

NON-CONFIDENTIAL

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

IN RE:)	
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)	
AETNA HEALTH INC. (ME) 2017 "WHOLE)	PRE-FILED TESTIMONY
HEALTH" INDIVIDUAL RATE FILING)	OF WILLIAM J. SWACKER
)	
Docket No. INS-16-1001)	JULY 15, 2016
)	

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1 **Q. Mr. Swacker, please state your name and your position with Aetna.**

2

3 A. My name is William J. (“Trey”) Swacker. I am an Actuarial Sr. Director at Aetna,
4 overseeing the team responsible for commercial medical pricing across New England, New York
5 and New Jersey.

6

7 **Q. Please describe any relevant education or experience that qualifies you as a witness**
8 **today.**

9

10 A. I am a Fellow of the Society of Actuaries and a Member of the American Academy of
11 Actuaries. I have been with Aetna since 2014, supporting commercial medical pricing across
12 large group, small group, and individual. I am currently the Healthplan Actuary for the
13 Northeast Territory, and previously supported the Ohio/Kentucky market.

14 Prior to joining Aetna I spent twelve years at Cigna in roles of increasing responsibility.
15 My responsibilities included large group medical pricing, new product pricing, reserving,
16 financial analysis and forecasting.

17 I have a Bachelor of Science degree in Mathematics from Bellarmine University in
18 Louisville, Kentucky.

19

20 **Q. Please state your reasons for testifying at this hearing.**

21

22 A. I am testifying at this hearing in support of Aetna’s Individual rate filing for its Individual
23 Aetna Whole Health HMO plans to be effective January 1, 2017. As detailed in our filing,

1 Aetna’s proposed Maine Individual Portfolio for 2017 contains several plans – including four
2 new plans with the Leap designation, and others with the Whole Health designation. I am
3 providing an overview and recap of Aetna’s filings relating to actuarial issues.

4
5 **Q. Were others at Aetna involved in putting together the actuarial elements of the**
6 **filing? And please provide relevant background.**

7
8 A. Yes. Key among those involved in putting together the actuarial elements of the filing
9 were Geoffrey S. Shannon and Jennifer Juke. Geoff is an Associate of the Society of Actuaries
10 and a member of the American Academy of Actuaries. He started his actuarial career at Aetna in
11 July 2006 and has experience in various facets of health insurance, namely Pharmacy, Medicare,
12 and Medical Economics, through Aetna’s Leadership Development rotational
13 program. Currently he is an Assistant Actuary for the New England market, servicing the
14 Individual, Small Group, and Large Group market sizes over the past two years. Geoff holds a
15 BS in Chemical Engineering and a MS in Actuarial Science from the University of Connecticut.
16 Jennifer currently oversees pricing for Aetna’s New England market. This includes the
17 Individual, Small Group, and Large Group markets, as well as reserving, forecasting, and new
18 product pricing. She has supported the Actuarial needs of the New England markets for the past
19 15 years, prior to which she spent 12 years underwriting Aetna’s National Accounts. She is a
20 graduate of Connecticut College with a BA in Anthropology.

21
22 **Q. Please provide an overview of the elements of Aetna’s “Whole Health” Individual**
23 **Rate filing.**

1 A. Aetna's comprehensive filing, received by the Bureau on May 10, 2016, contains several
2 constituent elements. They are as follows:

3 Section A – Historical Experience & Trend

4 Section B – 2017 Index Rate Development exhibits

5 Section C – 2017 Premium Rate Manual exhibits

6 Section D – 2017 Benefit Plans & Actuarial Value Calculation exhibits

7 Section E – URRT Part I & III and supporting documentation.

8 We have now also responded to: (1) the Superintendent's First Information Request in
9 our Responses dated June 9, 2016, (2) the Superintendent's Second Information Request in our
10 Responses dated June 28, 2016, (3) the Superintendent's Third Information Request in our
11 Responses dated July 1, 2016, and (4) the Superintendent's Fourth Information Request in our
12 Responses dated July 15, 2016. Additionally, we have responded to the Superintendent's Second
13 Order Regarding Rate Revisions on July 14, 2016. Please note also that a revised rate filing was
14 submitted on July 15, 2016.

15

16 **Q. Please provide your current In-Force Business (the Aetna Whole Health plans) and**
17 **Annualized Premiums and Average Premium under Aetna's current rates.**

18

19 A. Current membership is 639 members, with an annualized premium of \$2,380,217. This
20 converts to an annual average premium per Individual policy of \$6,486 and per member of
21 \$3,725.

22

23

1 **Q. In what parts of the State will Aetna's Individual plans be available?**

2

3 A. In 2017, Aetna's Individual plans will be available in the same counties as they are in
4 2016: York, Cumberland, Sagadahoc, Franklin, Knox, Lincoln, Oxford, Androscoggin and
5 Waldo.

6

7 **Q. Could you summarize the annual rate increases Aetna seeks in this filing?**

8

9 A. The average annual rate increase reflected in the revised rate filing, submitted July 15th, is
10 15.6%, with a minimum rate change of 14.0% and a maximum rate change of 17.0%. These rate
11 changes do not include the impact of individual-specific aging nor movement between
12 geographic rating areas. The primary drivers of the 15.6% average increase are as follows:

- 13
- 8.4% for Annual Incurred Claim Trend
 - 14 • 6.2% for Discontinuance of the Federal Reinsurance Program
 - 15 • 5.5% for Risk Adjustment assumptions
 - 16 • -4.5% to Expenses, primarily due to the 2017 Health Insurer Fee suspension

17

18 **Q. What is the history of rate adjustments for Aetna's Individual offerings in Maine?**

19

20 A. Aetna's Individual offerings in Maine were new as of January 1, 2015; the rate
21 adjustment as of January 1, 2016 was +0.5%.

22

23

1 **Q. On what bases were the rates in this filing developed?**

2

3 A. The basis for the development of rates in this filing is a blend of calendar year 2015
4 experience, paid through March 2016, for Aetna’s Maine Small Group and Individual segments.
5 This experience is adjusted for the specific geography, benefit, and network features inherent in
6 the proposed Individual Whole Health Leap plans, and for certain demographic and morbidity
7 differences between the existing Small Group and expected Individual populations.

8

9 **Q. Could you comment on the Morbidity Basis utilized and projected risk relative to**
10 **the market?**

11

12 A. The morbidity basis for this rate filing is the actual 2015 experience results for Aetna’s
13 off-Marketplace Individual offering in Maine, blended with existing non-grandfathered Small
14 Group PPO and Whole Health business, as shown on the “Historical Experience” exhibit in
15 Section A. This blending is necessary as Individual membership for 2015 was only roughly 10%
16 credible with just over 200 members.

17 As outlined in the revised Section B of the filing, Small Group results have been adjusted
18 by 1.039 to reflect expected morbidity differences between the existing Small Group and
19 Individual populations.

20 Further, we are projecting an additional 2.5% deterioration to morbidity between 2015
21 and 2017. This adjustment is the result of data not available at the time of the initial filing,
22 including the June 30th publication by CMS of 2015 Risk Adjustment and Transitional

1 Reinsurance results and the entrance of Anthem’s Grandfathered and Transitional membership
2 into the ACA market as of January 1, 2017.

3 In regards to Risk Adjustment, Aetna is projecting a risk adjustment payable of \$19.13
4 PMPM, or approximately 5% of projected premium. This is based on an analysis of the risk
5 profile of business that Aetna Whole Health plans have attracted in other states relative to the
6 market average risk pool.

7

8 **Q. Could you comment on the impact to the 2015 underwriting gain and loss ratio due**
9 **to the CCHIO report on actual Risk Adjustment and Transitional Reinsurance amounts for**
10 **2015? How did this compare to projections in your 2015 pricing?**

11

12 A. Incurred Claims in relation to Premiums paid for calendar year 2015 result in a Medical
13 Benefits Ratio (MBR) of 78.5%. This MBR changes to 92.9% when incorporating 2015 Risk
14 Adjustment and Transitional Reinsurance true-ups. Given that Aetna only had an average 210
15 members enrolled during calendar year 2015, this information did not impact the 2017 rate
16 projection.

17

18 **Q. Could you comment on the medical trend assumptions that were utilized for 2017**
19 **and differences compared to observed trend?**

20

21 A. Please refer to Section A, “Maine Historical and Projected Trends” exhibit to view
22 Commercial Group trend for 2015.

1 The historical breakdown of unit cost and utilization is based on actual provider billing
2 and claim payment practices. Over time, they are subject to fluctuations for several reasons
3 including: changes in provider billing practices, changes in claim payment practices, and shifts
4 in the mix of services and procedures delivered by the medical profession. These unit cost and
5 utilization trends should not be viewed in isolation nor should they be compared to other external
6 data sources or views of market-based price and utilization changes.

7 Projected trend used in pricing utilizes historical trend results only for reasonability.
8 Future pricing trend is developed by analyzing a variety of considerations, such as:

- 9 • Historical anomalies, such as extreme winter weather or a severe flu season;
- 10 • Credibility of a Market versus regional and national indicators/results;
- 11 • Anticipated changes in provider contracts and network changes;
- 12 • The introduction and use of new technology;
- 13 • Economic conditions;
- 14 • Formulary changes;
- 15 • Patent expirations;
- 16 • New pipeline drugs;
- 17 • Other general market share shifts; and
- 18 • The influence of these on member utilization

19 Specific to the differences between actual 2015 trend and projected 2017 trend, the
20 following should be noted:

- 21 • Managing inpatient hospital use is an important part of containing overall healthcare
22 costs. As a situation allows, members are encouraged to instead access care in
23 outpatient settings. However, given historical Inpatient utilization, we believe the

1 2015 utilization of -12.8% to be an anomaly and expect future utilization to be about
2 1%.

3 ○ The decrease to Outpatient utilization, which is made up of ambulatory and
4 emergency services as well as diagnostic services (x-ray and lab), is also not
5 considered sustainable, especially as economic indicators continue to improve.

6 Similar to Inpatient, we would expect Outpatient use to rise about 1% in Maine
7 for 2017 versus 2016. In comparison, national Outpatient utilization is
8 approaching 5% annually.

9 ○ Pharmacy unit cost trend results for 2015 were driven by the high generic
10 utilization specific to Maine. Continuing conversion from brand to generic
11 medications offset the increasing impact of Specialty medications, which
12 currently total over 40% of overall pharmacy costs. However, given the few
13 brand medicines projected to lose patent security in the near future, Aetna's unit
14 cost trend for 2017 reflects this increasing Specialty impact against a leveling-off
15 of brand-to-generic conversion.

16
17 **Q. Please address the manner in which the filing reflects Maine versus national**
18 **experience.**

19
20 A. Only experience from 2015 Maine Individual members and non-grandfathered Maine
21 Small Employers has been used to calculate Maine 2017 Individual rates. National experience
22 was not utilized. Please refer to the "Maine Historical Experience" exhibit in Section A for the
23 experience data, by legal entity.

1 **Q. How does your filing reflect the actuarial value of the various plan levels?**

2

3 **A.** In our filing, Section D – 2016 Individual plans and actuarial value exhibits provides
4 2017 benefit summaries and corresponding actuarial value results. Further detail on this is set
5 forth within our Supplemental Actuarial Memorandum.

6

7 **Q. Please provide a narrative explanation and quantitative derivation of the Plan**
8 **Design Adjustments in Exhibit E-2. Do these adjustments reflect differences in utilization,**
9 **differences in cost-sharing, or both? If both, please provide each separately.**

10

11 **A.** While HHS identifies an expected average utilization by metallic tier, actual plan design
12 utilization across a tier can vary significantly given the array of cost-sharing possible within the
13 plus or minus 2% Actuarial Value range.

14 Aetna's benefit pricing model is used to determine the impact of this induced utilization.
15 This is the same model used to develop the expected paid to allowed ratios. This model reflects
16 Aetna's actual national book of business large group data, balanced for credibility and adjusted
17 to recognize regional relative cost differentials and differences in distribution and use of services,
18 as well as the impact of specific benefit mandates, morbidity by cost-sharing, network-level
19 contractual agreements, and steerage within state-specific products. After these normalizations
20 we deem any other utilization impacts besides those induced by cost-sharing to be immaterial.

21 The derivation of the Plan Design Adjustments begins with the Pricing Relativities with
22 Utilization and Paid to Allowed ratios shown in the table below:

23

24

HIOS ID	Plan Name	Paid : Allowed	Pricing Relativity with Utilization
73250ME0070003	CB ME AWH Gold	0.781	1.164
73250ME0070006	CB ME AWH Silver Everyday Plus	0.748	0.899
73250ME0070005	CB ME AWH Silver Everyday	0.719	0.809
73250ME0070001	CB ME AWH Bronze	0.676	0.693
73250ME0070002	CB ME AWH Catastrophic	0.673	0.687
73250ME0040006	ME Aetna Whole Health Gold \$5 Copay PD	0.779	1.182
73250ME0040007	ME Aetna Whole Health Silver \$10 Copay PD	0.672	0.821
N/A	Anchor Base Plan	0.745	0.915

1
2

3 To convert from Aetna’s internal pricing model outputs to the Plan Design Adjustment
4 values, the following calculations are performed:

5

6 Step 1 – Calculate the Implicit Induced Utilization by benefit plan incorporating a socialized
7 CSR impact of 3.0%:

8 *(Pricing Relativity with Utilization / (Paid to Allowed / Anchor Plan Paid to Allowed)) **

9 *Socialized CSR Impact = Implicit Induced Utilization by plan.*

10

11 Step 2 – Normalize the overall projection to an Implicit Induced Utilization of 1.0:

12 *Sum the product of each plan’s Implicit Induced Utilization by each plan’s projected*

13 *Member Months and Paid to Allowed values to derive a weighted average of 1.0.*

14

15 Step 3 – Identify specific utilization adjustments reflecting the specific benefits and cost-
16 sharing features of each plan:

1 *Divide by the normalized HHS Metal Utilization and Socialized CSR Adjustments. This total*
2 *value by plan is displayed in the bottom section of Exhibit E-2 in the column “Utilization*
3 *Adjustment”.*

4

5 These three steps derive the Normalized Plan Design Adjustments.

6

7 **Q. Does the filing address prohibited rating practices?**

8

9 A. Consistent with Title 24-A, § 2736-C, 2.B, 2.C and 2.D, PPACA requires that Individual
10 health plans are guaranteed issue and guaranteed renewal. We have clarified in our response to
11 Question 1 in our June 28, 2016 Responses to the Superintendent’s Second Information request,
12 the manner in which guaranteed renewal is satisfied. In addition, the rates in this filing will not
13 be medically underwritten, nor will the premium level vary due to the gender, health status,
14 claims experience, nor policy duration.

15

16 **Q. How does this filing address permitted rating attributes?**

17

18 A. As established under PPACA and corresponding regulation, the allowable rating
19 variables applied to Individuals for 2017 consist of:

20

- The age of each member;

21

- Tobacco usage for each member;

22

- An area adjustment based upon the Individual’s residence;

23

- The relative value of the benefit plan chosen.

1 Further details on rate development and the rating factors associated with these variables
2 can be found in Section C, Premium Rate Manual exhibits. They are in compliance with the
3 permitted rating rules in Maine, as laid out in Title 24-A, § 2850-B, 3.

4
5 **Q. How does Aetna’s filing align to the Minimum Loss Ratio Requirements (MLR)?**

6
7 A. Our revised Supplemental Actuarial Memorandum and Certification provides a detailed
8 calculation of the “Pure” Medical Loss Ratio and estimated Federal MLR, and the underlying
9 expenses and percentages involved.

10 We have calculated the “pure” medical loss ratio to be 81.8%, which converts to a
11 Federal MLR of 87.65%. These adjustments took into account quality improvement expenses,
12 and took out the elements for federal and state taxes and fees. Under the ACA, at least 80% of
13 the premiums collected by health plans are expected to pay for medical care and activities that
14 improve health care quality for members. If the actual MLR turns out to be less than 80%,
15 rebates will be issued to members in accordance with the law.

16 Please note that this calculation is an estimate only, as it does not account for potential
17 MLR rebates, credibility adjustments, or Risk Adjustment program results.

18
19 **Q. Are the proposed rates excessive, inadequate, or unfairly discriminatory?**

20
21 A. In my judgment, the rates submitted for approval are not excessive, inadequate, nor
22 unfairly discriminatory.

1 **Q. Does this conclude your pre-filed testimony?**

2

3 A. Yes. I also welcome the opportunity to respond to questions at the July 22 Hearing.

4 Joining me to respond to questions on actuarial issues will be Geoffrey S. Shannon who has

5 worked with me on this pre-filed testimony and on the Aetna submissions.

6

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

IN RE:)	
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AETNA HEALTH, INC. 2017 “WHOLE HEALTH” INDIVIDUAL RATE FILING)	CERTIFICATE OF SERVICE
)	
Docket No. INS-16-1001)	
)	

The undersigned counsel hereby certifies that on this date, I caused to be mailed by electronic mail, copies of the Pre-Filed Testimony of William J. Swacker on the persons and at the addresses indicated below.

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DATED: July 15, 2016

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