Aetna Health Inc. (a PA corp.)
Actuarial Memorandum and Certification

I. General Information

Company Information:

Company Legal Name:	Aetna Health Inc. (a PA corp.) / Aetna Health Insurance Co.
State:	Arizona
NAIC ID:	95109 / 72052
HIOS Issuer ID:	78611
Market:	Small Group
Effective Date:	January 1, 2027

Company Contact / Signing Actuary Information:

[redacted]

Filing Information

Type of Filing:	Form/Threshold Rate Increase
Type of Plan:	HMO/POS; Off Exchange; New Business and In Force
Effective Dates:	January 1, 2027 – December 31, 2027

[redacted]

II. Purpose & Assumptions for Proposed Rates

<u>The purpose of this filing is to:</u>

1) Provide support for the development of the Part I Unified Rate Review Template (URRT);
2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms in this filing;
3) Request approval of the proposed monthly premium rates; and
4) Provide benefit plan design summaries for the products included in this filing.

Banner Health and Aetna Health Plan Inc. (BHI) is within Aetna Health Inc.'s (AHI) controlled group for purpose of 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 Arizona beginning January 1, 2027. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in Arizona.

Proposed Rates

Monthly premium rates for all Small Group Market products in Arizona are being revised for effective dates January 1, 2027 through December 31, 2027.

A. Reason for Rate Increase:

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 population morbidity, projected population distribution, and risk adjustment;
- 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.

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 Exhibits 1 and Exhibit A-1 (AV Screenshots). All benefit and cost sharing parameters comply with Arizona benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Modifications 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.
- Pricing does not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

Exhibit 2 shows the average increases for plans covered by this filing.

III. Experience Period Premium and Claims

Banner Health and Aetna Health Plan Inc. (BHI) is within Aetna Health Inc.'s (AHI) controlled group for purpose of experience reporting. Experience reported in Worksheet 1 and 2 of URRT Part I reflects experience from plans offered under the AHI entity.

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, 2025 through December 31, 2025 and paid through March 31, 2026.

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

Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered business in Arizona. Our internal projections, as of April 2026, indicate that the expected rebate for the Arizona Minimum Loss Ratio pool in 2025 is approximately [redacted] of premium, after taking into consideration risk adjustment payables/receivables. Experience period premium shown in Worksheet 1, Section I reflects an adjustment of this magnitude. The premiums before and after adjustment for MLR rebates are:

[redacted]

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 reported (IBNR) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNR completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNR 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 IBNR estimates for allowed claims.

IV. 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 in April, 2020. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, included day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, 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.

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.

V. Projection Factors

A. Changes in the Morbidity of the Insured Population:

The experience period data includes experience for community-rated policies issued to small employers in 2025.

B. 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 Single Risk Pool products that have essentially identical benefits as what will be covered in 2027.

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. This includes any changes in induced demand related to shift from benefit plans from manual experience to projected portfolio.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition, large claims pooling, adjustment for deductible suppression, and changes in induced demand.

Please see exhibit 5-1 for the different components of 'Other Adjustments'. These components include:

- Network adjustment: adjust for the different network mixes between manual experience and projection period
- Pooling impact: smooth out large claims that incurred within the manual experience
- Deductible suppression: adjust for the fact that some members are not in the experience period for full 12 months and their claims are masked by their deductible
- Average SG Premium trend: reflects anticipated membership enrollment by quarter

Exhibit 5-2 has a more detailed build-up of the network adjustment.

E. Trend Factors (Cost/Utilization):

Medical trend factors are based on our Medical Economics Unit's national guidance, 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 national and Arizona 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.

The anticipated annual trend from the experience period to the rating period is [redacted] Additional detail is provided in Exhibit 3.

Medical: [redacted]

[redacted]

Pharmacy: [redacted]

VI. Manual Rate Adjustments

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the Aetna experience incurred from January 1, 2025 to December 31, 2025 and paid through March 31, 2026 in the Arizona Small Group ACA compliant only market, HMO and PPO combined (all entities where we offer plans). This experience is considered an appropriate source for the manual rate since we are pricing and projecting for Small Group ACA business in 2027. The same manual data was used to price both the HMO and PPO blocks of business in order to maintain an appropriate differential between the products.

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 composition, in addition to unit cost and utilization trend, as illustrated in Exhibit 4.

C. Inclusion of Capitation Payments:

No services in the experience period were covered by capitation and no services provided in 2027 are expected to be covered by capitation arrangements.

D. Additional Adjustments:

[redacted]

VII. 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.

The following reasons explain why we chose to use our combined HMO/PPO ACA population as the basis for our manual rate development:

- The Credibility Manual section on Worksheet 1 of the URRT has over 113K member months and consists of Aetna's Arizona SG ACA-only population, HMO and PPO combined.
- We believe Aetna's HMO and PPO should have similar rates given the same benefit design, and that is best achieved if both HMO and PPO use the same credibility manual.
- We believe Aetna's broad network plans offered under the separate entities should have similar rates given the same benefit design and network, and that is best achieved if each entity uses the same credibility manual.

VIII. Development of Projected Index Rate

Refer to Section V, Projection Factors, for adjustments used to develop the projected index rate.

IX. Development of Market-Wide Adjusted Index Rate

A. Market-Adjusted Index Rate

Worksheet 1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustment for Risk Adjustment (and Exchange User Fees were) are discussed below. The risk adjustment is displayed on an allowed-basis.

B. Reinsurance – Experience Period

The transitional reinsurance program was only in effect from 2014 to 2016.

C. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level, as determined by CMS. The transfer is allocated to the member-level by applying the HHS risk transfer calculation to each member relative to the imputed market-average, such that members with higher resulting relative transfer scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The estimate Risk Adjustment transfer for the experience period is shown on Worksheet 1, Section I of the URRT. [redacted]

D. Risk Adjustment – Projection Period

[redacted]

[redacted]

E. Exchange User Fees

Exchange User Fees are not applied in this filing.

X. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 6.

The prospective general and administrative expenses are set to achieve the 80% MLR threshold requirement. Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2026 projections, and projected changes in expenses, inflation, and membership for our 2027 National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in Arizona. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2027, as well as Federal income tax and State Premium taxes. The risk adjustment user fee is included in the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

XI. Projected Loss Ratio

The projected loss ratio calculated in the traditional way and Medical Loss Ratio (MLR) as defined by PPACA and before any credibility adjustment, are shown in Exhibit 7.

The projection applies to products included in this filing and is a standalone calculation for the 2027 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

XII. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in Arizona through Aetna Health Inc.'s (AHI). The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d). Rates for plans that may be renewed outside the Single Risk Pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing.

XIII. 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.

Non-EHBs in the experience period include:

- Elective abortion (<0.01% of total claims)

Non-EHBs in the projection period include:

- Elective abortion (<0.01% of total claims)

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 of benefits in addition to EHBs, 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).

Small Group Market Trend Adjustments

Exhibit 8 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend and leveraging.

[redacted]

XIV. Market-Adjusted Index Rate

Exhibit 9 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustment for Risk Adjustment was discussed, previously. The risk adjustment is displayed on a paid-basis and the exchange user fee is estimated as a PMPM based on the target premium rate on Worksheet 1 of the URRT. These values have each been converted to percent of allowed claims in this exhibit.

XV. Plan-Adjusted Index Rates

Exhibit 10 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, Cost Sharing

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

1. We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The combination of these two analyses is a projection of the relative paid to allowed ratio which also reflects the impact of out of network coverage.

2. 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 2027 membership.

B. Distribution and Administrative Costs

The factors in Column 3 reflect 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 the following benefit:

- Elective abortions (less than 0.01% impact)

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 2025 for the experience period.

XVI. Calibration

Exhibit 10 illustrates the development of the Calibrated Plan Adjusted Index Rates from Plan Adjusted Index Rates. The Calibrated Plan Adjusted Index Rates are displayed in Column 13. The following briefly describes how each calibration factor in Columns 9 to 11 was determined.

A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit 11. Exhibit 11 demonstrates the determination of the Plan-Level Average Age Factor. Plan membership is based on issuer's similar February 2026 plan membership and projected changes in the market.

The age that most closely corresponding to the weighted average age factor and the age calibration factor is the reciprocal of the weighted average age factor shown in Exhibit 11.

B. Geographic Factor Calibration:

Exhibit 12 summarizes the rating area definitions and factors, and displays the projected membership by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor.

C. Quarterly Trend Calibration:

The development of the average projected trend factor is discussed in Section XIII.

XVII. 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:

Calibrated Plan Adjusted Index Rate * Age Factor * Area Factor * Trend 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 Exhibit 13.

AV Metal Values

The AV Metal Values on Worksheet 2 were based on the 2027 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 screenshots provide detail on the modified entries and adjustments to AV, as applicable. Exhibit A-1 provides a description of the benefits and screenshots from the AV Calculator.

XVIII. Membership Projections

The membership projections by plan can be found on WS2 of the URRT. Membership projections are based on historical experience, enrollment in ACA-compliant plans through March 2026, mapping of 2026 plans to 2027 plans, and our expectations for future sales.

XIX. Plan Type

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

XX. Uniform Modification

Cost sharing has been updated from 2026 to reflect requirements for coverage offered in 2027 in compliance with ACA uniform modification requirements. We did not change the covered benefits, service areas, or network types associated with our plans. Members are mapped into the 2027 plan with the same network and service area, and the most similar cost sharing as their 2026 plan.

XXI. Additional Information Necessary to Effective Rate Review

[redacted]

XXII. 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:

- [redacted]

XXIII. Additional Arizona Law Requirements

This filing meets the requirements in ARS § 20-2311:

- The only adjustments made to the Calibrated Plan Adjusted Index Rates are filed age, geographic area, trend, and family composition.
- Demographic adjustments are applied consistently across all small employers.
- The state defined seven rating regions are used.

In addition, Aetna intends to make available composite rates in accordance with Arizona's Small Group Alternative Composite Premium Calculation Method as approved by CMS.

XXIV. Actuarial 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] 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 Arizona, 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.
    h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

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.

6/9/2026
Date

Aetna Health Inc. (a PA corp.) / Aetna Health Insurance Company