

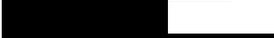
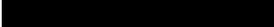
Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name: Aetna Life Insurance Company
State: New Jersey
HIOS Issuer ID: 89217
Market: Individual
Effective Date: 01/01/2017
Rate Filing Tracking Number: AETN-130542737
Policy Form(s): HIXGR-96806P, et al

Company Contact Information:

Name: 
Telephone Number: 
Email Address: 

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

- 1) Provide support for the development of the Part I Unified Rate Review Template;
- 2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above; and
- 3) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with our Qualified Health Plan (QHP) application in New Jersey beginning January 1, 2017. The rates comply with all rating guidelines under federal and state regulations. This memorandum covers plans that will be available on and off the public Marketplace in New Jersey.

2. Proposed Rate Increase

Monthly premium rates for Individual Market products in New Jersey are being revised for effective dates January 1, 2017 through December 31, 2017.

A. Reason for Rate Increase(s):

Revised rates for these products reflect the following:

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Elimination of the reinsurance program;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs; and
- Changes in provider networks and contracts.

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

The weighted average rate change across plans based on current ACA-compliant membership, inclusive of the impact of benefit and cost sharing changes, is 19.4%. The minimum rate change is 18.8% and the maximum rate change is 19.9%.

3. Experience Period Premium and Claims

A. Paid Through Date:

The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2015 through December 31, 2015 and paid through May 31, 2016. Claims experience is further detailed on Exhibit A.

B. Premiums (Net of MLR Rebate and Risk Adjustment) in Experience Period:

Experience period premiums are date-of-service premiums from our actuarial experience databases for Individual business in New Jersey. The premiums have been increased for expected risk adjustments receivables for our estimated accruals of risk adjustment based as discussed in section 9.B., below.

C. Allowed and Incurred Claims Incurred During the Experience Period:

Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

Exhibit B summarizes the experience data and documents the impact of the IBNP reserves, by date-of-service for each month within the experience period.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released February, 2016. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, included day-based mental health services. Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including visit-based mental health services. Other includes home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

Medical pharmacy expenses are for medications covered under the medical benefits. These typically are for drugs administered in a facility or office setting, and include vaccines, chemotherapy drugs, and similar drugs that are not dispensed through traditional pharmacies. They also include drugs that a member can self-inject. Drugs dispensed by a pharmacy refers to 'traditional' prescription coverage and include most drugs that members are prescribed for use in non-clinical settings.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

We considered the expected relationship between the morbidity of the Aetna Small Group experience used for our manual rate and the likely population that will be covered by Individual policies in 2017. Exhibit C discusses the assumptions used to project the change in population morbidity, and illustrates the resulting projection factor.

B. Changes in Benefits:

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits D and E contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts.

E. Trend Factors (Cost/Utilization):

Medical trend factors are based on our Medical Economics Unit's Local trend and network experience, based on analysis of a continuous normalized population, excluding catastrophic claims. Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical

technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

Pharmacy trends are based on local market commercial group Rx trend analysis. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. Pharmacy Trend is expressed in terms of allowed trend less rebates.

Exhibit F shows the anticipated annual trend from the experience period to the rating period.

6. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 1, 2015 to December 31, 2015 and paid through May 31, 2016 for Aetna Health, Inc. and Aetna Life Insurance Company in the New Jersey Small Group market. The Small Group market experience is considered an appropriate source for the manual rate due to similarities in covered benefits and market dynamics to the post-2014 ACA Individual market. The similar dynamics include: no Individual medical underwriting and rating by gender, limits on age-rating, and caps for rating on the number of dependents.

B. Adjustments Made to the Data:

The Small Group experience used as the basis for the manual rate was adjusted in a similar manner as the base period experience for changes in population risk morbidity, benefits, and demographic and area normalizations. The data is further adjusted for projected changes in network, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend, as discussed in Exhibits C-F.

7. Credibility of Experience

No credibility is assigned to the experience data. This is due to the use of alternate experience data that more accurately captures the essential characteristics of the market for which we are developing rates.

8. Paid-to-Allowed Ratio

The projected paid to allowed ratio is 78%. Exhibit G illustrates the development of this number along with the projected membership distribution by metal tier. Paid to allowed ratios are based on 2014 experience that is adjusted for the impact of any plan benefit changes based on our internal pricing models and trend deductible-leveraging.

9. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

Reinsurance recoveries in the experience period incurred claims were calculated by assuming 50% recovery of paid claim amounts less HHS cost-sharing payments between \$45,000 and \$250,000. Plan information is known on paid claims and thus, recoveries are listed in the appropriate HIOS ID on Worksheet II. Reinsurance recoveries are reduced by the \$3.67 reinsurance contribution assessed in 2015.

B. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2015 Wakely data. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2015 Risk Adjustment fees of \$0.08 PMPM in Worksheet 2.

C. Risk Adjustment – Projection Period

We project a risk adjustment payable net of the 2017 user fee of \$0.13 PMPM.

10. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit H.

The prospective general and administrative expenses are based on historical corporate Individual market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2017. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2017, as well as Federal income tax. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in pricing our 2016 plans.

11. Projected Loss Ratio

The expected 2017 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit I.

The projected loss ratio for these products in 2017, calculated using the allowable adjustments in NJ Bulletin No. 13-14, is shown in Exhibit J.

The projected MBR for this filing calculated in the traditional way (incurred claims divided by earned premium) is 82.5%.

12. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Individual market in New Jersey through Aetna Life Insurance Company. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

13. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits. The non-EHBs in the experience period and projection period are coverage for an adult eye exam every 12 months.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs and catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

14. Market-Adjusted Index Rate

Exhibit K-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustments (Risk Adjustment and Exchange User Fees) were discussed previously.

15. Plan-Adjusted Index Rates

Exhibit K-2 illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The Plan Adjusted Index Rates are displayed in Column 7. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value and Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:



B. Distribution and Administrative Costs:

Column 3 reflects the adjustment for projected administrative costs, including sales, marketing, and any commission expense, and profit & risk. These are discussed above in the ‘Non-Benefit Expenses and Profit & Risk’ section, and exclude the Risk Adjustment User Fee, and Exchange User Fee, which are reflected in the Market-Adjusted Index Rate. These expense and profit assumptions do not vary by plan.

C. Provider Network, Delivery System, and Utilization Management:

The factors in Column 4 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

D. Benefits in addition to EHBs:

The factors in Column 5 adjust for the impact of benefits in addition to EHBs. These factors represent the added cost of covering one adult eye exam every 12 months

E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

F. Experience Period Plan Adjusted Index Rates

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2015 for the experience period.

16. Calibration

The age factors are based on the HHS Default Standard Age curve.

We project a premium-weighted average age factor for the 2017 membership using the prescribed age curve and the projected age distribution based on national membership for Aetna Individual business. Exhibit L shows the weighted average age factor and the age that most closely corresponds to the weighted average age factor. The age calibration factor is the reciprocal of the weighted average age factor.

17. Area Definitions and Factors

New Jersey does not permit area to be used as a rating factor in the Individual market.

18. Consumer-Adjusted Premium Rate Development

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family’s premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

$$\text{Market Base Rate} * \text{Age Factor} * \text{Plan Factor}$$

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract’s premium determined by the member build-up calculation for a family of six, with more than three dependents under age 21, is shown in the Premium Rate Manual.

19. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

20. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

The resulting plan factors are displayed in the Premium Rate Manual. Plan factors do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

21. Membership Projections and Cost Sharing Reduction Subsidy Estimates

Exhibit M summarizes the membership projections by plan and plan variation.



Terminated Plans and Products

Exhibit N provides a plan and product crosswalk from 2015 to 2017. The crosswalk includes the list of products that have experience in the single risk pool experience period and products that were made available in 2016 and 2017.

22. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

23. Warning Alerts

The Experience Period Plan Adjusted Index Rate on Worksheet 2 differs from the Experience Period Premium PMPM on Worksheet 1 since 1) the Experience Period Premium reflects the actual enrollment mix for all business in the market in 2015 while the average Plan Adjusted Index Rate reflects the projected (vs. actual) mix, and 2) premiums reported on Worksheet 1 are net of estimated risk adjustment transfers while the Plan Adjusted Index Rates on Worksheet 2 do not consider the impact of risk adjustment transfers.

For the same reasons, the experience period Total Premium (TP) differs between Worksheets 1 and 2.

The Experience Period Incurred claims and Incurred Claims PMPM on Worksheet 2 adjust for the impacts of Reinsurance and Risk Adjustment. The Incurred Claims on Worksheet 1 are not adjusted for the impact of Reinsurance and Risk Adjustment. The warning alerts on rows 68 and 73 of Worksheet 2 result from the different treatment of Reinsurance and Risk Adjustment on the two worksheets.

24. Benefit Design

We are introducing 8 new plans for January 1, 2017 offered on our Meridian and Virtua ACO OAEPO Tiered networks. These networks were filed with DOBI and are awaiting approval. Our existing plans and these new plans are rated together as part of our single risk pool. Benefit designs for the new plans are included in the Summary of Benefits & AV Screenshots.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized in the Summary of Benefits & AV Screenshots. All benefit and cost sharing parameters comply with New Jersey benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

25. Marketing

Some of these plans will be made available through the public Marketplace. In addition, plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including directly to consumers through direct mail, telemarketing, and the internet and indirectly through brokers and general agents. Marketing and distribution approaches may change from time to time at management's discretion.

26. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the Marketplace as verification of eligibility.

27. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

28. Company Financial Condition

As of December 31, 2015, the capital and surplus held by Aetna Life Insurance Company was approximately \$3.7 billion. This amount is disclosed in page 3, line 37 of the Company's statutory financial statement dated December 31, 2015. The Company issues insurance nationwide for multiple lines of business including, large group medical, Small Group medical, individual medical, and various non-medical products.

Reliance

While I have reviewed the reasonableness of the assumptions in support of both the preparation of the Part I Unified Rate Review Template and the assumptions in support of the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

- URRT Methodology and Data Definitions
- Experience Period MLR Rebates
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Components of Retention/Administrative Fees
- Value of Network Arrangements
- Experience Period Data – Individual
- Experience Period Data – Small Group

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, [REDACTED], am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of New Jersey, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:
 - a. ASOP No. 5, Incurred Health and Disability Claims
 - b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
 - c. ASOP No. 12, Risk Classification
 - d. ASOP No. 23, Data Quality
 - e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
 - f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
 - g. ASOP No. 41, Actuarial Communications.
2. The Projected Index Rate is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) 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, deficient, nor unfairly discriminatory.

3. 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.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.
7. The rating methodology will not produce rates for each rate tier for the highest rated policyholder which are greater than 300 percent of the rates (for each rate tier) for the lowest rated policyholder for each plan and rider option.
8. This rate filing is complete and complies with all of the provisions of NJAC 11:20-6, unless superseded by the ACA.
9. The loss ratio is expected to be at least 80% over the rating period.

July 14, 2016

██████████, FSA, MAAA
Aetna Life Insurance Company

Date