



Official Submission: Proposed rates that reflect CSRs no longer being funded

Filing Information

1. Company Legal Name: Health Net of Arizona
2. State: Arizona
3. NAIC# : 95206
4. HIOS Issuer ID: 91450
5. Market: Individual
6. Effective Date: Individuals enrolling January 1, 2018 – December 31, 2018
7. Primary Contact: Name: [redacted]
8. Primary Contact Telephone Number: [redacted]
9. Primary Contact Email Address: [redacted]
10. Product Names: Ambetter

Documentation Required for the Individual Non-Grandfathered Health Plan

1. Parts I and III of HHS Forms. (Requirements per 45 CFR §154.215)

- Part I: Part I Unified Rate Review Data Template.xlsxm
Part I Unified Rate Review Data Template.xml
- Part III: Part III Rate Filing Documentation and Actuarial Memorandum.pdf
(redacted and unredacted formats)
Justification.xls (tables referenced in Part III in Excel format)

2. ADOI specific forms

- Rates Template
AZ Major Medical Actuarial Memorandum Outline Checklist
P-124-MM: Major Medical Rate Filing Certification and Significant Data Supplement A to P-124-MM
Supplemental HealthCare Exhibit
Actuarial Value Calculator
R2D2 Information

We are requesting that the ADOI keep the Part I (URRT), Part III (Actuarial Memorandum), and Rates Template out of public view.

Actuarial Memorandum and Certification

Scope and Purpose

This document contains the Part III Actuarial Memorandum for Health Net's individual health block of business annual rate filing, effective January 1, 2018. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT). This is a renewal rate filing

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

As instructed by the Arizona Department of Insurance (ADOI), we have prepared two formal rate proposals for 2018:

1. Proposed rates that reflect CSRs no longer being funded (*presented in this memo*)
2. Proposed rates that include the on-going funding of CSRs

Of the two rate proposals, this Actuarial Memorandum reflects (1) Proposed rates that reflect CSRs no longer being funded. As such, this memo is a component of our official submission which assumes CSRs no longer being funded. As our official submission, we request the ADOI review and approve rates presented here.

In a separate submission, we also present rates and rate justification that reflect the on-going funding of CSRs; however that alternative proposal is not our official submission.

It is our understanding that in the event there is still no clear and reliable direction from the federal government if they will directly fund CSRs through 2018, the ADOI will direct health plans to use rates that reflect CSRs no longer being funded. The date on which the ADOI will decide whether to move forward based on CSRs not being paid is still being reviewed, and the ultimate date will be set in consultation with the state's regulators.

Future modifications in legislation, regulation and/or court decisions may affect the extent to which the premium rates are sufficient and neither excessive nor deficient. Health Net reserves the right to file revised rates in the event of changes to the regulatory environment in which they were developed to ensure rates are appropriate. In addition to CSR payments, material rating impacts could arise from changes to various factors, including but not limited to:

- Advanced Premium Tax Credits
- Individual mandate and its enforcement
- Limit on age rating factors
- Open enrollment and grace periods
- Enrollment of other populations (Medicare, Medicaid, high risk pool)
- Rules for Health Savings Accounts
- Payments under Risk Adjustment, Risk Corridors, and Transitional Reinsurance

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- Taxes and fees

This information is intended for use by the ADOI, the Center for Consumer Information and Insurance Oversight (CCIIO) and their subcontractors to assist in the review of Health Net's individual rate filing. However, we recognize that this certification may become a public document. Health Net makes no representations or warranties regarding the contents of this letter to other users. Likewise, other users of this letter should not place reliance upon this actuarial memorandum that would result in the creation of any duty or liability for Health Net or its employees under any theory of law.

The results are actuarial projections. Actual results will vary from those projected in the filing for a number of reasons, including population changes, claims experience, and random deviations from assumptions.

Introduction

Submitted for your review are Health Net's proposed premium rates for our Ambetter Gold, Silver and Bronze HMO plan designs. Note all plans are offered both on and off Exchange. All rates are guaranteed for a 12-month period.

Two formal rate proposals for 2018 have been prepared:

1. Proposed rates that reflect CSRs no longer being funded (*presented in this memo*)
2. Proposed rates that include the on-going funding of CSRs

As a component of our official submission, this memo assumes (1) Proposed rates that reflect CSRs no longer being funded.

Both sets of rates submitted to the ADOI in this filing reflect base rate changes made since the initial filing on June 1, 2017, including:

- Additional claims run out on CY 2016 experience
The Paid Through Date for claims incurred in CY 2016 was updated from December 31, 2016 to May 31, 2017. This resulted in a small increase to Experience Incurred Claims.
- Removal of CSR receivables as this filing reflects CSRs not being funded.
- Lowering the Risk Pool Decline assumption to [redacted].
- [redacted]

Proposed Rate Increase(s)

This rate filing is for Individuals with effective dates starting in 2018. The rates are guaranteed until December 31, 2018.

The projected claims experience was developed using calendar year non-grandfathered 2016 experience.

[redacted]
[redacted]

The table below shows the average rate changes by plan and region for adults and children. Note child ages 0-20 will deviate significantly due to the increase in federally mandated child age factors.

[redacted]

Impact of Rate Factor Changes

Plan premiums are calculated as Calibrated Plan Adjusted Index Rate x Area Factor x Age Factor (subject to the three child limit). The age factors are the federally mandated 2018 ACA age factors. The area and network factors are determined by Health Net, based on underlying regional cost variations which are assessed annual in conjunction with our rate setting.

Impact of Benefit Plan Changes

We are introducing three new plans in Maricopa county and four new plans in Pima county (see table above).

Experience Period Premium and Claims

Experience Period:

January 1, 2016 – December 31, 2016

Paid Through Date:

May 31, 2017

Premiums in Experience Period:

Premiums are actual member premiums collected during the experience period. No rebate adjustment has been made to the 2016 premium

Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims, as defined by the URRT instructions, were determined from Health Net's internal claims system. Incurred but not paid amounts were estimated using a combination, as appropriate, of the loss ratio and completion methodologies. The estimation for incurred but not paid amounts is based on the experience period claims reported. Actual claims run-out may reflect some variability from future expectations.

Claims shown below is CY 2016 claims experience for all members and plans active in 2016.

[redacted]

Benefit Categories

Benefit categories are determined using a combination of diagnostic, procedural and other codes pulled from claims data. Similar to how claims are mapped in Milliman's Health Care Cost

Guidelines, an industry wide standard. Health Net's algorithm is developed and maintained by our Health is internally developed by our Health Care Solutions department.

Projection Factors

- (1) Eligibility requirements and exclusions conform to ACA.
- (2) The Index Rate as of January 1, 2018 was developed based on CY 2016 costs for Individual non-grandfathered HMO business and adjusted to reflect anticipated Individual demographics for 2018.

[redacted]

(J) Treatment of CSR Receivables

The proposed rates reflect CSRs no longer being funded. If funds are not appropriated for the Cost Sharing Reduction subsidies, we expect plan premiums to increase from a [redacted] rate reduction to the proposed [redacted] increase. [redacted]

(K) Plan Mix

This adjustment ensures that claims cost reflects the actual ACA population that will be impacted by the proposed rates. It is calculated as the claims cost of the renewing ACA market weighted by the expected member months in the rating period, rather than the experience member months.

Plan mix reduces claims by [redacted] as current members migrate to lower cost plans and region.

(L) Risk Pool Decline

We do not make an adjustment to claims for the impact of risk pool decline at this time.

(M) Morbidity Shift

[redacted]

(N) Age Adjustment

We adjust CY 2016 claims to reflect the average age factor of the population in the rating period. [redacted]

(O) No Attained Age

The ACA dictates that age attainment be delayed until renewal. [redacted]

(P) Area Adjustment

We must adjust CY 2016 claims to reflect the average area factor of the population in the rating period.

[redacted]

(Q) Plan Adjustment

We must adjust CY 2016 claims to reflect the expected benefits to be paid in the rating period.

[redacted]

(R) Adjustment for Grace Period

Claims have been adjusted for the impact of the 90 Day Grace Period to pay plan premiums. We are required to pay enrollee claims for the first 30 days before suspension, provided they are Exchange members. Thus there is an adjustment to claims for bad debt. The adjustment is derived by comparing system generated premium versus premium simulated by using the census pulled as of a snapshot date and the associated rate sheet of that date to calculate premium. Our system generated premium has fluctuated considerably in the past few months. Our valuation of bad debt is [redacted] which was calculated as the difference between the simulated premium and the system premium.

(S) Pricing Trend

Trends are built from a “first principles” approach, calculating the expected unit cost change by hospital and medical group which is then weighted using the historic volume associated with each provider. Variables of trend such as anti-selection, underwriting wear-off, demographic changes, margin for trend, technology/intensity not included. There is no trend margin or fluctuation factor in trend development. Cost trends are supported by known and forecasted contractual increases based on our expectations of contracts in 2018.

The average medical and pharmacy trend is [redacted]. The components of trend are detailed below. All components are based on our Commercial book of business.

[redacted]

Medical Unit Cost Trend is the increase in health care costs due to medical inflation. It is estimated by reviewing current and anticipated future provider reimbursement arrangements. Note, deductible leveraging is not a component of trend. Instead it is reflected in the change in AV from current year to the rating period as implicit in the change in the AV calculator.

Medical Utilization Trend is the increase in health care costs due to changes in service. It includes evolutionary changes in medical care practices, increase in the supply of services, and changes in the overall health and/or attitude of the population.

Rx Trend is the increase in health care costs due to prescription drug inflation. We estimate that trend will be [redacted] based on segment specific claims and utilization experience.

(V) Other Claims Adjustments – Pay For Performance

Due to ACA requirements, we expect to fund a quality incentive for Maricopa county. [redacted]

We consider Pay for Performance initiatives to be a provider payment, thus a claims adjustment. Claims adjustments can be particular to one region but the single risk pool methodology aggregates all experience together to develop the Index Rate.

Operating expenses are related to the administrative cost of the company, rather than costs payable to providers. We did not think it was appropriate to categorize Pay for Performance Initiatives here.

Geographic area factors and network factors can change annually but are set to be revenue neutral, thus Pay for Performance is not built into these factors. We did not think it was appropriate to categorize Pay for Performance Initiatives here as they are not neutral.

(W) Admin to Reclass Claims

This is the portion of administrative costs that can be allocated to claims cost per federal MLR guidelines.

Credibility Manual Rate Development

Health Net did not employ the use of external claims experience.

Credibility of Experience

Our Arizona Individual HMO non-grandfathered experience data includes [redacted] lives and we considered it fully credible for the purpose of premium setting.

Paid to Allowed Ratio

The Paid to Allowed Ratio was calculated as the average AV of the book. Paid claims are [redacted] of Allowed claims.

Risk Adjustment and Reinsurance

[redacted]

(Y) Risk Adjustment Estimate

[redacted]

Non-Benefit Expenses and Profit & Risk

Total Premium Retention is the amount to be retained by the insurer to cover all of the insurer's non-claim costs including expected profit. Note we display profit on an after-tax basis per the methodology established by the Unified Rate Review template which specifies that taxes and fees should include income tax and profit should be reported on an after tax basis.

[redacted]

(AA) Administrative Expenses

Projected operating expense is [redacted]. This allowance is based on the projected enrollment and is estimated to appropriately cover expenses for stop loss insurance, overhead, operations, sales, and marketing expenses.

(AB) Commissions

Broker commissions are [redacted] of premium. This is based on our agreements with the brokers and is calculating using current membership distribution by product, metal tier and Exchange status.

(AC) Broker Bonuses

Broker bonuses are 0% of premium. We do not offer bonus currently.

(AE) Premium Tax

We are a foreign carrier in Arizona and assessed the premium tax.

(AF) Risk Adjustment Fee

The Risk Adjustment Fee for 2018 is \$1.68 per member per year, or \$0.14 PMPM.

(AG) Reinsurer's Fee

We are not assessed the Reinsurer's Fee for 2018.

(AH) Exchange Fee

Based on our projected 2018 membership, [redacted] of our projected membership will be in the Exchange. Business in the Exchange is assessed an Exchange Fee of 3.5% of premium. However, this fee must be spread to the entire book, both on and off Exchange, as rates off the Exchange for Qualified Health Plans must match rates on the Exchange. That implies that all plans must incur at charge of 3.5% of revenue to reflect the assessment of the Exchange Fee.

[redacted]

(AI) Insurer's Fee

We estimate the Insurer's Fee for 2018 as [redacted] of premium ([redacted] of risk adjusted premium). This estimate does not include the tax implications of the fee. For 2017, there was a moratorium on the fee.

(AJ) PCORI

These are fees set by the Federal Government. PCORI is \$0.20 PMPM in 2018.

(AK) Income Tax

Income tax is calculated as:

$$\text{Income Tax} = \frac{(\text{After-Tax Profit} + \text{Insurer's Fee})}{(1 - \text{Corporate Tax Rate})} \times \text{Corporate Tax Rate}$$

[redacted]

(AM) Adjusted Earned Premium

A renewal increase is calculated by comparing the proposed premium with an effective date of January 1, 2018 versus the adjusted earned premium one year prior or January 1, 2017.

The adjusted earned premium is the Individual HMO rates filed for ACA plans with 2017 effective dates. It is calculated by pulling a census of every non-grandfathered member in Arizona Individual HMO business as of February 2017. All members are rated as if they were on 2017 ACA plan using the rating formula:

$$\text{Member Premium} = \text{Plan Specific Base Rate} \times \text{Age Factor (with 3 child limit)} \times \text{Area Factor}$$

$$\text{Book of Business Premium} = \text{Sum of all Member Premiums (subject to the 3 child limit)}$$

The age factor of this population is determined by mapping every member to their 2017 ACA age factor, with the 3 child limit based on their age on January 1, 2018, so that one year's worth of aging is not included in the renewal increase.

The area factor of this population is determined by mapping every member to their ACA area factor based on their current zip code.

The average plan factor of this population is the plan actor of the ACA plan they are currently enrolled in.

Thus current premium and projected incurred claims use the same demographics basis and a comparison of Required Premium versus Adjusted Earned Premium is the Renewal Rate Increase, the annual increase from 2017 to 2018.

(AQ) Margin/Profit

The 2018 target profit is [redacted]. Target profit is necessary to cover expenses, maintain an adequate capital base and to prevent excessive rate increases for the block in the future. Note the requested rate change does not fund future claims beyond the 2018 rating period.

(AU) Requested Renewal Increase

The comparison between required premium (which is projected incurred claims plus administrative expenses plus profit) and current premium determines the renewal increase.

The proposed rates reflect CSRs are no longer being funded. The overall renewal rate change is a [redacted] increase. This increase does not include the impact of demographic shifts. The renewal increase by metal and region for age 40 is shown below.

[redacted]

Note that the CMS standard children's age factors from plan year 2017 to 2018 will not impact the pool's average renewal increase as this change was revenue neutral to the single risk pool. But the child age factors were increased from 2017 to 2018, thus child renewal rates are higher and adult renewal rates are lower than what they would have otherwise been. The adult renewal rates are [redacted] lower than the book average due to the change in child age factors.

[redacted]

Projected Loss Ratio

The proposed rates reflect CSRs are no longer being funded. The projected medical loss ratio (MLR) is [redacted]

[redacted]

Single Risk Pool

The rate development in this filing is based on experience drawn from the Single Risk Pool, as established according to the requirements in 45 CFR 156.80. This filing reflects all covered lives

under every non-grandfathered product/plan combination sold by Health Net of Arizona in the Arizona individual market.

Index Rate

The Allowed Index Rate for the effective period is [redacted]. It is calculated by taking the Projected Incurred Claims (before ACA adjustments) and dividing it by the allowed modifiers to the Index Rate and the Paid to Allowed Ratio.

[redacted]

(BG) Projected Incurred Claims

Assumptions that went into Projected Incurred Claims are discussed in detail in the following sections of this memorandum:

Experience Period Premium and Claims
Projection Factors

(BH) Paid to Allowed Ratio

We expect the paid to allowed ratio of future business to be [redacted]. This valuation was calculated based on the member weighted average of the AVs of our projected 2018 portfolio as of February 1, 2017. The AVs were determined based on the standalone AV calculator which is a paid to allowed calculator.

Market Adjusted Index Rate

After developing the Index Rate, the Market Adjusted Index Rate is calculated as:

[redacted]

(BK) Federal Reinsurance Program Adjustment

There is no Reinsurance Program Adjustment.

(BL) Risk Adjustment

This is the negative sum of (Y) Risk Adjustment Estimate and (AF) Risk Adjustment Fee divided by (BH) Paid to Allowed Ratio.

(BM) Exchange User Fee Adjustment

This is (AH) Exchange Fee divided by (BH) Paid to Allowed Ratio.

(BN) Market Adjusted Index Rate

Market Adjusted Index Rate is calculated as follow:

(BJ) Index Rate PMPM – (BK) Federal Reinsurance Program Adjustment – (BL) Risk Adjustment + (BM) Exchange User Fee Adjustment

Plan Adjusted Index Rate

After developing the Market Adjusted Index Rate, the Plan Adjusted Index Rate is calculated using the plan specific factors allowed by 45 CFR Part 156.80(d)(2).

[redacted]

(BP) Actuarial value and cost-sharing adjustment

The actuarial value and cost-sharing adjustment is the product of the AV of the plan as computed by the standalone calculator, the Induced Demand Factor and the Normalization Adjustment.

This varies by plan design and is calculated using the standalone Actuarial Value calculator. A normalization factor is also applied so that the average plan factor before and after induced demand is the same (i.e., applying induced demand is revenue neutral.)

[redacted]

[redacted]

(BQ) Provider network

There are no adjustments for provider network.

(BR) Adjustment for benefits in addition to the EHBs

There are no benefits in addition to the EHBs.

(BS) Impact of specific eligibility categories for the catastrophic plan

Catastrophic plans are their own single risk pool and this adjustment factor is meant to adjust the catastrophic rates so that they reflect their own experience. We have no catastrophic plans in 2018.

(BT) Adjustment for distribution and administrative costs

This is calculated as:

$$1 + \frac{\text{Total Administrative Costs} + \text{Total Taxes and Fees} - \text{Exchange User Fees} + \text{Profit}}{\text{Projected Incurred Claims w/ ACA Adjustments} + \text{Exchange User Fees}}$$

The resulting adjustment is [redacted].

Calibration

(BW) Age Curve Calibration

This is the inverse of the expected average age factor using the ACA age factors and the 3 child limit.

The age curve factor was calculated by pulling a census of every non-grandfathered member in ACA Individual HMO as of February 2017. The ACA age factor is based on the member's age in years (rounded down) as of January 1, 2018 - the age implicit in (AM) Adjusted Earned Premium. The 3 child limit was applied so that dependent children age 0-20 were not counted if they were the 4th or more child in a family contract. The result of this analysis demonstrated that the average age factor for this block is [redacted]. Thus to calibrate the plan adjusted index rate so that the implied age factor is 1.000, we multiply by the inverse of the average age factor of the block. The inverse of [redacted] is [redacted].

(BX) Geographic Factor Calibration

This is the inverse of the weighted average of the proposed area factors, weighted by current ACA membership. To calculate average area factor, we pulled the census of every non-grandfathered member in Arizona Individual HMO as of February 2017. The average area factor was calculated based on this population and using our proposed 2018 area factors. The calculated value is [redacted].

Note we adjust the calibration factor by [redacted] in order to account for average differences between the renewal produced by the “Rating factors” tab and the renewal calculated by the Rate Development. Without the Geographic Calibration Adjustment found in the Rating’s Factor tab, this factor would be [redacted].

Consumer Adjusted Premium Rate Development

We do not rate for tobacco. Per member premium is calculated as:

Calibrated Plan Adjusted Index Rate
x Age Factor with 3 child limit
x Area Factor

Age Factors and Tier Factors:

We use ACA age factors with the 3 child limit. Per-member build-up of rates is required to determine group aggregate premium based on census at time of quote.

Area Factors:

The area factors have been updated from those filed and approved in 2017. Area factors reflect the regional differences in provider contracting and claims cost after risk adjustment. [redacted]

AV Metal Values

All AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were entirely based on the AV Calculator.

AV Pricing Values

Per the 2018 URR Instructions, the AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate.

Hence the AV Pricing Value for a particular plan is the product of the actuarial value and cost-sharing adjustment; provider network, delivery system and utilization management adjustment; impact of specific eligibility categories for the catastrophic plan and adjustment for distribution and administrative costs detailed in the Plan Adjusted Index Rate section above.

Membership Projections

We project [redacted] members or [redacted] member months on 2018 ACA plans in Arizona Individual HMO.

Unified Rate Review Template

Section I: Experience period data:

Allowed and Incurred Claims Incurred During the Experience Period:

In order to supply the requested information for the URRT we have included all non-grandfathered Arizona HMO Individual business.

Incurred claims were pulled directly from Health Net's internal claims system. A completion factor of was applied to account for claims incurred but not reported.

Section II: Allowed Claims, PMPM basis

Population Risk Morbidity - The morbidity adjustment is [redacted]. See above Projection Factors (K) – (M) for further details regarding the quantitative development of these items.

[redacted]

Other – This is the product of the following factors below. See above Projection Factors (J) – (W), for further details regarding the quantitative development of these items.

[redacted]

Note that Equalize Paid to Allowed is equal to the ratio of the 2016 portfolio / 2018 portfolio. It represents benefit / leveraging changes due to the change in plan benefits as calculated by the AV calculator. The AV of the 2016 portfolio is [redacted] while the AV of the 2018 portfolio is [redacted].

Administrative Expense Load – This is the product of the following factors below. See above Non-Benefit Expenses and Profit & Risk (AA) – (AC), for further details regarding the quantitative development of these items.

[redacted]

Profit – See above Non-Benefit Expenses and Profit & Risk (AQ) for further details regarding the quantitative development of this item.

Taxes and Fees – This is the sum of the following items below. See above Non-Benefit Expenses and Profit & Risk (AE)-(AK), for further details regarding the quantitative development of these items

[redacted]

Terminated Products

The following plans have experience in the Single Risk Pool for CY 2016 but were terminated before the effective date (1/1/2018).

Terminated Plans			
Plan HIOS ID (14-Digit)	Plan Name	Metal	Effective Date
91450AZ0080026	CommunityCare HMO Gold \$30/\$60/\$6000/\$375 with Pediatric Dental	Gold	1/1/2016
91450AZ0080027	CommunityCare HMO Silver \$30/\$50/\$4500 with Pediatric Dental	Silver	1/1/2016
91450AZ0080031	CommunityCare HMO Bronze 40%/40%/\$5750 with Pediatric Dental	Bronze	1/1/2016
91450AZ0080032	CommunityCare HMO Bronze 40%/40%/\$5750 without Pediatric Dental	Bronze	1/1/2016

Plan Type

The Plan Type for each plan listed in Worksheet II, Section I of the URRT is consistent with the plan type selected in the drop-down box.

Warning Alerts

N/A

Effective Rate Review Information (optional)

N/A

Reliance

Health Net did not rely on any information or underlying assumptions provided by another individual.

Actuarial Certification

I, [redacted], am an actuary for Health Net, Inc. I am a member of the American Academy of Actuaries in good standing and meet its qualification standards for actuaries issuing statements of actuarial opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work. This filing is prepared to comply with applicable State and Federal Statutes for individual rate filings.

I certify the rates were developed in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis was placed on the following:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Plan Entities
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 50, Determining minimum value and Actuarial Value under the Affordable Care Act

I certify that to the best of my knowledge and judgment:

1. The Index Rate for the Projection Period is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102)
 - b. Developed in compliance with the applicable Actuarial Standards of Practice
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
 - d. Neither excessive nor deficient based on my best estimates of the 2018 individual market.
2. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
3. The percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice. The EHB portion of premium is appropriate as the basis of determining APTCs.
4. The geographic rating factors used reflect only differences in the cost of delivery, and do not include differences for population morbidity by geographic area.

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5. The CMS Actuarial Value Calculator was used to determine the AV Metal Values shown in Worksheet 2, Section I of the URRT for all plans.

The URRT does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

The information provided in this actuarial memorandum is in support of the items illustrated in the URRT and does not provide an actuarial opinion regarding the process used to develop proposed premium rates. It does certify that rates were developed in accordance with applicable regulations, as noted.

Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Note that these rates were developed based on the legislative and regulatory provisions in effect at time of submission. Subsequent changes to any material payment provision or key marketplace rule, including but not limited to; individual mandate enforcement, could impact whether rates are aligned appropriately with incurred costs. In the event that a material provision is impacted, a revision to the rates will be needed. In particular, rates were developed assuming steady funding of Advanced Premium Tax Credits (APTCs) and Cost-sharing Reduction (CSR) payments. The loss of such funding will impact whether rates are sufficient. Health Net of Arizona. intends to use the methodology outlined by HHS for advanced Cost-sharing Reduction payments.

[redacted]

[redacted]

9/12/2017

Date