To: Commissioner Nick Gerhart
From: Tom Keller, FSA, MAAA, FCA
CC: Craig Magnuson, FSA, MAAA, FCA
Subject: Wellmark BCBS, Inc. – January 2017 Individual Market Rate Filing Review #WMIA-130558306
Date: August 20, 2016

Scope and Purpose

The scope and purpose of this engagement was to provide an independent actuarial review of the Wellmark Blue Cross Blue Shield of Iowa, Inc. (Wellmark) January 2017 Individual Market rate filing tracking # WMIA-130558306, originally provided to Magnum Actuarial Group, LLC (Magnum) on May 10, 2016. This filing proposes revised prices for an ACA-compliant Individual Market product series encompassing three metal levels (no Platinum), along with introduction of three new plans and the elimination of ten old plans. The actions are being submitted for a January 1, 2017 effective date. The initial proposal submitted on May 10th included an average 42.6% rate increase with variations by plan. These rates and plans are offered off Exchange only.

Magnum also provided independent actuarial review of a sister company filing, Wellmark Health Plan of Iowa's (WHPI) January 2017 Individual Market rate filing, SERFF tracking # WMIA-130558482. Where appropriate, we will compare the two filings to provide additional context.

The objectives of this review were to:

- Determine whether the filing complies with HHS instructions and regulations,
- Ensure the IID took into consideration all of the issues required of an effective rate review,
- Determine whether the proposed rates are reasonable, i.e., non-discriminatory, justified, and neither excessive nor inadequate.

In dealing with the question of premium rate reasonableness, we considered only applicable and relevant laws and regulations, not issues such as affordability and company profitability.

This report discusses a situation that is, in Magnum's experience, unique to this filing in that a single member's potential ongoing claims has a significant impact on deriving the appropriate

rate level for the product. HIPAA considerations prevent Wellmark from disclosing much detail about this claim and Magnum from disclosing anything that it has learned about the claim or claimant, whom we will refer to as Member X. We direct the reader to ***Extraordinary Actuarial Issue*** in which we discuss the implications of this claim and demonstrate that without this claim, Wellmark's rate increase request could have been 10% lower.

This report is intended to be only used by the Iowa Insurance Division (IID) to support its decisions concerning this rate filing. Unapproved use for other purposes may not be appropriate.

Responsible Actuaries

Tom Keller conducted this review, with peer review by Craig Magnuson. Both are Senior Partner level actuaries for Magnum, carry the credentials FSA, MAAA, and FCA, and meet the American Academy of Actuaries qualifying standards for issuing actuarial statements of opinion concerning health insurance pricing.

We are available to provide any supplementary information or answer any questions that may arise in regards to this work product.

We have no conflicts of interest with either the IID or Wellmark.

Sources of Data

The primary sources of data were the URRT (Part I), Rate Increase Narrative (Part II), Actuarial Memorandum (Part III), IA Assister File, and responses to a series of questions we raised. All of the data underlying this analysis was provided by Wellmark via the initial rate filing of May 10th, 2016, along with updated information received on June 27th and August 5. Exhibit 1 shows answers to questions submitted to Wellmark by Magnum in regards to the rate filing and the subsequent responses.

Compliance with HHS Instructions and Regulations

The Actuarial Memorandum contains all of the sections that the January 20, 2016 Unified Rate Review Instructions for 2017 require in the prescribed order. For the most part, it provided enough information to review and validate the data shown in the URRT. However, we did need to ask some follow up questions in order to appropriately validate all of the considerations as required under an effective rate review process. Wellmark provided timely and thorough answers to questions we raised concerning the actual process. (See Exhibit 1.)

The URRT is complete and contained six warnings in worksheet 2 that Wellmark explained satisfactorily in the Actuarial Memorandum.

We found no inconsistencies between the documents.

Effective Rate Review Checklist

HHS released a checklist prescribing the minimum requirements for an effective rate review process (See Exhibit 2). In this section of our report, we will discuss our findings concerning each issue on the checklist.

Data, Assumptions, and Implementation of Market Reforms

The experience in the URRT Worksheet 1 Section I includes both ACA and Transitional Individual policy experience for 1/1/15 to 12/31/15, with claims paid through 1/31/16 and completed through 2/29/16, in keeping with HHS' instructions in reflecting a single risk pool for the market. This experience is fully credible, with 890,909 member months.

The assumptions were developed using Wellmark's experience. We found no instances where the assumptions or pricing factors were unreasonable or inconsistent with market reform implementation constraints and guidelines.

The next section on Specific Factors will address in more detail our findings and opinions concerning all the issues on the HHS checklist.

Specific Factors

HHS has specified a list of factors that must be examined as part of an effective rate review process. We compared the current 2017 factors to those from 2016 and the methodology used, reviewed the reasonableness of each factor, and assessed the materiality of potential differences of opinion. The materiality standard we applied was whether a feasible difference in an assumption or factor could make the difference between Wellmark's projected 89.7% MLR and the 80.0% threshold.

Exhibit 1 documents the dialogue between Wellmark and Magnum concerning the basis of the most pivotal specific factors, with our comments about the evidence presented.

Trend

Wellmark's actuarial memorandum and supporting documentation describe two sources of trend that affect pricing – 9.0% allowable claims trend featured on the URRT along with plan deductible leverage factors that range from 1.4% to 3.6% in the calculation of the Plan Adjusted

Index Rates. The weighted average of the leverage factors is 2.53% and the range is consistent with proprietary data Magnum uses for pricing.

Wellmark trend assumption for allowable claims was 9.0%, a 4.0% increase from the 5.0% assumption Wellmark used in its 2016 filing. Question 6 of Exhibit 1 documents a lengthy dialogue between Magnum and Wellmark concerning this assumption and concludes with our analysis based on data they have provided. Wellmark cited several data points, but did not describe changes to negotiated provider fee schedules that could have substantiated a large increase in the trend assumption. We cite several other interpretations of Wellmark's own data that would point to a lower assumption.

We believe that the 9.0% assumption is an over-reaction to what was actually an under-estimation of the increase in risk pool morbidity, including one member with higher claims than we have ever come across. We also believe that Wellmark has adequately provided for future risk pool morbidity increases. As a result, we limit the allowable claims trend assumption to 7.3% in our independent MLR projections for this filing and the WHPI ACA filing.

This change would not make Wellmark's requested rate increase unreasonable, per se, because allowable claims trend would have to drop to 2.9% for the projected MLR to drop below the 80% threshold, which is the standard used by the IID and HHS to determine reasonability.

Utilization (Changes) and Benefit (Changes)

No adjustments were made to the base experience period for ACA benefits, as the single risk pool experience represents all of the EHB's.

Changes in benefits factors and induced utilization adjustments are embedded in the development of AV & Cost Sharing factors. These changes account for the proposed range in average rate increases by plan, from 39.2% to 45.0%. Wellmark shared the confidential and proprietary data and calculations it used to derive the AV & Cost Sharing factors with Magnum and we found both components to be actuarially sound and appropriate. This information allowed us to confirm that:

- The 0.833 Paid to Allowed Factor in Projection Period shown in Part I of the URRT is the weighted average of the plan AV & Cost Sharing factors.
- Induced utilization assumptions did **not** introduce any artificial inflation in the overall pricing because the weighted average was 1.000.
- Induced utilization adjustments were consistent with the actuarial principle that less cost sharing induces greater utilization because they were developed using a linear regression and the correlation coefficient was, as would be expected, 1.000.
- Induced utilization adjustments were developed independent of member morbidity.

- Trend deductible leverage assumptions were consistent with the actuarial principle that higher deductibles will generate greater leverage.

Cost sharing (Changes)

The 0.833 Paid to Allowed Average Factor for the Projection Period is up from the 0.787 assumed in in the 2016 filing. This change is due to higher paid to allowed ratios experienced in the underlying 2015 single risk pool, compared to data used in the pricing model for 2016 pricing and an additional year of deductible leverage.

Enrollee risk profile and pricing (Changes)

The aggregate adjustment for projected changes in enrollee risk profile issues increased from 54.5% in the 2016 filing to 71.2% in the 2017 filing, primarily because of the projected increase in the Population Risk Morbidity:

URRT Adjustments from Experience to Projection Period					
2017			2016		
Population Risk	Other	Product	Population Risk	Other	Product
1.082	1.582	1.712	0.953	1.622	1.545

These adjustments are necessary because in both filings the composition of the pool that contributed experience to URRT Section I Allowed Claims PMPM was demonstrably and drastically different than the most likely composition of the future single risk pool being priced. We will comment on both adjustments below.

Population Risk Morbidity

Question 4 of Exhibit 1 documents the dialogue between Wellmark and Magnum concerning this pivotal assumption. The methodology is straightforward, actuarially sound, and similar to the one used for its 2016 filing. It projects the evolution of risk pool membership as the sum of three components - members in force at the end of 2015, members entering the pool via open enrollment in 2016 and 2017, and members entering the pool via special enrollment in 2016 and 2017. The pool morbidity is the exposure-weighted average of morbidity assumptions for each segment. This process came up short in the 2016 filing because the morbidity for each segment turned out to be higher than expected, especially for special enrollment members. For the 2017 filing, Wellmark assumed that demographic-adjusted morbidity from the initial group of members and new open enrollments would be the same as it was in 2015. The assumption for new special enrollments was much lower than the actual 2015 experience because Wellmark excluded $18 Million of 2015 allowed claims from one member in developing the assumption. Wellmark assumed that it would continue to pay 2017 claims on

this member at about 65% of the 2015 level, the reduction coming from applying global lapse rates in developing the population risk pool morbidity adjustment.

We concluded that the 8.2% adjustment is reasonable under the assumption that Wellmark will pay about $10.5 Million of claims on this member in 2017, but there is a wide range of uncertainty surrounding this assumption. See the section Extraordinary Actuarial Issue for more extensive discussion. It will show that anywhere within this range, Wellmark's request meets the IID's standard for reasonableness.

Other

The chart below compares the major components of the 2017 and 2016 Other adjustments:

	2017		2016	
	Adjustment	Factor	Adjustment	Factor
Treatment of different morbidity on ACA and transitional product members	64.3%	1.643	69.2%	1.692
Projected demographic changes	0.2%	1.002	-4.1%	0.959

- HHS has instructed companies to show the combined 2015 experience of ACA and transitional product business in URRT Section 1, even though the rates being developed are only for 2017 ACA business. Transitional product member morbidity (issued prior to the pricing restrictions in 2014) is much lower than ACA product member morbidity because those members were subject to underwriting. The adjustment shown above is greater than shown on the URRT because Wellmark provided more current data we used to cross check the calculation of the assumption.
- The 2017 and 2016 demographic changes were based on the straightforward estimate of best estimate age and sex factors (not unisex HHS-mandated pricing factors) to projected enrollment. We reviewed and validated these calculations.

The proposed rates are unisex and include a 15% tobacco usage load, which is unchanged from 2016. Wellmark is using the default HHS age factor slope of 3:1.

Prior trend misestimates

It is not possible to distinguish prior misestimates of trend and risk pool morbidity separately. Confidential work papers demonstrated that the 2016 filing under-estimated the combined impact of the two by 16.8% before taking into account the Member X claims discussed in the section below titled ***Extraordinary Actuarial Issue.***

Reserves (Changes)

Incurred claims include approximately 3.5% for IBNP reserves, down from the 11.1% for 2016. This decrease was attributable to including one more month of runout in this year's filing. There was no change to the actuarially sound methodology and level of reserves is reasonable.

Changes in QI costs (Changes)

There were no QI costs separately identified for 2017, or contained in the projected 2017 MLR. For 2016, these were 0.6% of premium.

Other administrative costs (Changes)

Administrative costs are shown as 7.2% of premium in Worksheet 1 of the URRT, or $46.33 PMPM compared to $43.25 PMPM (9.3% of premium) for 2016. These administrative cost levels are at the lower levels of industry practice.

Taxes, licenses and regulatory fees (Changes)

Because the ACA Health Insurer's Fee has been waived for 2017, the assumptions shown in the URRT and Actuarial Memorandum Table 3 decreased from 3.06% of premium and $14.17 PMPM in the 2016 filing to 1.03% of premium and $6.67 PMPM in the 2017 filing. This fee had been projected to be 2.02% of premium in the 2016 filing, so its absence accounts for the entire difference.

MLR

The Actuarial Memorandum states that the projected 2017 MLR is 89.7% compared to the 87.5% projected in the 2016 filing. This difference is almost identical the 2.1% of premium decrease in projected Administrative expenses. Wellmark did not include any QI expenses in its projected 2017 MLR, which would have made it slightly higher.

Capital and surplus

We review capital and surplus only to confirm that a company's solvency or insurance license would not be jeopardized by intentional or unintentional underpricing. According to Wellmark's December 2015 Annual Statement, capital and surplus was $1.3B and adjusted capital and surplus was 943% of the RBC Authorized Control Level. Projected 2017 Individual Market premium is $167M. At this time, we believe it would be unlikely for Individual Market underpricing to jeopardize Wellmark's capital and surplus position, even with an unprecedented run of large claims.

Geographic factors and variations

Wellmark is using four different geographic factors, ranging from 0.9624 to 1.0828, for the seven geographical regions in Iowa. The Company re-sloped and properly re-calibrated its geographic factors in 2017, capping any increase at 2.0%.

Aggregate and plan specific changes within single risk pool

For 2016, Wellmark had 18 plan offerings. Wellmark will be terminating seven plans, and adding three new plans, as shown in the URRT worksheet 2, resulting in a total of 14 plans being offered in 2017.

Reinsurance and risk adjustment payments and charges

In its 2016 Wellmark incorporated an estimated net reinsurance recovery worth $15.33 PMPM in its premium rate development process. Without this program, its 2016 rate request would have been 3.3% higher. 2016 is the last year for the ACA reinsurance program, so this source of rate relief will not be available in 2017.

Wellmark estimated that the 2017 risk adjustment recovery more than tripled from $33.46 to $107.34 PMPM. Without this program, its 2017 rate request would have been 16.6% higher. We reviewed the confidential and proprietary model Wellmark used to project, in concert, both the ACA risk adjustment recovery and the population risk pool morbidity change. The two assumptions should be strongly, but not perfectly, correlated. The model is actuarially sound and the results internally consistent. The increase in the estimated payment is consistent with the fact that Wellmark is projecting an 8.2% increase in population risk pool morbidity that was already higher than the market average. The fact that Wellmark's projected incurred claims are $296.08 PMPM larger than WHPI's ($682.86 versus $386.77) with almost identical average demographic adjustments is consistent with the $170.22 difference in the impact of the risk adjustment program (a recovery of $107.34 versus a payment of $62.88).

Extraordinary Actuarial Issue

As mentioned in the discussion of Population Risk Morbidity, in July 2015, a member generating an average of about $3 Million of **monthly** allowed claims joined the risk pool. In our nearly 80 years of combined experience, Magnum's two senior partners have never seen a claimant incur recurring costs this large. In this discussion, we will refer to him/her as Member X. ACA pricing guidelines and conventional actuarial practice provide little guidance to the "right" way of handling such a situation.

In the past, some companies would substitute a pooling charge for the actual claims over a pooling limit in the product pricing experience base. This mechanism would ensure that the company received revenue to cover all anticipated claims, while spreading the cost over all Individual and Group lines in all states. ACA provisions make applying this mechanism unadvisable and, in some respects, in conflict with regulations. For example, companies cannot attempt to have their Small Group or South Dakota business subsidize the Individual Market by increasing those premiums because it could force them to pay Small Group MLR rebates. Similarly, companies cannot use premiums from one state to subsidize another.

The ACA risk sharing and interim reinsurance programs provided minimal protection against this claim because:

- The reinsurance program had a cap of $250,000 of covered claims on one member and the program will not exist in 2017.
- No matter how sick, one member will have an immaterial impact on the risk score that determines the amount of the risk adjustment transfer, even if his or her claims have a material impact on financial results.

Without stronger, more flexible risk management mechanisms, unlimited lifetime benefits could jeopardize the survival of all but the largest health insurers and, as this filing demonstrates, compromise rate stability for members of companies even as large as Wellmark.

Wellmark has taken three steps to mitigate pricing distortions created by this claim:

- Excluding Member X claims entirely in developing the assumption for allowed claims PMPM from future special enrollment members. We agree that this is a sound, responsible approach,
- Including only six months of 2015 claims in the experience base for projecting 2017 claims, when a strong argument could have been made for annualizing the claim by doubling that amount,
- Applying global lapse rates that reduced the projected 2017 claims from this member to roughly 65% of the 2015 level. The mechanics of this approach are reasonable and actuarially sound, but we believe that a more transparent way of handling it would have been to state the assumption as an explicit dollar amount.

Magnum used Wellmark's data and proprietary worksheets to test an approach for handling this claim that we believe would increase transparency. We re-cast the numbers to create proforma projections as if this member had not joined the risk pool. That process revealed several surprises:

- It convinced us that the proposed 9.0% allowed claims trend assumption was being distorted by this one very large claim. We have assumed a 7.3% allowed claims trend assumption in our pro forma development.
- It demonstrated that, even without this claim, morbidity on special enrollment members was very high, much higher than Wellmark had estimated in the 2016 filing.
- The ratio of 2015 ACA only morbidity to total URRT pool morbidity decreased from 158.2% to 148.1% without Member X.
- Without Member X claims the 2015 starting point and projected 2017 allowed claims PMPM would be lower, but the % increase, the adjustment Population Risk Morbidity on the URRT would be larger, 1.123 versus 1.082. It suggested that if we believed this member would not generate any 2017 claims, the appropriate rate increase would be 32.7%, not 42.6%.

Based on what Wellmark could share with us without violating HIPAA restrictions, we feel the Company is justified in expecting very high 2017 claims from this member. The important question is "What is a reasonable level to assume for pricing?" The member submitted $18.2 Million of allowable claims during the last six months of 2015 and $9.1 Million during the first four months of 2016. The table below demonstrates two possible implications of Member X claims on the rate request issue:

- The first column shows how the rate increase request necessary to attain the target 89.7% MLR varies based on assumed Member X claims. For example, if the assumption were $12.5 Million, which is well below the current claim run rate, the "right" increase would be 43.4%, a little higher than the current request.
- The second shows how the projected MLR under the requested 42.6% increase varies based on assumed Member X claims. For example, even if Member X lapsed prior to 2017, the projected MLR would be 83.5%, which is above the 80% MLR rebate threshold.

Member X 2017 Allowed Charge Assumption	Rate Increase Required *(1)*	Projected MLR *(2)*
$ -	32.7%	83.5%
$ 2,500,000	34.9%	84.8%
$ 5,000,000	37.0%	86.2%
$ 7,500,000	39.1%	87.5%
$ 10,000,000	41.3%	88.9%
$ 12,500,000	43.4%	90.2%
$ 15,000,000	45.5%	91.5%
$ 17,500,000	47.7%	92.9%
$ 20,000,000	49.8%	94.2%
$ 22,500,000	51.9%	95.6%
$ 25,000,000	54.1%	96.9%
$ 27,500,000	56.2%	98.2%
$ 30,000,000	58.3%	99.6%
$ 32,500,000	60.4%	100.9%
$ 35,000,000	62.6%	102.3%

(1) Increase necessary for target 89.7% MLR

(2) Under requested 42.6% increase

Rate Reasonableness

By law, there are three criteria - non-discriminatory, justified, not excessive or inadequate.

Non-Discriminatory

The proposed rates adhere to ACA constraints on rating differences by age, sex, tobacco usage, and geography, therefore are not discriminatory.

Justified

The first test we used to ensure rates are justified is to confirm Wellmark followed the appropriate rate development process as defined in the Part III instructions and shown below:

Sections XIII to XVII of the Actuarial Memorandum illustrated and described all steps as noted above. Magnum was able to follow all steps and confirm the calculations.

The second test was to compare the CAIR rates, calculated for both 2016 and 2017 using the process listed above, with the expectation that the differences would reflect the plan specific rate increases for each of the plans in existence for both 2016 and 2017, as detailed in the Actuarial Memorandum. Based on the chart below, we calculated the average effective rate increase of 42.5%, not the 42.6% shown in the Actuarial Memorandum, even though the individual plan % increases were identical, except for rounding.

				Rate Increase	Member	Rate Increase
2017 Plan Name	Plan ID	2016 CAIR	2017 CAIR	CAIR % Change	Months	per AM
BlueSimplicity Bronze HSA PPO	72160IA0170001	$402.64	$567.73	41.0%	29,331	41.0%
BlueSimplicity Silver HSA PPO	72160IA0170002	$451.87	$643.64	42.4%	34,166	42.4%
SimplyBlue 5500 PPO	72160IA0180002	$367.82	$524.41	42.6%	12,320	42.6%
CompleteBlue 3000 PPO	72160IA0190002	$457.80	$658.79	43.9%	39,231	43.9%
EnhancedBlue 1250 PPO	72160IA0200002	$517.61	$736.66	42.3%	34,422	42.3%
CompleteBlue Silver 4200 PPO	72160IA0210001	$492.86	$713.04	44.7%	15,177	44.7%
CompleteBlue Silver 3100 PPO	72160IA0210002	$453.15	$656.89	45.0%	13,072	45.0%
myBlue HSA Silver 4000 PPO	72160IA0220001	$479.32	$672.66	40.3%	20,343	40.3%
myBlue HSA Bronze 6500 PPO	72160IA0220002	$407.47	$567.22	39.2%	10,706	39.2%
EnhancedBlue Gold 1500 PPO	72160IA0230001	$537.11	$761.14	41.7%	21,492	41.7%
SimplyBlue Bronze 5600 PPO	72160IA0240001	$379.95	$550.93	45.0%	12,174	45.0%
BlueSimplicity Bronze PPO	72160IA0250001	New Product			2,254	New Product
BlueSimplicity Silver PPO	72160IA0250002	New Product			7,177	New Product
BlueSimplicity Gold PPO	72160IA0250003	New Product			6,297	New Product
Exposure Weighted Average of % Increases				42.5%		42.6%
Premium Weighted Average of % Increases				42.5%		

The third test to ensure the actual premium rates are justified is the ability to tie the *Single Risk Pool Gross Premium Avg. Rate, PMPM* of $647.97 from the URRT to the actual premium rate schedules supplied with the rate filing (Rate Table Template). From the details as provided in the Actuarial Memorandum and responses to the questions posed by Magnum, we were able to reconcile the Calibrated Plan Adjusted Index Rates to the rates as provided in the Rate Data Template, and therefore we were able to confirm the rates are accurate.

The final premium rates are therefore deemed appropriate and reasonable.

Not Excessive or Inadequate

The discussion and charts in the section ***Extraordinary Actuarial Issue*** demonstrate that is extremely unlikely that Wellmark could see an MLR less than 80% under the requested 42.6% increase and virtually impossible that losses could impair capital and surplus position materially.

Consequently, we conclude that under the law and regulations, the requested rates are not excessive or inadequate.

Conclusion

Wellmark is proposing an average rate increase of 42.6% for its suite of ACA-compliant Individual Market medical products, along with the addition of four new plans, effective January 1, 2017.

This filing, in conjunction with Wellmark's responses to supplemental questions:

- Complied with HHS Instructions
- Used appropriate data and reasonable assumptions in implementing a single risk pool under ACA market reforms
- Provided adequate explanation and documentation of the factors must be examined under an effective rate review

Based on our review of this material we find that the proposed rates are adequately justified, not discriminatory, not excessive, and not inadequate. We recommend approval.

Exhibit 1

1st Set of Magnum Questions/Requests
Wellmark Responses Received 6/27/2016

We recognize that Wellmark's large rate increase request, an average of 42.6%, is being driven primarily by the difference between the 118.1% ACA product loss ratio for CY 2015 shown in the Assister file and the 88.9% target shown in the 2017 URRT.

1. **Magnum Question -** The Trend Pre-ACA tab of the Assister file does not differentiate between grandfathered and transitional product experience, so we cannot reconcile to the 113.3% loss ratio shown on the 2017 URRT and AM. Please provide an additional Assister tab, in "Trend" format, that details only transitional product experience.

   Wellmark Response - *Provided in the attached Excel spreadsheet WI Individual Assister File - GF-NGF Split Out.xlsx.*

   Magnum Comments – The revised Assister file had more complete and current claims experience that demonstrated a loss ratio higher than 113.3%.

2. **Magnum Question -** The 2016 Actuarial Memorandum (AM) described the assumptions the company made leading to rate requests with a projected loss ratio of 85.2%. The 2017 AM describes a nearly identical actuarial methodology and assumption set. Please demonstrate which assumptions had material variances in 2015 and their impact.

   Wellmark Response - *This isn't as straight forward to demonstrate, as the 2016 AM projected 2016 experience and this filing is projecting 2017, while only 2015 is available. However, higher claims experience than expected was seen in 2015. The attached file 2016 vs 2017 Assumption Comparison – Obj Response 1b.xlsx compares the assumptions with the largest variances between the filings with explanations.*

   Magnum Comments – We did not phrase this question as well as we hoped, so their response did not address what we were trying to ask. Supplementary confidential exhibits they submitted in support of the 2016 filing showed a detailed projected year by year progression of experience from 2014-2016. The 2015 experience used to develop the 2017 rate request was much worse than they had projected a year earlier. We were asking why. Exhibits Wellmark provided in response to other questions allowed us to answer this one for ourselves. The 2015 risk pool was comprised of carryover from 2014, members entering via Open Enrollment and members entering via Special Enrollment. Carryover and Open Enrollment morbidity

was within 10% of expected, but Special Enrollment morbidity was more than twice expected.

3. **Magnum Question -** Please describe any material changes to the process and assumptions Wellmark used to set IBNP reserve estimates.

   Wellmark Response - *The process to set our IBNP assumptions is the same as what was done in the previous rate filing. Completion factors were also created using paid claims data through the end of February, similar to our prior year filing.*

   Magnum Comments – We verified and cross checked this process last year and found it consistent with industry best practice. The size of the IBNP reserves used to complete 2015 incurred claims was consistent with our expectations and the range of potential error immaterial in the overall rate calculation.

4. **Magnum Question -** Similarly, please describe and demonstrate any material changes to the process used to project the change in population risk morbidity from the experience period to the pricing period and provide the work papers supporting the projected 8.2% increase in this assumption.

   Wellmark Response - *The process used to calculate the projected 8.2% morbidity assumption is similar to our prior filing. We analyzed historical open enrollment experience as well as special enrollment experience to project future open enrollment and special enrollment period experience. The special enrollment period data for 2015 had an outlier; however, this member's data was removed for projecting future special enrollment period experience. This outlier will be addressed more in objection 8. Demographic adjusted allowed claims for members new to Wellmark during a special enrollment period in 2015 were $1,429 pmpm. After removing the outlier member, this experience decreased to $1,007 pmpm; which is the same number used in our projections for 2016 and 2017 special enrollment periods for members new to Wellmark. This increased morbidity assumption also led to an increased risk adjustment receivable assumption which is also provided in the attached Excel spreadsheet Morbidity Work Papers – Obj Response 3.xlsx.*

   Magnum Comments – These work papers demonstrated projections of risk pool morbidity and the ACA risk adjustment. We reviewed these work papers closely and found them actuarially sound, appropriate, and internally consistent. The methodology they used assumed that they would continue to pay claims on the outlier added to the pool in 2015, but would not add any new outliers.

5. **Magnum Question -** Please provide the work papers supporting the transitional product adjustment component of the 58.2% Other Adjustment.

   Wellmark Response - *Provided in the attached Excel spreadsheet Other Adjustment – Obj Response 4.xlsx.*

   Magnum Comments – The more current data Wellmark provided would have supported a larger adjustment than 58.2%., which would have resulted in a larger requested rate increase.

6. Last year Wellmark assumed 5.0% annual allowable charges trend. This year it proposes using 9.0% as a best estimate based on three data sources.

   a. **Magnum Question -** Annualized PMPM increases of 9.5% and 7.7% on members continuously enrolled for one and two years ending 12/2015, respectively. Wellmark either did not conduct or report the results of a similar analysis last year. The Actuarial Memorandum states that "the impact of aging was removed." What demographic factors did you use to make this adjustment?

      Wellmark Response - *You are correct, we did not conduct this analysis last year. This is the first year that we have two years of claims experience and can consider trend for this risk pool. However, since there is significant member movement, comparing the last two years of total experience isn't a good determination of secular trend. We therefore evaluated the change in claims for the same set of continuously enrolled members in both periods. To remove the impact of aging from trend, we adjusted for the change in demographic factors. We looked at using both CMS demo factors as well as Wellmark gender/age specific demo factors for this purpose. The CMS demo factors came up with about 2.8% for the aging impact, while the Wellmark demo factors came up with about 2.3%. The 2.8% factor was the one used to produce the 9.5% and 7.7% trends above. Using the Wellmark demo factors for adjusting age would have actually produced higher trend amounts. The work papers are provided in the attached Excel spreadsheet Trend – Obj Response 5a.xlsx.*

      Magnum Comments – The reliability of conventional methods for measuring what trend has been in the past depend on whether the risk pool morbidity has been reasonably homogeneous during the measurement period. The approach Wellmark describes is one appropriate way of enforcing the homogeneity condition.

b. **Magnum Questions –** 8.5% corporate trend assumption that Wellmark is using for fully insured large group business. Last year that assumption was 7.2%. Please describe/present the development of that assumption.

Wellmark Response - *The 8.5% build-up is shown in the attached Excel spreadsheet Trend – Obj Response 5b.xlsx. The 8.5% is derived from a combination of observed Wellmark claims trend for group business as well as forecasted claims trend for group business.*

Magnum Comments – Large blocks of Group business tend to have reasonably homogeneous morbidity from year to year, so they can also provide a credible yardstick. However, the 8.5% Wellmark cites is the weighted average of a 6.0% assumption that is based on historical data and a 9.3% assumption that Wellmark describes only as a forecast, with no documentation of its basis.

c. Magnum Question: The 4%-12% range suggested in the Milliman 2016 Health Care Guidelines. Wellmark's 2016 Actuarial Memorandum reported that range to be 4% to 11%.

Wellmark Response - *Milliman let us know that the top end of their range increased from 11% to 12%.*

d. Magnum Question: One of the three supporting data points, corporate trend, increased 1.3%. Another data point, based on Milliman HCG's, increased approximately 1.0%, depending on where one lands in the range. Yet, Wellmark proposes a 4.0% increase in trend, to 9.0%, at a level that seems to be closer to the high end than the mid-point of its most directly relevant set of data points. Please provide any additional evidence or commentary that would support such a large increase in assumption.

Wellmark Response - *Correct, we are closer to the top end of relevant data points. The experience of this block of business just witnessed a 14.4% increase in allowed claims from the 2014 experience period used in the prior year filing to the 2015 experience period used in this filing. As indicated in our response to objection 1b, the 5% trend assumptions in prior filings was too low which resulted in the high loss ratios we've been experiencing. Our combined trend and morbidity assumptions better reflect the actual experience of this population. There are no indications leading us to believe that this will improve. If anything, it could continue to increase.*

Experience Period is 14.4% higher for this filing than last year's filing. Assumption for morbidity and/or trend was too low in the prior year filing.

We are experiencing higher trends than originally anticipated. Historically in our individual market we've experienced trends around 9% annually but around 4%-5% in small group. We originally thought trends for this guarantee issue block of business would be similar to what we've experienced historically in our small group guarantee issue block of business. We were mistaken.

Magnum Comments – The 14.4% metric Wellmark cites includes the combined effect of trend, risk pool morbidity changes, and demographic changes. To isolate trend, one should start with demographically adjusted allowed claims, which increased between 17.9% and 18.5%, depending on whether the projection was performed with the CMS or Wellmark adjustments. This increase included roughly $18 Million of allowed claims on the one member discussed in the section Extraordinary Actuarial Issue. Without that member the combined effect of risk pool morbidity changes and pure trend would have been 1.067%. The risk pool morbidity component of this pro forma change was 3.7%, which would have implied pure trend of only 2.9%.

We are also had discussions with Wellmark concerning several non-ACA Individual filings in which durational underwriting wear off clouded analysis of trend. In a filing for a product which had experienced more homogeneous morbidity, Wellmark assumed incurred claims trend of 10.0%, which included both allowed claims trend and deductible leverage. As mentioned in the Trend discussion, Wellmark's average plan deductible leverage factor on this product is 2.53%. Combined with the 10.0% incurred claims trend assumption, the implied allowed claim assumption would be 7.3%.

7. **Magnum Question -** Please provide the work papers supporting the development and application of the cost sharing induced utilization adjustments in Table 4 AV Cost Share column.

   Wellmark Response - *Provided in the attached Excel spreadsheet Table 4 Detail – Obj Response 6.xlsx. Please provide the work papers supporting the development and application of the cost sharing induced utilization adjustments in Table 4 AV Cost Share column.*

The build-up of the cost sharing induced utilization adjustments by plan are shown in the attached Excel spreadsheet Table 4 Utilization – Obj Response 7.xlsx. More recent data was used to recreate a regression formula, which was the same process used to create our prior induced utilization factors. The updated data was creating a significant change from the prior utilization factors. Therefore, we decided to only apply half of the difference in the factors to existing plans. This will allow for a smoother transition to more appropriate factors for existing members. There are three new plans for 2017 which do not have any members on them. It was decided to use the new regression formula for these plans in determining their utilization factors. Again, a calibration is required to adjust the overall assumed utilization to 1.0. Any assumed utilization change for the block must be placed in the "Other Adjustment" portion of the rate calculation.

8. **Magnum Question -** The Des Moines Register reported that Wellmark EVP claimed that "*about 10 percentage points of the increase stem from the costs of a single, extremely complicated patient who is receiving $1 million per month worth of care for a severe genetic disorder.*" Was that claims on a member with an ACA, transitional, or grandfathered plan? How did Wellmark handle it in calculating its rate increase requests?

   Wellmark's Response - *This member is currently enrolled on an ACA Individual policy with Wellmark Inc. This member's claims are included in the 2015 experience period. Monthly paid claims for this individual are provided in the attached Excel spreadsheet Large Claimant – Obj Response 8.xlsx. Based on our review of the situation, it is expected that payments of this magnitude will continue through the 2017 rating period. Because, this member came enrolled effective 7/1/2015, only about half a years' worth of claims are included for this member in the experience period. An entire year's worth of this member's claims is included in the morbidity adjustment factor. By taking a look at the Excel spreadsheet Morbidity Work Papers – Obj Response 3.xlsx this is why you see the morbidity factor of 8.1% for the change from CY 2015 to CY 2016, but then 0% for the change from CY 2016 to CY 2017. Since this member is an outlier to the Wellmark's SEP member experience, this member was removed from that experience when projecting the impact of future SEP business.*

Exhibit 2

Effective Rate Review Checklist

The State's rate review process includes an examination of:

- *The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions.*
- *The health insurance issuer's data related to past projections and actual experience.*
- *The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.*
- *The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.*

The examination must take into consideration the following factors to the extent applicable to the filing under review:

- *The impact of medical trend changes by major service categories.*
- *The impact of utilization changes by major service categories.*
- *The impact of cost-sharing changes by major service categories, including actuarial values.*
- *The impact of benefit changes, including essential health benefits and non-essential health benefits.*
- *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 Service Act.*
- *The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.*
- *The impact of changes in reserve needs;*
- *The impact of changes in administrative costs related to programs that improve health care quality;*
- *The impact of changes in other administrative costs;*
- *The impact of changes in applicable taxes, licensing or regulatory fees.*
- *Medical loss ratio.*
- *The health insurance issuer's capital and surplus.*
- *The impacts of geographic factors and variations.*
- *The impact of changes within a single risk pool to all products or plans within the risk pool.*
- *The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.*