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October 3, 2014

Ms. Mila Kofman, JD
Executive Director
DC Health Benefit Exchange Authority
1100 15th Street, NW, 8th floor
Washington, DC 20005

Subject:
Actuarial Review of Kaiser's January 2015 Rate Filings (Kaiser Permanente Individual KPMA-129592583 and Kaiser Permanente Small Group KPMA-129593007)

Dear Executive Director Kofman:

At your request, Mercer Government Human Services (Mercer) has undertaken a review of the above captioned filings submitted by Kaiser for products that are proposed to be offered in the individual and small group markets in the District of Columbia (the District), effective January 1, 2015. Our work was intended to supplement the reviews conducted by the Department of Insurance, Securities, and Banking (DISB), the District regulator tasked with rate approval authority, and to assist them in conducting the volume of reviews that needed to be completed in short order. This letter summarizes the analysis we performed.

It is our understanding that only the information submitted in association with Kaiser's initial proposed and final proposed rates are considered to represent publicly available information, and all correspondence between DISB and Kaiser throughout the review process is considered confidential. Given this report will be made public, some detailed information that appears in the more thorough, confidential version of this report has been redacted in order to comply with confidentiality requirements in the District. Therefore, in some cases we are unable to include a discussion of the additional information that may have been provided by Kaiser that ultimately led us to agree or disagree with an assumption made.

Mercer is not engaged in the practice of law and this letter, which may include commentary on regulations, does not constitute, nor is it a substitute for, legal advice. There are no third party beneficiaries with respect to this letter, and Mercer does not accept any liability to any third party. In particular, Mercer shall not have any liability to any third party in respect to the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

At your request, our review focused on the prescribed 15 items highlighted by Health and Human Services (HHS) regulation 45 CFR 154.301, to the extent the necessary information was available to us. The list is included in Appendix A for reference, along with other District-specific items that were considered in our review. To ensure internal consistency in our reviews, we used a comprehensive effective rate review.

Summary of Analysis Performed

While we identified many specific issues that could exert upward and downward pressures on rates, it is our opinion that the rates submitted by Kaiser are, if anything, aggressive. As discussed later in this report, we raised concerns about the potential for further Risk Based Capital (RBC) deterioration, and DISB requested and received Kaiser's assurances that they had access to capital should the need arise. Kaiser's enrollment projections, for the individual market in particular, seem to indicate Kaiser's interest in increasing enrollment in that market, which may be causing them to bid aggressively. Due to limitations in the data, we were provided to perform our analysis; our findings should be used with caution. A table summarizing the key areas where errors were made or assumptions were not supported, along with directional impact, can be found in Appendix B.

Methodology and Data Limitations

While Mercer was able to review and comment on the rate filings in many of the 15 key areas listed in Appendix A, there were some areas where we were not able to complete an in-depth analysis due to data limitations.

On June 16, 2014, we were able to download the filings as submitted via System for Electronic Rate and Form Filing (SERFF). Per DISB's request, we performed a preliminary review of the completeness of the filings and submitted our initial observations to DISB on June 20, 2014. There were four major observations, such as screen shots showing the actuarial values (AVs) were not included; the Actuarial Data sets were not complete; information pertaining to trend was not complete, and some references to 2014 rates as opposed to 2015 rates were made. In that communication, we indicated that after we had the opportunity to complete a more thorough review, we may have additional questions. On July 1, 2014, we submitted a more comprehensive set of questions to DISB. On July 7, 2014, we received responses to most of the questions posed in our June 16, 2014 request, although there were some technical issues associated with SERFF that precluded our ability to view certain responses. On July 11, 2014, we received responses to our comprehensive set of questions we sent on July 1, 2014. These responses resulted in additional communications between DISB, Mercer, and Kaiser. Kaiser did not provide sufficient answers to eight out of 20 of our first round of questions. These related to trend support, incurred but not report (IBNR) support, essential health benefit (EHB) breakout, morbidity assumption support, and administrative fee support. We communicated our assessment that we needed more information from Kaiser to DISB. We asked two minor follow-up questions after our first round of questions, which were forwarded to Kaiser by DISB, and responses to those questions were received on August 25, 2014.

Because only a partial response, or no response, was provided for many of our questions, we were not able to perform an in-depth review of all 15 items required under an effective rate review program at the level typically required to form an opinion as to the reasonableness of the assumptions being made by the carrier. Our analysis was limited to the information included in the

filings and Kaiser's responses to the questions we believe Kaiser answered sufficiently. If additional information or clarification were to be provided, our analysis results may change. A detailed discussion of our analysis follows.

Analysis Performed

In this section, Mercer discusses each of the assumptions reviewed. Where sufficient information was provided to perform analysis and arrive at an independent estimate, we present the results of our analysis and a comparison with the carrier's assumption(s). In other areas, we indicate whether or not the carrier's assumption appears reasonable or whether it appears over or understated.

Base Period Experience

Kaiser started with the combined 2013 allowed experience of their individual and small group business in the District, as required by District rule. Kaiser's experience is different from other carriers in that it is a combination of internal allocated claims (that is, about 70% of the total is internal fixed costs), and external estimated incurred claims, plus member cost sharing (30% external, which includes hospital, referral, and outside claims for outpatient surgery, emergency room, and out-of-area). Kaiser did not provide details as to how it developed its internal expense determination. Therefore, we are unable to opine regarding the reasonableness of their allocation of internal expenses as part of this review. We were able to focus on the reasonableness of the reported Kaiser experience compared to other sources.

Mercer compared the claims and membership included in the filing to the 2013 Supplemental Health Care Exhibit (SHCE) from the Statutory Financial Statement submitted by Kaiser to ensure that the starting claim costs were reasonable and represented the combined individual and small group experience. We would not expect these amounts to tie exactly, given the SHCE includes both grandfathered and non-grandfathered businesses, while the rate development must be based on only non-grandfathered policies.

The following table shows a comparison of the base experience with the information in the SHCE.

Kaiser 2013 Claims

	Allowed Claims PMPM in Filing	Incurred Claims PMPM in SHCE
Individual	$305	$380
Small Group	$343	$350

For the individual experience, the allowed claims in the filing include non-grandfathered business including dues subsidy members, whereas the SHCE includes both grandfathered and non-grandfathered business, excluding dues subsidy members because the instructions for the SHCE indicate it should not include dues subsidy. (Dues subsidy members are in a charitable

program and receive health insurance coverage with highly subsidized premiums.) For the small group experience, the allowed claims include non-grandfathered business, whereas the SHCE includes both grandfathered and non-grandfathered business.

Since Mercer knew of these reporting differences based on our review last year, we requested a "cross walk" between the information contained in the SHCE filing and the information contained in the Exchange filing in our initial set of questions. Kaiser did not provide the requested "cross walk"; however, in the filing, Kaiser indicates that, for the purposes of setting 2015 rates, it has removed a large claim that occurred in its experience period.

Opinion: The base period experience used in the rate development utilizes non-grandfathered claims, consistent with federal regulations. Since Kaiser did not provide a "cross walk" between the SHCE filing and the base period experience contained in the filing, Mercer cannot opine that the starting level is reasonable; especially, in light of the fact that, for the individual market, the allowed claims in the filing are less than the paid claims in the statutory statement. This does not mean that the information in the filing is not appropriate; only that we cannot opine on its consistency with statutory statements. The experience of the individual and small group markets has been combined into a single risk pool consistent with the District rule.

The impact of removing the large claim is a decrease of about $45 per member per month (PMPM) in the starting allowable PMPM. Had this claim been included, the starting PMPM would increase by about 14%; so excluding the claim results in significant downward pressure on claims and resulting premium, it is appropriate to remove at least a portion of large claims if these claims are not expected to reoccur. However, large claims do occur periodically and rates should reflect this possibility. Often times, this is accomplished by incorporating a portion of the claim in the experience accompanied by pooling charge for the balance. The pooling charge would be based upon all of Kaiser's commercial experience. Kaiser removed the entire amount of the claim and did not add a pooling charge. Incorporating such a charge would add upward pressure to the rates, but certainly not in the same magnitude as the credit for removing the claim. We estimate that the pooling charge for claims >$250,000 would be about 3%. By not including such a charge, Kaiser's rates could be low by 3%.

IBNR Reserves

Kaiser's experience period reflected claims incurred in calendar year 2013 and paid during the same time period (often referred to in the industry as a 12-12 experience period, meaning claims incurred in 12 months and paid in 12 months). Kaiser incorporated a reserve estimate for the remaining outstanding claims not paid as of the end of calendar year 2013.

Opinion: Most carriers will include one to three months of additional claim runout to minimize the magnitude of IBNR reserves. As an integrated model, Kaiser will not be subject to the same volume of runout claims. However, part of Kaiser's experience is provided by non-Kaiser facilities.

These claims will be subject to the same runout patterns as other fee-for-service insuring entities. IBNR estimates for 12-12 experience periods can be very volatile and company-specific. An aggressive 12-12 IBNR would be 20%, meaning that 20% of all claims are still outstanding. If we apply this to Kaiser's 30% of claims provided outside their system, we estimate that the IBNR should be around 6%. Kaiser's estimate appears aggressive. Kaiser did not provide us sufficient data to independently generate the IBNR reserve.

Index Rate Development

According to 45 CFR 156.80(d), the index rate is to reflect the average expected allowed cost for EHBs during the projection period. In developing the index rate, there are several adjustments that must be made to the base period experience to reflect differences between the population, provider costs, and benefits underlying the single risk pool and those expected in the projection period. These include, but are not limited to, changes in covered services, utilization adjustment, normalization to 1.0 on the District age curve, trend, and change in morbidity.

Changes in Covered Services

In 2015, plans offered in the individual and small group markets must provide coverage for the EHB package. Kaiser identified several non-EHB coverages included in their historic experience: adult preventive dental, abortion, adult vision, bariatric surgery, private duty nursing, chiropractic treatment, and hearing aids. Kaiser subtracted $4.22 PMPM in allowable charges from the index rate.

Opinion: Kaiser has made reasonable adjustments to the base period experience of the merged individual and small group risk pool to reflect the removal of non-EHB benefits from the base period. Kaiser did not make any adjustments to add benefits to reflect the EHB package.

Utilization Adjustment

According to 45 CFR 156.80(d), the index rate is to reflect the average allowed cost, and therefore, the average utilization, anticipated during the projection period. Kaiser calculated a utilization adjustment factor of 1.088, which represents the impact of moving from average copayments in the experience period to a zero cost-sharing environment. Kaiser then employs a second utilization factor (.908) to reflect the difference between a zero cost sharing plan and the average copayments anticipated in the projection period.

Opinion: Kaiser used a two-step approach to reflect changes in utilization between the experience period and the projected period. Theoretically, this is acceptable. Mercer requested supporting documentation for the utilization adjustment factors, but they were not provided by Kaiser; therefore, we are not able to opine on the reasonableness of the specific factors. We do have a concern that Kaiser used the merged market utilization adjustments to develop market-specific utilization adjustments. It is our understanding that the merged market utilization adjustments were to be employed when developing the merged market index rate, but

market-specific adjustments were to be employed when developing the rates for each market. If market-specific utilization adjustments were employed, the rates for individual would decrease 3.4% and the rates for small group would increase 2.3%. There would be no change in the index rate for the merged market.

Trend

Kaiser assumed a 3.5% annual trend rate in the development of the proposed rates. Mercer requested that Kaiser explain and provide support for how trend was derived for internal and external claims, and actual experience for external claims so that we could perform our own independent calculation of the historical trend as a reasonableness check on the proposed trend assumption. Kaiser did not provide any further support for its trend assumptions and DISB indicated to Mercer that they did not think it was necessary to request anything further.

Opinion: The annual trend assumption of 3.5% is low when compared to other carrier trends. Kaiser's own Base Period PMPM increased 5.9% from 2012 to 2013, as shown in the Actuarial Memorandum. Kaiser's written explanations of how they expect utilization trends to change were reasonable, but they did not provide actual experience that would allow us to perform an independent analysis of their historical trend. Although Mercer is unable to opine on the reasonableness of a 3.5% annual trend assumption due to the lack of information provided by Kaiser supporting their trend assumption, it is likely not overstated for the external portion of the experience. According to the semi-annual Oliver Wyman Carrier Trend Survey for July 2014, a 3.5% pricing trend is in the lowest quartile for both group and individual Health Maintenance Organization products. Without further information on how the internal budget was developed, we cannot comment on the impact of the application of that same trend for the internal portion of the experience.

Change in Morbidity

As required in the District, the experience of the individual and small group blocks have been combined and used as a basis for developing a single index rate for the combined market. Kaiser originally incorporated an overall morbidity adjustment of a 5.0% increase; comprised of a 13.0% increase for change in risk in Kaiser's individual business, and a 0.4% decrease for Kaiser's small group business. The key factors driving the 13.0% individual increase were an assumption that new entrants and transfers would have 30% higher morbidity and that the change from gender - based to unisex rating would increase morbidity by 10%. The key factor driving the 0.4%% assumed decrease in morbidity for Kaiser's small group business was that new small group business would be at the market level (as opposed to Kaiser's current small group business, which Kaiser believes has a morbidity that is 5% above market level).
Opinion: Kaiser has projected approximately a 5.0% increase in overall rates due to the projected change in the average morbidity of the merged risk pool between the base period and the 2015 projection period. This is a decrease from 2014 levels of 9.3%. Mercer asked Kaiser to provide documentation supporting these assumptions. Kaiser did not provide sufficient documentation.

Mercer cannot opine on the reasonableness of the underlying morbidity assumptions driving this factor.

Projected Membership

Kaiser is forecasting it will double its membership in the individual market and increase its small group membership by about 10%. Kaiser indicated that their projected 2015 membership was based on a proprietary model they contracted with Deloitte Consulting Group to build. Kaiser also believes its 2015 rates will be more competitive relative to the market and will result in increased membership.

Opinion: Without the further documentation requested on overall projected membership, we cannot opine on the reasonableness of the projected membership assumptions.

Risk Adjustment

The Affordable Care Act (ACA) establishes a risk-adjustment program intended to transfer funds from carriers that attract lower than average risk to carriers that attract higher than average risk within the same state and market. 45 CFR 156.80(d) states that "the index rate must be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment program." The intent of this requirement is that carriers, who anticipate receiving money from other carriers under the risk transfer program, reflect these payments in their rate development, leading to lower premiums due to the fact that payments from other carriers will cover a portion of the anticipated claims cost. The same is true for carriers anticipated to make payments to other carriers in that they must collect additional premium to cover the cost of the anticipated payments, and these additional costs are to be recognized in the premium development. This allows the premiums charged by all carriers to reflect a risk closer to the market average, and does not disadvantage carriers that attract a higher than average risk.

It is difficult for carriers to estimate what these transfer payments might be in 2015 given there is limited information available on what the market composition may look like, and what the carrier's risk portfolio may be relative to the rest of the market given the significant changes that have not yet occurred. Kaiser has assumed an 8.5% greater risk relative to the individual market for 2015, and therefore, is assuming a 92.2% adjustment for risk recoveries in the individual market. For the small group market, they have assumed a 4.6% greater risk relative to the market and are therefore assuming a 95.6% adjustment for risk recoveries.

Opinion: As described in the Change in Morbidity section, Kaiser did not provide support for its calculation of the change in membership and average morbidity. Without support for their projections and underlying assumptions, we cannot opine on the reasonableness of their risk recovery assumptions. If Kaiser's estimate of risk score relative to the market is overstated, then it will not enjoy transfer payments in the magnitude reflected in its premiums resulting in financial losses. If Kaiser's estimate of risk score is understated, then it will enjoy additional transfer

payments. Assuming a net credit from the risk adjustment process is aggressive, especially in light of the lack of documentation and modeling supporting such an assumption.

Transitional Reinsurance

A transitional reinsurance program will be in effect in the individual market for the years 2014–2016. Kaiser indicates that they have used the experience of their September – August 2013 large group business to develop a continuance table that was then used to calculate the estimated reinsurance recoveries. Kaiser indicated it was their opinion that the distribution of claims in their large group experience will better reflect the individual market in 2015 in terms of the ultimate risk profile rather than today's underwritten individual population. In their Notice of Benefit and Payment Parameters for 2015, the Centers for Medicare & Medicaid Services (CMS) indicated that the reinsurance parameters for 2015 would be 50% of claims between $70,000 and $250,000. In subsequent communications, CMS has indicated that it "intends" to decrease the lower limit for 2015 from $70,000 to $45,000; although to our knowledge, this has not been finalized. Kaiser has developed the credit using the wider range. Kaiser developed an average percentage recovered per claim of 7.0% from the large group experience. The factor they used for the market adjustment to the index rate for reinsurance recoveries was 100% minus the 7.0% or .93.

Opinion: Kaiser assumed that average 2015 individual market recoveries would be the same as percentage recoveries in their current large group market, assuming the large group experience would be more similar to the 2014 individual market since it is guarantee issue. This assumes that the percentage recoveries of an average 2013 large group claim will generate the same percentage recoveries in the 2014 individual market. We independently calculated what we believe would be a reasonable credit using proprietary data distributions that were calibrated to Kaiser's anticipated 2015 allowed PMPM and generated similar results. Therefore, if the ultimate reinsurance band is $45,000 to $250,000, the credit reflected in Kaiser's filing is reasonable. However, if the band does not get expanded from $70,000 at the lower end to $45,000 at the lower end, the credit is overstated by about 3%.

Pricing AVs

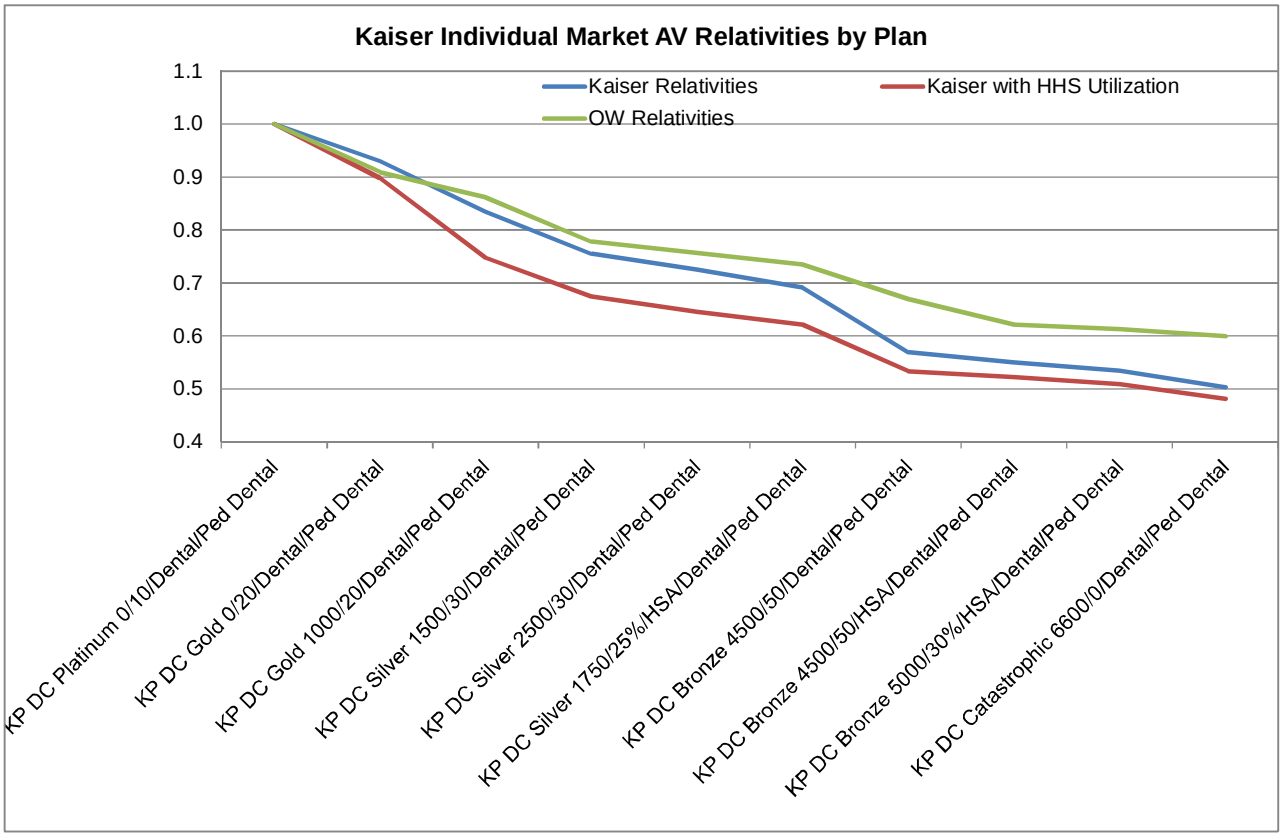
Using Oliver Wyman's (OW's) proprietary pricing model, Mercer independently calculated pricing AVs consisting of both the paid-to-allowed factor and utilization factor for each of Kaiser's nine individual plans (excluding the catastrophic plans). We calibrated the model to reflect the overall projected allowed cost prior to calculating the factors. However, the results in this section should be used with caution. While we utilized the benefit summaries in the filing and subsequent submissions, given the data limitations and the fact that we did not receive detailed benefit plans, there is the potential that not all aspects of the benefit plans were fully considered. In its filing, Kaiser indicated that it changed its methodology for determining the utilization copay effect for its plans to "better reflect the impact of member cost share." For 2015, Kaiser has considered the

deductible levels, as well as the copayments in this process. Inclusion of both copayments and deductible levels is appropriate.

An analysis was conducted to perform a reasonableness check on the relative difference in the factors among plans. Mercer ran each of the Kaiser plans through OW's pricing model to develop our estimate of the pricing AV for each plan. We compared these results to Kaiser's pricing AV for each plan by calibrating both sets of factors to be relative to a selected reference plan.

Individual Plans

For the Individual plans, we also generated factors using Kaiser's paid-to-allowed statistics but substituted CCIIO's utilization curve. OW's pricing model reflects CCIIO's utilization curve. The following chart shows the relativities among the various plans between the different approaches.

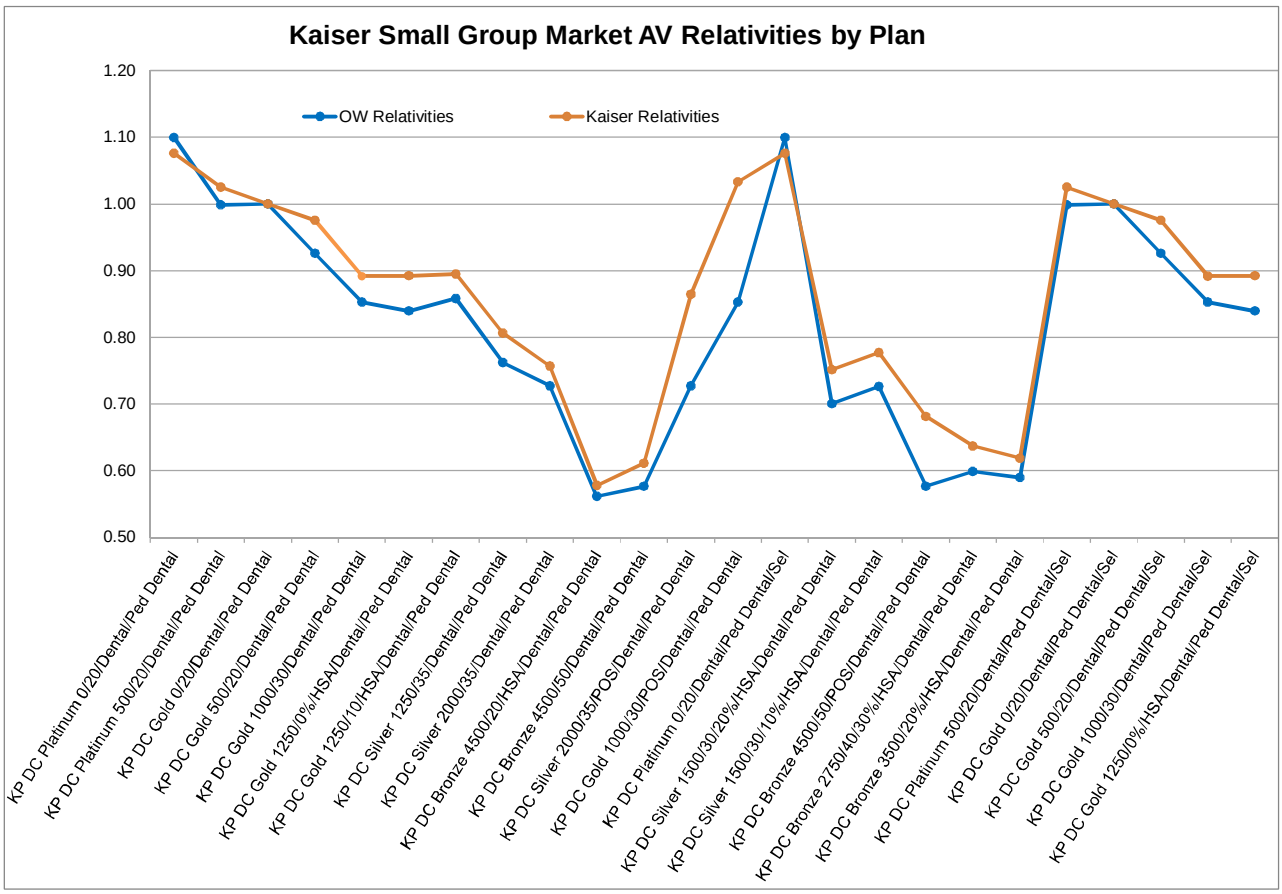


OW's curve appears to be "flatter" at the higher deductibles. The proposed Kaiser factors are generally between OW's relativities and Kaiser factors with HHS utilization. The Kaiser proposed pricing AVs for non-health savings account (HSA) plans and HSA plans with similar or identical

deductibles are similar, which indicates that Kaiser is not incorporating any special factors for HSA plans, which is appropriate.

Small Group Plans

Kaiser is offering different network options, as well as point of service (POS) plans in its small group product portfolio. This results in a portfolio of 24 plans. For small group, we show the comparison of OW's factors to Kaiser's factors.



Some of the differences in the factors are attributable to different provider networks. Kaiser did not include any specific analysis pertaining to the values of the different networks other than the pricing differential. The same is true for its POS products. Kaiser did not include any assumptions pertaining to the percentage of total services and corresponding costs for out-of-network providers. However, the differentials that are reflected in Kaiser's proposed factors are within a range we observe in the market.

Opinion: Mercer finds the proposed pricing AVs for Kaiser's individual and small group plans to be within a range that is reasonable.

Non-Benefit Expenses (Non-ACA Related Taxes and Fees)

Kaiser has assumed a non-benefit expense portion of premium, excluding ACA-related taxes and fees, equal to 19.4% for individual and 20.9% for small group. They explained the difference between the individual and small group expenses as attributable to the fact that they included an additional 1.5% in Corporate and Other Overhead in small group to account for the transitional reinsurance fees, whereas these amounts are included as offsets to the transitional reinsurance recoveries in the individual calculation. No support for these non-benefit expense assumptions has been provided.

Mercer compared the administrative expenses and commissions included in the current rate development with expenses shown in the 2012 and 2013 SHCE exhibits included in the statutory statements, as well as the 2014 rate filings.

Supplemental Health Care Exhibits						
	Individual	**Small Group**	**Individual**	**Small Group**	**Individual**	**Small Group**
	2012		2013		% Over 2012	
General Admin Expense	$14.65	$13.43	$19.61	$12.91	33.9%	-3.9%
Claims Adjustment Expense	$19.39	$16.96	$31.21	$20.08	61.0%	18.4%
Commissions	$2.58	$20.15	$2.92	$21.25	13.2%	5.5%
Total	$36.62	$50.54	$53.74	$54.24	46.8%	7.3%

Rate Filings						
	Individual	**Small Group**	**Individual**	**Small Group**	**Individual**	**Small Group**
	2014		2015		% 2015 over 2014	
Total Admin and Commission (excluding taxes and fees)*	$44.24	$51.97	$47.66	$63.92	+7.7%	23.0%
% over 2012 SHCE	20.8%	2.8%	30.1%	26.5%		
% over 2013 SHCE	-17.7%	-4.2%	-11.3%	17.8%		

*From URRT and includes both administrative expenses and commissions and does not include profit & risk load

We were especially surprised at the material increase in expenses between 2012 and 2013 for the Individual market, as reflected on the SHCEs for the applicable years. We asked Kaiser to explain this.

Opinion: In the 2015 filings, the total administrative expenses including commissions, contribution to surplus, and taxes and fees, have decreased from 2014 levels. As a percent of premium, total administrative expenses, including commissions, has decreased. This is driven mainly by a decrease in the contribution to surplus and omission of the new Exchange assessment. Kaiser indicated its administrative expenses increased materially in 2013, as it was expanding resources to prepare for new enrollees. There appears to be inconsistency in reporting expenses on the SHCE and internally within Kaiser. Kaiser did not provide the detailed information required for Mercer to independently form an opinion regarding the accuracy of the administrative expense allowance for 2015. We note that the administrative expenses included in the filing will generate a medical loss ratio that meets the federal minimums.

ACA Related Taxes and Fees

Kaiser included 0.88% for insurance tax along with the DC premium tax of 2.0% in their tax category of their retention exhibit. An assumption of approximately 0.3% was indicated to cover the $2.12 per year Patient Center Outcomes Research Institute (PCORI) tax and miscellaneous other taxes, such as real estate, consistent with prior year filings. Kaiser assumed a 1.3% factor for individual and 1.0% for small group to reflect the amount to be charged to carriers to fund the transitional reinsurance program in 2015. Kaiser did not include an addition to premium for an exchange fee or risk-adjustment user fees.

Opinion: With respect to the health insurer fee, Mercer finds the assumed 0.88% assumption to be reasonable, and at the low end of a range of assumptions. We note that in the Oliver Wyman

report titled “Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans”, dated October 2011 the cost of the health insurer fee in 2015 was estimated to range from 2.6% to 3.2%; however, there is reduction for non-profits. Regarding the reinsurance contribution, HHS has proposed that a fee of $3.67 PMPM be charged to carriers to fund the transitional reinsurance program in 2015. The percentages specified in the table above appropriately reflects this proposed $3.67 fee as a percentage of premium. In addition, we note that the percentages representing the PCORI fee appropriately represent $0.18 PMPM as a percent of premium. In addition, Kaiser chose not to include exchange fees being assessed in D.C (representing 1% of premium), and Kaiser also did not include risk-adjustment user fees (representing $0.08 PMPM translated to a percent of premium).

Contribution to Surplus and Risk-Based Capital

Kaiser is reducing their contribution to surplus in 2015 for both Individual and Small Group from 2% of premium to 1% of premium. The following chart shows Kaiser’s RBC ratio for the most recent five years.

RBC Ratio				
2013	2012	2011	2010	2009
330%	354%	331%	463%	611%

There is a general rule of thumb that a 2% of premium contribution is required to maintain existing levels of risk-based capital (RBC). Thus, incorporating a 1% contribution could result in a deterioration of the RBC ratio. This is further complicated by the fact that Kaiser did not build the 1% of premium Exchange assessment on District carriers to fund the Exchange. [Kaiser indicated it had developed the rates prior to the communication of the new assessment and elected not to modify the rates]. Because of this, Kaiser does not have any contribution to surplus built into its rates. Mercer and DISB asked Kaiser about the RBC situation. DISB concluded that Kaiser’s response was sufficient.

Opinion: Exclusion of any contribution to surplus is only consistent with standard actuarial principles if the insuring entity has what could be characterized as “excess” surplus, and the company wants to return some of that excess to policyholders in the form of reduced premiums. Kaiser’s current RBC ratios could not be considered “excess”, and the reduction in the last several years is worrisome. By Kaiser’s own standards, an RBC level below 350% would necessitate a request for additional surplus notes. Kaiser’s 2013 RBC is below that target. It is Mercer’s opinion that Kaiser should not have decreased its contribution to surplus from 2% to 1% and should have modified its rates to reflect the Exchange assessment of 1%, which omission effectively reduces the contribution to surplus to 0%.

Conclusion

As previously noted, Mercer's review was limited to the information included in the filings to which we had access and minimal additional information provided by Kaiser. While we developed a list of questions and requests for additional information, Kaiser did not provide quantitative responses and the support necessary to enable us to conduct an independent review. Had this additional information been provided, our opinions noted herein may have differed. Since the proposed rates are an estimate of future contingent events, the actual results may vary.

I am a member of the American Academy of Actuaries and meet all of its requirements to render the opinions provided in the letter. I have utilized generally accepted actuarial methodology in reaching these opinions.

Please do not hesitate to contact me if you have any questions at +1 425 478 0712.

Sincerely,

Sheree Swanson, ASA, MAAA

Copy:
Karen Bender, Oliver Wyman
Tammy Tomczyk, Oliver Wyman

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Appendix A

Rate Review Checklist

1. Medical trend changes by major service category.
2. Utilization changes by major service category.
3. The impact of cost-sharing changes by major service categories, including actuarial values.
4. The impact of benefit changes, including essential health benefit (EHBs) and non-EHBs.
5. The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use, under Section 2701 of the Public Health Services Act.
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.
7. The impact of changes in reserve needs.
8. The impact of changes in administrative costs related to programs that improve health care quality.
9. The impact of changes in other administrative expenses.
10. The impact of changes in applicable taxes, licensing, or regulatory fees.
11. Medical loss ratio.
12. Capital and surplus.
13. The impact of geographic factors and variations.
14. The impact of changes within a single risk pool to all products or plans within the risk pool.
15. The impact of reinsurance and risk adjustment payments and charges under Sections 1341 and 1343 of the Affordable Care Act.

In addition to these federal regulations, our review also considered the following items specific to the District:

1. Carriers operating in both the individual and small group markets must utilize the pooled experience from both markets in calculating their index rate.
2. Carriers must use the District-specific standardized age curve.
3. Carriers may not rate by geography.
4. Carriers may not rate by tobacco use status.

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Appendix B

Summary of Proposed and Alternate Assumptions

	Individual			Small Group		
	Filing	**Mercer/Oliver Wyman Review**	**Potential Rate Impact**	**Filing**	**Mercer/Oliver Wyman Review**	**Potential Rate Impact**
Impact on all Plans						
Base Period Experience	$305 PMPM	Less than 2013 incurred claims (Kaiser Adjusted for a Large Claim)	+/– Unable to validate base claims	$343 PMPM	Less than 2013 incurred claims	+/– Same as individual
Incurred But Not Reported Reserves	4%	Kaiser did not provide sufficient data to enable an independent calculation. We cannot opine whether it is reasonable, redundant or inadequate. Given that the experience period reflects claims incurred in twelve months and paid in twelve months, the factor would be very aggressive for traditional fee-for-service insuring entities. We would expect Kaiser to have a lower estimate than fee-for-service carriers, however this estimate appears aggressive.	+?	4%	Same as Individual	+?
Trend	3.5%	Kaiser did not provide sufficient detail to enable an independent calculation.	+/- Unable to validate trend	3.5%	Same as Individual	+/- Unable to validate trend

	Individual			Small Group		
Utilization Adjustment	-1.2% (=1.088*.908-1)	Overall adjustment across both markets was a two-step process – apply 1.088 to adjust base to zero-copay, then apply .908 to adjust to projected average cost-sharing	+/-	-1.2% (Same as individual)	Same as individual	+/-
Adjustment for Induced Demand at Market Level	0.0%	Kaiser used merged market utilization factors to generate market specific rates	-3.4%	0.0%	Kaiser used merged market utilization factors to generate market specific rates	+2.3%
Change in Morbidity	5.0%	Kaiser did not provide sufficient detail to enable an independent calculation	–	5.0%	Kaiser did not provide sufficient detail to enable an independent calculation	–
Risk Adjustment	-7.8%	Potentially aggressive	+	-4.4%	Potentially aggressive	+
Reinsurance Recovery	-7.0%	Potentially aggressive since Kaiser assumed a lower limit of $45,000; using a lower limit of $70,000 would increase premiums	+3%	N/A	N/A	N/A

	Individual			Small Group		
Administrative Expenses	19.4%	Kaiser did not provide sufficient detail to enable an independent assessment; Inconsistent reporting on 2013 SHCE.	–	20.9%	Kaiser did not provide sufficient detail to enable an independent assessment; inconsistent reporting on 2013 SHCE	–
Exchange Fees	0.0%	Aggressive, Fees are 1%	+1.0%	0.0%	Aggressive, Fees are 1%	+1.0%
Contribution to Surplus	1.0%	Aggressive, Represents a decrease from 2% in 2014; generally, 2% is required to maintain existing RBC levels.	+1.0%	1.0%	Aggressive, Represents a decrease from 2% in 2014; generally 2% is required to maintain existing RBC levels.	+1.0%
Risk Based Capital	2013–330% 2014–354%	RBC decreased in 2013. Still above Action Level of 200%, but given decrease in contribution to reserves, is aggressive.		2013—330% 2014—354%	Same comments as Individual	
ACA fee	2.88%	Reasonable	N/A	2.87%	Reasonable	N/A
Pediatric dental	$3.11 PMPM for dental	Reasonable	N/A	$3.11 PMPM	Reasonable	N/A
Limit of ability to bill for max of 3 dependents under age 21	0.5%	CMS indicates this should not be incorporated into rates	-0.5%	0.5%	CMS indicates this should not be incorporated into rates	-0.5%
Network Differentials	Not enough information provided to fully assess					
Impact on Specific Plans						
Plan Factors	Pricing of actuarial values of all specific plans was checked and found to be reasonable.					