CONFIDENTIAL/PROPRIETARY

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For UnitedHealthcare Insurance Company

State of Arizona Rate Review

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FEDERAL Rate Justification PART III – Actuarial Memorandum & Actuarial Certification

General Information

Company Identifying Information

Company Legal Name:	UnitedHealthcare Insurance Company
State:	Arizona
NAIC Number:	79413
HIOS Issuer ID:	82011
Market:	Small Group
Effective Date:	1/1/2022

Company Contact Information

Contact Name:	[redacted]
Contact Telephone Number:	
Contact Email Address:	

Filing Information

Type of Filing:	Non-Threshold
Type of Plan:	PPO; Off Exchange; New Business
Requested Rate Change:	[redacted]
Latest Effective Date:	12/15/2022

Purpose & Assumptions for Proposed Rates

Following is a rate filing prepared by UnitedHealthcare Insurance Company (UHIC). This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of Arizona. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold off the Small Business Health Options Program (SHOP) in Arizona for the 2022 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the Arizona Department of Insurance. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors, and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by AZ (state confidentiality regs). If the prohibition against disclosure by the Arizona Department of Insurance is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

Proposed Rate Change(s)

Reason For Rate Change(s)

UHIC is filing 2022 rates for existing benefit plans under policy forms [redacted] that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). Our 1/1/2022 rates for existing plans are [redacted] on average over our approved 1/1/2021 rates[1].

The proposed pricing trend is [redacted] annually, which is equivalent to a quarterly rate [redacted]. This trend is applied uniformly to all filed plans.

The primary drivers of the proposed rate changes are the following:

[1] [redacted]

- Changes in medical service costs
    - Increasing Cost of Medical Services – Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
    - Increased Utilization – The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
    - Higher Costs from Deductible Leveraging – Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
- Cost shifting from the public to the private sector – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost difference is being shifted to private health plans. Hospitals typically make up this reimbursement shortfall by charging private health plans more.
- Impact of New Technology – Improvements to medical technology and clinical practice often result in the use of more expensive services, leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
    - UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
    - Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.
    - State and/or Federal government imposed taxation and fees are another significant factor that impacts health care spending. These fees include ACA taxes and fees which have increased health insurance costs and need to be reflected in premium. As a result of new legislation, the Health Insurer Tax (HIT) is repealed effective 1/1/21. The impact on rates as a result of this change is included in this filing.

We refined the medical and pharmacy plan relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc.

were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing only by the estimated value of the benefits and expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Experience Period Premium and Claims

Experience Period, Paid Through Date

The experience period is [redacted]

Experience Period Premiums

Earned premium for our small group market business in Arizona in the experience period was approximately [redacted]. This estimate was provided by UnitedHealthcare's finance department. [redacted]

Experience Period Incurred Claims

The incurred claims presented in Worksheet 1, Section I represents UnitedHealthcare's best estimates of claims incurred during the experience period. Incurred claims were developed by first starting with actual claims [redacted]. Estimates of incurred but not paid claims were added to these paid claims.

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors. The same completion factors are applied to both incurred and allowed claim amounts.

Experience Period Index Rates

Experience Period Index Rates are defined as the allowed claims PMPM for Essential Health Benefits during the Experience Period. With the breakout of service level EHB claims, the information provided reflects a reasonable estimate of the EHBs.

Benefit Categories

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

Inpatient Hospital

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

Capitation

Includes all services provided under one or more capitated agreements.

Prescription Drug

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

Projection Factors

The projection period is [redacted].

Changes in the morbidity of the insured population

The total Population Risk Morbidity adjustment on URRT Worksheet 1 [redacted]

Demographics Changes

[redacted]

Plan Design / Benefit Changes

[redacted]

Other Adjustments

The total other adjustments total to [redacted], comprised of the following factor(s):

[redacted]

[redacted]

[redacted]

[redacted]

Trend Factors

Two years of annual trend were applied to our 2020 experience to project it to the 2022 rating period. Our most recent analysis indicates average annual trend in the state of Arizona for the 2020 and 2021 calendar years will be [redacted] The table below details the components of each trend factor. Please note that due to URRT template constraints, the experience could only be trended by 24 months. [redacted]

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component. In addition, the costs associated with future treatment, vaccination and testing due to COVID-19 are included in the future trends used in the claims projection.

Utilization rates by category are measured and projected, net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Manual Rate Adjustments

The legal entity experience is fully credible. Therefore, no manual rate is needed.

Credibility of Experience

UnitedHealthcare Insurance Company had [redacted] member months enrolled in ACR-compliant policies in the state of Arizona over the experience period, which exceeds the minimum member months to be considered fully credible. Therefore, full credibility (100%) is applied to the base period experience.

Development of Projected Index Rate

The projected index rate is [redacted] PMPM.

The Index Rate For the experience period is approximately [redacted] of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly. The Index Rate in the projection period represents [redacted] of allowed claims due to the benefits in excess of EHBs.

The projected index rate of [redacted] was calculated by trending and adjusting the experience period index rate to the projection period. The adjustments were detailed in the Projection Factors section above. It is established in accordance with the requirements of 45 CFR §156.80(d).

Development of Market-wide Adjusted Index Rate

The projected Market Adjusted Index Rate is [redacted] PMPM.

Reinsurance Recoveries & Exchange User Fees

There is no reinsurance program in force for this business, and as a result there are no reinsurance recoveries to report.

There are no exchange user fees applicable, and therefore no adjustments are made.

Risk Adjustment Transfer

UnitedHealthcare Insurance Company anticipates [redacted] of premium as risk adjustment transfers in the state of Arizona in the experience period. Per URRT instructions, this number includes the anticipated risk transfer amount and the assessment fee for the high cost risk pool adjustment.

We are assuming the risk level of our business relative to that of our competitors for the projection period will be similar to what it was in the experience period. For the purpose of calculating the Market Adjusted Index Rate, we make an adjustment to the projected index rate. The adjustment made to the projected index rate is [redacted] PMPM.

The final calculated Market Adjusted Index Rate is [redacted].

Non-Benefit Expenses and Profit & Risk

Administrative Expenses

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load is consistent across most products and plans; however, a small number of plans may have different expense loads due to unique features of those plans. These assumptions are based on the general ledger actual results for 2020 and 2021 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

Breakdown of administrative expenses, as % of total premium, are as following:

[redacted]

Profit & Risk Margin

The profit and risk margin is shown in Worksheet 2, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the administrative expenses, taxes and fees, and 1 minus the target loss ratio and the administrative expenses, taxes and fees.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

Taxes and Fees

Taxes and fees are expected to be [redacted] and include premium tax, risk adjustment user fees, and federal income tax.

The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
[redacted]	[redacted]

Projected Loss Ratio

The calculations below demonstrate that the projected loss ratio exceeds the minimum MLR requirement of 80%.

[redacted]

UnitedHealthcare Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

Single Risk Pool

The single risk pool reflects all covered lives for every small group non-grandfathered product and plan combination for UnitedHealthcare Insurance Company in the state of Arizona. It is established in accordance with the requirements of 45 CFR §156.80(d).

Experience from transitional plans was not used in the development of the projected index rate, and therefore is not included in the URRT.

Index Rate

The Projected Index Rate is [redacted] and was calculated by trending and adjusting the experience period index rate to the projection period.

This was detailed in the **Development of Projected Index Rate** section of this memorandum.

Market Adjusted Index Rate

The market adjusted index rate is [redacted], and was calculated by adjusting the Projected Index Rate by risk adjustment transfer amounts, high cost risk pool adjustment assessment fees, and exchange user fees, if applicable.

This was detailed in the **Development of Market-wide Adjusted Index Rate** section of this memorandum.

Plan Adjusted Index Rates

The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations (45 CFR 156.80 and 147.102).

The development process of Plan Adjusted Index Rates is detailed in URRT Worksheet 2, Section 3. We will use the plan, HIOS ID [redacted] to illustrate this example.

Actuarial Value and Cost Sharing Adjustment

The Actuarial Value is composed of the following two components:

1. Projected Plan Factor
2. Scaling Factor

Projected Plan Factor

The projected plan factor i [redacted]

Scaling Factor

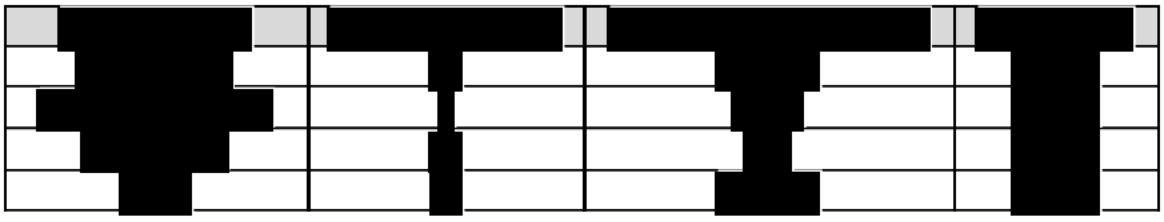
The scaling factor is [redacted]

The product (after rounding) of the two components results in the total actuarial value of the plan, which is [redacted]. The adjustment will vary by plan, [redacted].

Provider Network, Delivery System and Utilization Management Adjustment

The network adjustment accounts for differences in provider networks between plans. Any differences in network are based on provider contracted rate differentials and not based on differences due to health status.

The adjustment needed for each plan type, respectively, is shown below:



The example plan, HIOS ID [redacted], utilizes the Choice network. Therefore, the adjustment is [redacted].

Benefits in Addition to EHBs

As stated above in the **Development of Projected Index Rate** section, the Index Rate represents approximately [redacted] of allowed claims due to benefits in excess of EHBs.

The adjustment is [redacted], applied uniformly to all plans.

Distribution and Administrative Costs

Distribution and administrative costs include premium tax, PCORI fees, SG&A, quality improvements, federal income tax, and after-tax income. The administrative load is consistent across most products and plans; however, some plans have different expense loads due to unique features of those plans. These items were previously discussed in the **Non-Benefit Expenses and Profit** section of this memorandum.

The adjustment needed is 1 / (1 – distribution and administrative costs). For the example plan, HIOS ID [redacted].

Calculation of Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the product of the above adjustments and the Market Adjusted Index Rate. For the example plan, this is [redacted].

Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

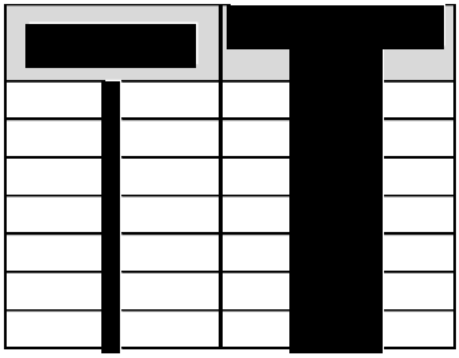
Age Curve Calibration

The calculated age curve calibration is [redacted], which is equal to the reciprocal of the average age factor of the expected member distribution by age. The age factors used in this calculation are the HHS-specified age curve.

Geographic Factor Calibration

The geographic factor calibration is [redacted], which is equal to the reciprocal of the expected average area factor.

[redacted]



Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2022 rate development.

Tobacco Factor Calibration

Tobacco factors are not used in the rating of these products, and no calibration is needed.

Calibration

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

Consumer Adjusted Premium Rate Development

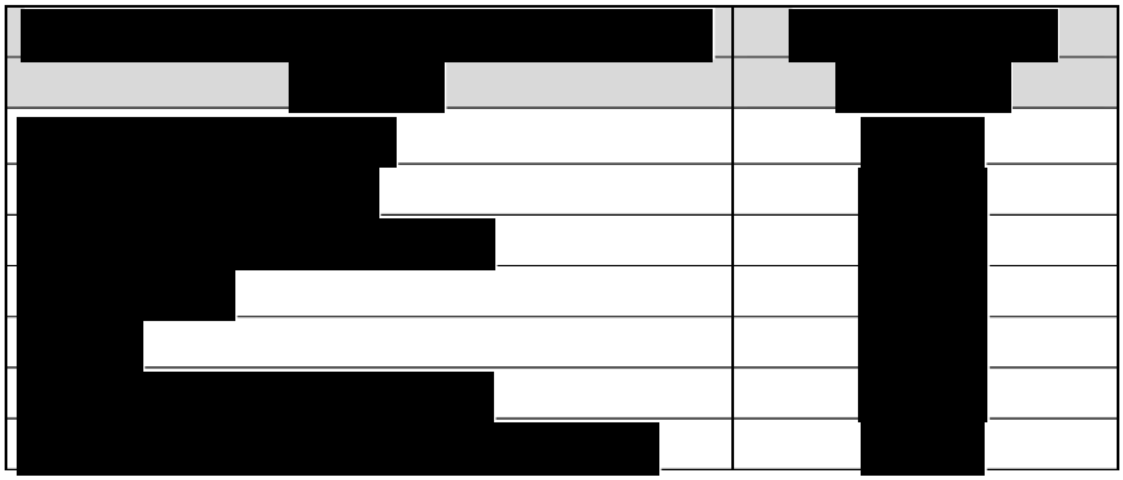
The Consumer Adjusted Premium Rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate by the average age and geographic rating factors, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate
x Age Calibration Factor
x Geographic Calibration Factor
x Consumer-Specific Age Rating Factor
x Consumer-Specific Geo. Rating Factor
x Small Group Trend Adjustment
= Consumer Adjusted Premium Rate

Small Group Trend Adjustment

The Plan Adjusted Index Rate is calibrated to represent the premium rate for a plan (before applying consumer-specific rating adjustments) in the first quarter of 2022. Therefore, no small group trend adjustment is needed to calculate the Q1 premium. In order to calculate the premium rate for the remaining three quarters, the calibrated rate needs to be multiplied by the quarterly trend factor, which is calculated equivalent to [redacted]

Exact numbers may be different due to rounding in the below exhibit and in previous calculation steps.



AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

- [redacted]

All screenshots from the AV calculator for each plan are attached as part of this filing, in the *Supporting Documentation* section.

Membership Projections

The total projected member months for the projection period is [redacted]

We do not have internal membership projections by plan. Strictly for purposes of the URRT, we have projected membership by plan. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2022.

Plan Type

All products included in this filing are PPO products with in-network and out-of-network benefits. All plan designs are compliant with 2022 plan requirements.

Uniform Modification

Using the most recent version of the AV Calculator, some plans in UHIC's plan portfolio for 2021 resulted in AVs outside the de minimum range of AV Metal Value requirements. We made necessary uniform modifications to these plans in order to bring their AVs within compliance. Modifications to other plans were made for business reasons.

All modifications made to renewing plans meet Uniform Modification criteria. Changes were made to the plans' copays, deductibles, and out-of-pocket maximums, but each plan's basic cost-sharing structure remained the same in all cases.

Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3.

A list of reliances is included below:

UnitedHealthcare Finance Department

- Projected SG&A Assumption

UnitedHealthcare National Pricing Team

- Plan Relativity Modeling

UnitedHealthcare Healthcare Economics Department

- Projected Trend
- Claims Reserves
- ACO/Premium-Designated Provider Cost Savings Estimates

Additional Arizona Law Requirements

UnitedHealthcare establishes its premium rates for health plans offered to small employers based on the experience for its existing block of small group customers in Arizona with appropriate adjustments to take into account required Essential Health Benefits, PPACA insurer fees, etc.

Under the ACA, premium rates for a small employer group do not vary based on the health status of the employees and dependents contained in that group. Rates can only vary by plan design, age (based on the specified HHS age curve), geography based on the state-defined geographic rating regions, and family status. At this time UnitedHealthcare is not varying rates based on tobacco status. These rating characteristics are applied uniformly across all small employer groups in Arizona.

An annual small group certification is filed with the state each year attesting to the company's compliance with the applicable rating rules as established by ARS-2311.

Actuarial Certification

I, [redacted], am an Actuary for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
    - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
    - Developed in compliance with the applicable Actuarial Standards of Practice.
    - Reasonable in relation to the benefits provided and population anticipated to be covered.
    - Neither excessive, deficient, nor unfairly discriminatory.

- 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.

- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.

- 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. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. The unique plan design actuarial certification required by 45 CFR Part 156.135 has been separately attached.

- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop their 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 exchanges, and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers.

Respectfully,

[redacted]

[redacted]