Evergreen Health Cooperative, Inc.
Preliminary Rate Justification
2017 Individual Commercial Products

1. Scope and Range of the Rate Increase

Evergreen Health Cooperative (EHC) is increasing premium rates for individual plans by 8.8% in aggregate (broken out by product: 8.1% for the HMO Open-Access, 10.6% for POS, and 7.4% for Select). A subscriber's actual rate could be higher or lower depending on the benefit plan and product selected, age of the subscriber, and dependent coverage. There are 11,799 members enrolled in these products as of March 2016, who are affected by the increase.

2. Financial Experience

As of the time of this rate request, there is one full year of 2014 and 2015 experience data and limited 2016 experience data available. Due to the very low enrollment in individual products in 2014, the 2014 experience was deemed not credible and not used as the basis for 2017 rate development. Rates for 2017 are based on a combination of the 2015 experience data and external claims data sources. We have assigned 64.6% credibility to experience data in pricing 2017 products, due to the quantity of enrollment in that year, 48,602 member months. We have considered experience in developing assumptions surrounding anticipated plan mix, demographics, and enrollment.

For calendar year 2015, EHC has paid medical and prescription drug claims of $12,881,308, which is approximately equal to $265.04 per member per month (PMPM). Under the ACA, premiums are set based on the expected health status of the entire market, not of EHC's own enrollees – so low costs for EHC do not directly translate into rate decreases.

The proposed rate increase is expected to produce a medical loss ratio (MLR) of 84.1%. It should be noted that the projected MLR meets the minimum requirement of 80.0% as defined in the Affordable Care Act (ACA). If the actual MLR were to fall below this level (such as if actual claim costs turn out to be lower than expected), DHMP would pay rebates to members as required by the ACA.

3. Changes in Medical Costs

The primary drivers of the components of the proposed rate increases are medical trend, member demographics, the removal of transitional reinsurance recoveries and member morbidity which is mitigated through the anticipated changes in the administration of the risk adjustment program in the state of Maryland limiting risk adjustment transfer payments to a maximum of 3% of total premium,.

Note that the federal and state transitional reinsurance programs provided a significant amount of premium reduction to the individual market in 2016. Both of these programs will be eliminated in 2017.

4. Changes in Benefits

The rate increase is partially mitigated by increases in certain cost sharing parameters (deductibles, coinsurance, out-of-pocket maximums, copayments). For 2017, the federal government revised the tool that insurance issuers must use to determine whether a plan's benefit design qualifies for a particular metal level (platinum, gold, silver, or bronze), and this revised tool necessitated changes in EHC's existing benefit designs to comply with ACA regulations.

Several of the 2016 products are discontinued and will not be offered in 2017. Continuing HMO, POS, and Select products from 2016 will be offered in 2017 with changes to their benefits.

2017 EHC product offering will consist of three POS, four HMO Open-Access and two Select products:

The three POS products will be offered statewide in 2017. These products will have modest out of network benefits, and will employ a moderate level of utilization management commensurate with a typical POS plan and will also offer a two-tiered network, with differential cost sharing between the tiers (the preferred tier will have lower member cost sharing than the non-preferred tier). The preferred tier is for staff model primary care centers, and also for a select network of preferred lab and radiology providers.

The four HMO Open-Access products will be offered statewide in 2017. To purchase HMO products, the individual must reside in Maryland and seek care from providers in the state of Maryland. These products will have an open access network, and will employ a higher level of utilization management than POS products and will also utilize a two-tiered network, with differential cost sharing between the tiers (the preferred tier will have lower member cost sharing than the non-preferred tier). The preferred tier is for staff model primary care centers, and also for a select network of preferred lab and radiology providers. Members enrolling in the HMO will be auto-assigned to a Primary Care Physician (PCP) from the care centers. All PCPs will perform a gatekeeper function, approving all care non-primary care services.

The two Select products will be offered to individuals who live or work in the following counties (all located in Rating Areas 1-3): Baltimore City, Baltimore County, Howard County, Anne Arundel County, Washington County, Wicomico County, Somerset County and Worcester County. These products will have a narrow high performance network of preferred providers and incorporate a number of Value Based Insurance Design features focused specifically on the members with diabetes. These products will employ the highest level of utilization management compared to the POS and HMO products offered by Evergreen. Members enrolling in the Select plans will be auto-assigned to a Primary Care Physician (PCP) from the primary care centers.

All PCPs will perform a gatekeeper function, approving all care non-primary care services.

5. Administrative Costs and Anticipated Provision for Profit and Contingencies

This submission is for products available for sale January 1, 2017 by Evergreen Health Cooperative. The following changes were made to the assumed administrative costs:

- Removed the transitional reinsurance contribution fee of $2.25 PMPM.
- General administrative expenses increased from those assumed for 2016 pricing, to reflect the anticipated 2017 budget.
- Taxes and Fees: We removed the health insurance provider fee for 2017, per the moratorium on this fee as stated in the Consolidated Appropriations Act of 2016.
- Updated the commercial reinsurance premiums and expected recoveries to correspond to the latest reinsurance contracted rates in place.
- Commissions were revised to reflect 2017 contracts.
- We added an additional charge to represent the cost of implementing the incentive program, which offers a $100 deductible credit ($400 maximum credit per family) to members that have not yet reached their annual deductible who have visited the primary care provider and completed a health risk assessment survey within first 120 days of enrollment.
- We reflected the most recent information regarding the network access fees for dental, vision and behavioral services.