expected and it is the source of funds to repay CHO's solvency
300 loan and its converted start-up loan.

301 Together, these items represent 19.8% of premium.

302 **22. How were the Area Rating Factors developed?**

303 The original area factors were established for the 2014 rates based on area relativities from Milliman's
304 Health Cost Guidelines. These reflect expected utilization differences and differences in the cost of care
305 by area across the state. The area factor for Area 4 has been modified upward based a combination of
306 reviews of provider contracting differences across the state, early actual experience, and marketplace
307 area relativities, along with a recommendation from the Bureau of Insurance that CHO review its area 4
308 factor.

309 **23. In your actuarial judgment, are the proposed rates excessive, inadequate or unfairly
310 discriminatory?**

311 In my judgment, based on the data and other information available at the time the rate filing was
312 prepared, the proposed rates are not excessive, they are not inadequate, they are not unfairly
313 discriminatory, and they were computed in accordance with the rating requirements established by the
314 Affordable Care Act.

315 **24. Does this conclude your testimony?**

316 Yes.

317

318

319 July 15, 2016

320 Submitted by:

321

322 /s/William Thompson

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324 Principal & Consulting Actuary,

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326

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