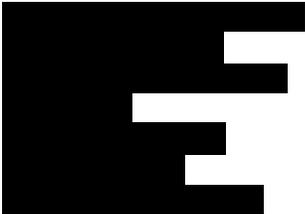


TRADE SECRET

**Aetna Health Inc. (Pennsylvania)
Actuarial Memorandum and Certification
Individual On- and Off-Exchange Rates Effective 1/1/2016**

1. General Information

- a. Company Information: Aetna Health Inc. (Pennsylvania)
HIOS Issuer ID: 38408
NAIC Number: 95109
- b. Contact Information: 
- c. Scope and Purpose of Filing: The purpose of this actuarial memorandum is to support the development of premium rates for Individual products sold on and off the Exchange effective January 1, 2016. Aetna Health Inc. ("Aetna") intends to use the premium rates for individual business within its South Carolina service area effective 1/1/2016 through 12/31/2016. It should be noted that this filing includes experience data for Coventry Healthcare of the Carolinas (CHC Carolinas) which merges with Aetna Health Inc. effective 1/1/2016. The purpose of this filing is to provide the Department with the proposed rates for the products noted below; this information may not be appropriate for other purposes. As stated more fully below, the rates requested in this submission assume that members who purchase through the federal-facilitated marketplace will remain eligible for federal subsidies. We reserve the right to amend or withdraw this rate filing if the Supreme Court holds otherwise in the pending case of King v. Burwell.
- d. Market: This filing covers products that will be offered in the Individual market, both on and off the Exchange.
- e. Policy Forms: The filing supports rates for the forms that will be filed in the next few weeks referencing the HIOS Issuer ID above. We will update the memo with the final form numbers.
- f. Description of the Benefits: A detailed description of all proposed plan designs can be found in the form filing for the policy forms referenced above.
- g. Marketing Methods: Plans will be marketed on the Exchange, as well as directly and through brokers.
- h. Identification of Block as Open or Closed: All plans included in this filing will be open to new membership.
- i. Terminated Products/Plans: Products being retired from 2014 are denoted in the attached URRT.

2. Proposed Rates

Reference Exhibit I: Rate Development for detailed calculations supporting the following section.

- a. History of Rate Adjustments:
 - i. January 1, 2014 Initial Introduction of these products
 - ii. January 1, 2015 5.3%

- b. Effective Date: The rates included in this filing will be effective 1/1/16 through 12/31/2016.
- c. Months of rate guarantee: These rates are guaranteed for calendar year 2016. Individual policies will all renew on January 1st of each proceeding calendar year.
- d. Proposed % Rate Adjustments:
- i. Average Adjustment: 31.8%
 - ii. Threshold Rate Increase: HMO On-Exchange – CB {28.58%}; POS - On-Exchange (COV) {30.90%}; POS – PD (COV) {33.60%}
 - iii. Maximum Rate Adjustment: 39.0%
 - iv. Minimum Rate Adjustment: 28.2%
 - v. Cumulative Rate Adjustment: 31.8%
- e. Description of Rate Development: Premium rates were developed by projecting allowed claims cost in 2016 using our current individual ACA book of business with appropriate adjustments as described below. Projected allowed claims were then converted to the expected paid claims net of reinsurance recoveries and risk adjustments. Finally, we applied assumed SG&A expenses, taxes and fees, etc. to develop our projected single gross premium for the 2016 individual book.
- f. Reason for Rate Adjustment: 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);
 - Revisions to our assumptions about population morbidity and the projected population distribution;
 - Changes to the reinsurance program;
 - Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;
 - Changes in our pricing models used to determine the impact of cost sharing designs; and
 - Changes in provider networks and contracts.
- g. % of Rate Adjustment Attributable to Experience: Base period claims experience has been updated to reflect calendar year 2014 individual ACA experience (instead of calendar year 2013 small group) resulting in an approximate 35% increase to the starting point claims projection.
- h. Average Annual Premium per Member:
- i. Before Rate Adjustment \$4,066
 - ii. After Rate Adjustment: \$5,358
- i. Number of Policyholders: As of March 31, 2015 we had approximately 34,000 enrolled members in our ACA compliant plans.

3. Experience Period Premium and Claims

- a. Dates of Service for the Experience Period: 1/1/14 – 12/31/14
- b. Date Through Which Claims Were Paid: 2/28/2015
- c. Estimate of Allowed Claims Used to Develop Rates:

See Exhibit I, Section A for allowed experience. Allowed claims come directly from the claim records for hospital and physician services. Capitated benefits, including pharmacy, use the capitation rate for incurred claims and the allowed claims are calculated as the incurred claims plus estimated cost sharing.

- d. Treatment of Experience for Grandfathered Policies: Not applicable.
- e. Method Used for Determining Allowed Claims: See section 3(c) above

- f. Incurred But Not Paid Claims: The same process is used for developing incurred but not paid estimates for both paid and allowed claims. Paid and allowed claims are adjusted for incurred but not paid completion factors.

Historical experience of claims is used to develop the medical claims reserve (commonly known as "IBNR"), a reserve for all medical claim amounts incurred but not yet reported and incurred, reported but not yet paid. More specifically, historical claims payment patterns are used to predict each month's ultimate incurred claims from paid claims. IBNR estimates are developed using actuarial principles and assumptions that consider, among other things, contractual requirements, historical utilization trends and payment patterns, benefits changes, medical inflation, product mix, seasonality, membership and other relevant factors including a review of large claims.

The completion factors are developed using the historical claim costs for the same block of business underlying the base period experience from Worksheet 1, Section 1.

- g. Premium in Base Period: Earned premium for the block is reported on Exhibit I, Section A, before any adjustments prescribed when calculating the MLR rebates, such as taxes and assessments. The 2014 MLR rebate is \$0.0M, that we anticipate to report on the 2014 Supplemental Health Care Exhibit, resulting in the total earned premium, net of rebates, reported on Worksheet I, Section I.

4. **Adjustments to Allowed Claims During the Base Period**

- a. Private Reinsurance: No adjustment has been made to Allowed Claims for the impact of reinsurance.
- b. Pooling: Not applicable

5. **Projection Factors**

- a. Changes in Benefits: The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for both Single Risk Pool products that have essentially identical benefits and coverage issued outside the Single Risk Pool which does not cover all EHBs. The projection factor reflects the pro-rated impact of these additional benefits. The benefit changes determined to have an impact on rates are detailed in Exhibit 3. The PMPM was then converted to a percentage of allowed when applied to the claims cost projection in Exhibit 1.

Additionally, benefit plans offered by Aetna on the Exchange include coverage for pediatric dental with an assumed cost as shown on Exhibit 3.

- b. Trend Factors (Cost/Utilization): Anticipated annual trend from the experience period to the rating period for the product line is shown in Exhibit 4:

- i. Medical Trend

- 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. The trends noted in the table above are for our current full network prior to any cost savings associated with network changes.

- ii. Pharmacy Trend

- Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in Exhibit 4

are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend if applicable.

- c. Projected Changes in the Demographics of the Population Insured: The overall change in the morbidity of the population insured (as described in below in section d.) inherently includes changes in the demographics of the underlying population; a portion of the morbidity change described below has been allocated to the demographic adjustment. The demographic change is based on our combined pre-ACA and ACA experience is adjusted to the demographics of the projected ACA only book of business. See Exhibit 2 for additional detail.
- d. Projected Changes in the Morbidity of the Population Insured: The experience period data includes claims for both single risk pool policies issued in 2014 and non-grandfathered individual policies issued prior to January 1, 2014. The projected change in the morbidity of the population is based on modeling summarized in Exhibit 2. The summary shows the starting point risk relative to the market in 2014 for the two subsets of experience and the final 2016 projected risk level based on current members and anticipated new entrants to the single risk pool, along with the anticipated change in the morbidity for each.
- e. Other Projected Changes:
 - i. Network Impact – Aetna developed specific networks for ACA products in order to improve the affordability of health care coverage for our members. The impact of network changes reflects provider contract rates for 2016 products including steerage to low cost providers based on benefit design compared to the base period 2014. Network savings specific to certain plan designs (i.e. Aetna's HPN model noted in section 1 above) are included in the Pricing Actuarial Value on Worksheet 2. Overall network savings (averaged using Worksheet 2 projections by product) are estimated to decrease claims as detailed in Exhibit 9.
 - ii. Area Impact – The distribution of members by rating region (a.k.a. area) is generally assumed to mirror the experience period for the ACA population and adjusted for the proposed rate increases by rating area. The slight change in membership distribution by rating region has an impact on expected claim costs as shown on Exhibit 1 and detailed in Exhibit 8.

6. Credibility Manual Rate Development

- a. Methodology Used to Develop the Credibility Manual Rate: The Individual ACA experience used as the basis for the manual rate was adjusted in a similar manner as the base period Individual experience for changes in population risk, benefit design, demographic, network, and rating regions. Capitated benefits that will occur in the projection period also occurred in the base period Individual ACA experience for the manual rate.
- b. Source and Appropriateness of Data Used: The source data for the manual rate is our HMO based Individual ACA experience. Individual ACA experience is an appropriate source for the manual rate because it already reflects benefit coverage requirements, guaranteed issue requirement and impact of subsidized plan designs on the Exchange. See Exhibit 1 for the full rate development.
- c. Adjustments Made to the Data: See 6.a above.
- d. Inclusion of Capitation Payments: Capitation was projected in the same fashion as all other categories of claims.

7. Credibility

- a. Credibility Methodology and Selected Levels: Aetna chose to rely on Individual ACA business experience only to reduce the number of adjustments required (going from pre-ACA to ACA coverage

with the prior pre-ACA Individual plans requires a number of assumptions about cost changes). The Individual ACA block of business includes 233,948 member months during the experience period and is considered fully credible.

- b. Given the previous underwriting and coverage levels offered in the Individual market in South Carolina, Aetna's pre-ACA Individual block (included in the experience on Worksheet 1) was not considered in the final claims projection and was given 0% credibility.

8. Covered Services

- a. EHBs: A complete list of EHB items can be found in the HIOS templates included in the separate Forms filing.
- b. State Mandated Benefits which are not EHBs: All benefits are EHBs.
- c. Eliminated Benefits: Not applicable.
- d. Additional Supplemented Benefits: Not applicable.
- e. Changes in the Level of Covered Services: Not applicable.
- f. EHB Substitutions: Not applicable.
- g. Changes in Formulary: A complete list of Formulary changes can be found in the HIOS templates included in the Forms filing.

9. Credibility Adjusted Projected Claims PMPM – Calculated by credibility weighting the Projected Base Period experience PMPM and the Credibility Manual Rate as shown in Exhibit 1.

10. Single Risk Pool / Projected Index Rate

The projected 2016 index rate is calculated in accordance with federal regulations, normalized for the allowable modifiers which include member age (including child cap), tobacco use status and rating factors for each geographic region.

For the catastrophic plans, Aetna developed an adjustment relative to the single risk pool to reflect the healthier and younger population we anticipate to enroll in these plans, based on eligibility requirements. Because the catastrophic plan is handled separately in terms of the risk adjuster mechanism, it is appropriate to reflect this in the pricing. We assumed the majority of enrollees will be less than 30 years old.

11. Projected Adjusted Index Rate

- a. Risk Transfer Payments/Charges: Based on Aetna's projected relative risk compared to the market as a whole, as well as the projected market average premium, we are projecting a risk transfer charge as shown in Exhibit 2 in addition to the risk adjustment user fee of \$0.15 PMPM.
- b. Transitional Reinsurance: The net impact of reinsurance is shown on Exhibit 1. We estimate 2016 reinsurance recoveries by relying on an internally developed model using state specific small group claims data incurred September 2012 through August 2013, trended forward with a factor of 9.7% to 2016 as well as state specific individual ACA claims incurred January 2014 through December 2014. We assume claims would be reimbursed at the federally established parameters of 50% of paid claims between \$90,000 and \$250,000, adjusted for 2016 enrollment assumptions and adjusted for the state specific geography. We expect the transitional reinsurance program to reduce average claims for these products by the amount shown in Exhibit 1 in 2016 including the impact of the Reinsurance Contribution.

- c. Exchange User Fees: The Exchange user fee is based on a 3.5% user fee that is projected to apply to members that purchase coverage through the Exchange.

12. Plan Adjusted Index Rates

- a. Exhibit 7 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 15. The following briefly describes how each set of adjustments was determined.
- b. **Actuarial Value and cost sharing**: We use internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also review the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The result of these analyses is the cost sharing adjustment (1.0 indicates full coverage of allowed claims) in Column 8. In Column 9, we applied an adjustment for the impact different levels of cost sharing have on the use of medical services, which is based in part on the induced utilization factors used in the Risk Adjustment program. These adjustments are first normalized to result in an aggregate factor of 1.0 when applied to the projected 2016 membership.
- c. **Provider network, delivery system, and utilization management**: The network adjustment (Column 6) reflects the estimated 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 estimate the expected impact on allowed claims.
- d. **Benefits in addition to EHBs**: Column 7 indicates the projected impact on allowed claims. Since all plans include the same benefits in addition to EHBs, the adjustment does not vary by plan.
- e. **Catastrophic Plan Eligibility**: We apply a uniform factor to all catastrophic plans. Development of the factor is discussed above in the 'Index Rate' section. The impact is reported on Exhibit 7.
- f. **Distribution and administrative costs**: Column 14 reflects the projected administrative costs and profit margin.

13. Actuarial Values

- a. AV Metal Values: The AV Metal Values on Worksheet 2 were based on the AV calculator.

As seen in the submitted Unique Plan Design Justification, the following benefits within Aetna's 2016 Individual portfolio are not compatible with the parameters of the Actuarial Value Calculator:

[REDACTED]



As certified in the Unique Plan Design Justification, only in-network cost-sharing, including multi-tier networks, was considered.

The plans have been accurately entered into the AV Calculator and the metal levels assigned accurately reflect the results of the AV Calculator.

For further detail and certification, please refer to the submitted Unique Plan Design Justification.

- b. 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.

14. Paid to Allowed Ratio – The projected paid to allowed ratio in the projection is based on the projection of members by benefit plan on Worksheet 2. The paid to allowed ratio is approximately 66.7% in the 2016 projection.

15. Non-Benefit Expenses Including Risk and Profit Margin

- a. Projected Non-Benefit Expense

See Exhibit 1

- b. Varying Non-Benefit Expenses by Plan: The HMO On-Exchange – CB products will be administered on a different platform than the POS - On-Exchange (COV) and POS – PD (COV) products and will have differing non-benefit expenses.

16. Calibration

- a. Age Curve Calibration: We used actual exchange enrollment by age to develop a demographic adjustment as shown in Exhibit 10. The calibration factor is set by determining the average age factor (using the HHS standard age curve) for the projected enrollment by age and taking its reciprocal. The average age factor is a member-weighted average. We also apply an adjustment factor to the average

age factor to account for the impact of limiting billable members to three dependents younger than 21. This can be seen in Exhibit 10.

- b. **Geographic Factor Calibration:** Exhibit 11 summarizes the rating area definitions and factors. Exhibit 11 displays the projected membership by area and the projected average area factor. The Geographic Factor Calibration is the reciprocal and is reflected in Column 18 of Exhibit 7.

Rating area factors were developed by analyzing provider level historical service category claims data for our commercial fully insured group business, adjusted for utilization, case mix differences, known and anticipated future contracting changes, etc. Data is then rolled up using utilization at each provider for the state defined Region level and compared to the overall state average (weighted by utilization). The resulting ratios represent expected costs in a particular rating area relative to the average expected costs for the state as a whole; they do not include expected utilization differences by Rating Region or morbidity differences. Proposed area factors for regions Aetna is planning to do business in can be found in the attached Exhibit 11.

- c. **Tobacco Factor Calibration:** We apply a 10% load for all tobacco users age 21 and older. We expect approximately 4% of enrollees to be tobacco users. The average tobacco factor is calculated on Exhibit 12. The non-tobacco adjustment (to derive a rate for non-tobacco users) is the reciprocal of the impact as illustrated in Column 10 of Exhibit 7.

17. Development of Rate Tables – Base rates for each Aetna proposed plan design can be found in the attached Exhibit 7 including calibration factors described above in section 16.

Consumer Adjusted Premium Rate Development

Column 18 of Exhibit 7 shows the final base rate for each plan effective 1/1/2016. The base rate is the rate that would be charged to an enrollee for whom the tobacco, area, and age factors are each 1.0. The Consumer Adjusted Premium Rate for each member is determined by taking the product of the base rate from Column 18, and the age, area, and tobacco factors

Rating Methodology

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

The premium for each billable member is calculated as:

Plan Base Rate * Age Factor * Area Factor * Tobacco Factor

The resulting rate for each member is rounded to the nearest cent.

An example of this calculation is shown in Exhibit 13.

18. Company Financial Position

- a. As of December 31, 2014, Aetna Health Inc. (Pennsylvania)'s statutory net worth is approximately \$446 million. Aetna believes that the planned filing will only improve the operations of the business and poses no significant business risk to the company.

19. Loss Ratios

- a. **Loss Ratio Requirements:** Under the current pricing assumption, the average MLR, as defined by PPACA, is projected in the attached exhibits assuming adjustments made for items detailed in the following subsection.

- b. Projected Federal MLR: See Exhibit 1. Note the impact of Market Stabilization programs is assumed to be \$0 and the impact of Fraud Reduction activities is assumed to be reflected in our run rate experience.

20. Reliance: Although I have reviewed them for reasonableness, the following assumptions were developed by others. I have not reviewed the methodology in detail due to the substantial amount of additional time required and therefore have relied upon the expertise of the individuals in the attached reliance statements.

- Actuarial Value And Modifications
- Capitation Rates
- Contracting Assumptions

21. Actuarial Certifications:

- a. I, [REDACTED], am [REDACTED] for Aetna and am issuing this opinion on behalf of Aetna Health Inc., a wholly owned subsidiary. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I hereby certify in my opinion that,

- b. The projected index rate is:
 - i. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1))
 - ii. Developed in compliance with the applicable Actuarial Standards of Practice
 - iii. Reasonable in relation to the benefits provided and the population anticipated to be covered
 - iv. Neither excessive nor deficient
- c. 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.
- d. 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.
- e. No EHB substitutions were made to the products in this filing.
- f. Geographic factors represent expected costs in a particular rating area relative to the average expected costs for the state as a whole; they do not include expected utilization differences by Rating Region or morbidity differences.
- g. The proposed rates are in compliance with all applicable South Carolina and Federal laws and regulations.
- h. This filing is in conformity with all applicable Actuarial Standards of Practice, including, but not limited to:
 - i. ASOP No. 5, Incurred Health and Disability Claims
 - ii. ASOP No. 8, Regulatory Filings for Health Plan Entities
 - iii. ASOP No. 12, Risk Classification
 - iv. ASOP No. 23, Data Quality
 - v. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
 - vi. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
 - vii. ASOP No. 41, Actuarial Communications.

