

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name: Aetna Health Inc. of Maine
State: Maine
HIOS Issuer ID: 73250
Market: Individual
Effective Date: 01/01/2017
Rate Filing Tracking Number: AETN-130553497
Policy Form(s): Form-HI IVL HPOL-CB-2017[-HIX] 01
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FORM-HI IVL HPOL-2017-01
SOB-HI IVL SOB NM 000 01
Form Filing Tracking Number: SERFF-AETN-130562087; AETN-130562039

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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 premium rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan design summaries for the products included in this filing.

The development of the rates reflects the impact of 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 Maine 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 Maine.

2. Proposed Rate Increase

Monthly premium rates for Individual Market products in Maine 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; and
- Updates to our pricing models used to determine the impact of cost sharing designs.

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.
- Aetna's internal pricing models have been updated to reflect more current information on claim expectations associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Table 1 of the supporting documentation exhibits shows the average threshold increases for products covered by this filing.

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 March 31, 2016.

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 Maine. Our internal projections indicate that no MLR rebate is expected to be paid in 2016 (for 2015 experience) for the Individual MLR Pool in Maine. As such, no adjustment was made to premiums to account for expected rebates.

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

Allowed claims come directly from the claim records for hospital and physician services. For markets with capitated services, the capitation rate is used for incurred claims; allowed claims are then the same as the incurred claims.

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. The Maine Historical Experience exhibit in Section A documents the impact of the IBNP reserves by calendar year.

In addition to the fee-for-service and capitation payments discussed above, some of our provider contracts include provisions under which we share claim cost differences with the provider relative to a pre-determined target amount. These adjustments serve to increase our claims cost when results are favorable to the target and decrease our claims costs when results are unfavorable. We adjust both allowed and incurred claims by our current estimate of the impact of provider risk sharing provisions.

4. Benefit Categories

Aetna's 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 February, 2016.

Individual Experience – Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including 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 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.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The June 30th release of 2015 Risk Adjustment and Transitional Reinsurance results by CMS, as well as the January 1, 2017 entrance of Anthem's Grandfathered and Transitional membership into ACA plans, has caused Aetna to re-evaluate its population morbidity assumptions for calendar year 2017. Details are included in Section B, Index Rate Development, as well as the Supplemental Actuarial Memo.

B. Changes in Benefits:

The experience data includes experience for Single Risk Pool products that cover all EHBs. The projection factors reflect the impact of any changes in 2017 State Benchmark EHBs and any new state mandated benefits. Specific to Maine, Aetna has not identified any Benchmark changes nor new state mandates that have a material impact to experience projections.

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 shifts in the age/gender and area mix using internally-developed factors. Section B, Index Rate Development, includes exhibits detailing this normalization process for both items.

D. Other Adjustments:

The 'Other' adjustment also includes the projected impact of any changes in network composition and/or provider contracting.

E. Trend Factors (Cost/Utilization):

Medical trend factors are based on local trend and network experience excluding catastrophic claims, with national trend results used for reasonability testing. 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 with projected paid trend.

Pharmacy trends are also based on local market commercial group trend analysis, with national expectations as a benchmark. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

Table 2, in the supporting documentation exhibits, displays anticipated annual trend from the experience period to the rating period. Further trend details are provided in Section A and the Supplemental Actuarial Memo.

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 through December 31, 2015 and paid through March 2016 for issuers 73250 and 53357 in the Maine Small Group (HMO / PPO) 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.

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. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including 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.

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 Individual 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 unit cost and utilization trend, as discussed in Section B, Index Rate Development as well as the Supplemental Actuarial Memo.

C. Inclusion of Capitation Payments:

The manual experience includes capitation for the same services that are expected to be capitated for the products in this filing in 2017. We have adjusted the manual experience for known or anticipated changes in capitation contracts and projected changes in demographics where capitation rates vary based on demographics.

7. Credibility of Experience

The CMS Medicare full credibility standard is 24,000 member months. Based on Aetna's experience, the Medicare population has significantly higher utilization – in the realm of 10 times of the Commercial population. Hence, we assumed a full credibility standard of 240,000 member months and calculated our credibility based upon the partial credibility calculation $(2,523 \text{ ACA experience MMs} / 240,000)^{0.5} = 10.3\%$

8. Paid-to-Allowed Ratio

The projected paid to allowed ratio is 76.7%. The development of this number, along with the projected membership distribution by metal tier, is illustrated in Section B, Index Rate Development. Paid to allowed ratios are based on 2015 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. 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 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

Maine is a relatively new market, thus we have priced to the assumed market average morbidity adjusted to reflect Aetna's national results for its Aetna Whole Health product versus Traditional products. This impact has been measured at approximately 5% of premium. Thus, we project a risk adjustment payable of \$19.13 PMPM, which includes 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 Section B – Index Rate Development.

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 an 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.

Federal taxes include Federal income taxes as well as PPACA taxes and fees based on the Notice of Benefit and Payment Parameters for 2017. 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 component 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 **87.65%**, as shown in Table 3 of the supporting documentation. Please note that this calculation is an estimate only, as it does not account for potential MLR rebates, credibility adjustments, nor Risk Adjustment program results.

12. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer or renew in the Individual market in Maine through Aetna Health Inc. 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.

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, as well as 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 E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustments (Risk Adjustment and Exchange User Fees) were discussed previously. The risk adjustment on Worksheet 1 of the URRT is displayed on a paid basis. The exchange user fee is estimated as a PMPM based on the target premium rate. However, the values reflected in Exhibit E-1 have each been divided by the paid to allowed ratio to convert them to an allowed-basis to match the Projected Index Rate.

15. Plan-Adjusted Index Rates

Exhibit E-2 illustrates the development of the Plan Adjusted Index Rates by applying 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, and Tobacco:

The factors in Columns 2a & 2b are the product of three separate adjustments:

1. Aetna uses internal models developed on large group claims experience to estimate the impact of different cost sharing designs. The projected experience and projected membership by plan was also reviewed to estimate an overall paid-to-allowed ratio. The combination of these two analyses is a projection of the relative paid to allowed ratio.
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 2017 membership.
3. The non-tobacco adjustment is the reciprocal of the average tobacco factor, as illustrated in Section B, Index Rate Development.

B. Distribution and Administrative Costs:

Column 3 reflects the adjustment for projected administrative costs, including sales, marketing, 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. These adjustments were developed in consultation with our contracting area and other subject matter experts to determine 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. The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). Hence, all factors are 1.00.

E. Catastrophic Plan Eligibility:

After reviewing the morbidity of enrollees younger than age 30 across our book of business, and after considering the impact of those eligible to enroll in the plan due to hardship, we have priced our catastrophic premiums to be approximately 15% below an equivalent metallic plan.

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

A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve, as displayed in Sections B & C.

We project a premium-weighted average age factor for the 2017 membership using the prescribed age curve and the projected age distribution based on 2016 Maine Marketplace statistics. 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 Section B.

B. Geographic Factor Calibration:

Section B also 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. Trend Calibration:

This factor is specific to Small Group, and is therefore 1.0 for this filing.

17. 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 * Tobacco 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 Table 4 of the supporting documentation.

18. AV Metal Values

The AV Metal Values on Worksheet 2 are 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.

19. 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 above. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

20. Membership Projections

Exhibit E-3 in the supporting exhibits summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through January 2016, and our expectations for future sales. Projected enrollment in cost sharing reduction subsidy plans is based on membership distribution enrolled in these variants on the Maine Marketplace as of January 2016.

Terminated Plans and Products

Table 5 of the supporting exhibits provides a plan and product crosswalk from 2015 to 2017. The crosswalk includes the list of single risk pool plans and products that have terminated prior to January 1, 2017 due to non-compliance with Actuarial Value in the successive year, products that have experience in the single risk pool experience period, and products that were made available in 2016 and 2017.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

21. Plan Type

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

22. Warning Alerts

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.

23. Benefit Design

This filing includes the following standard plans: one Catastrophic, one Bronze, three Silver, and two Gold. The Silver and Gold plans within HIOS Product ID ME004 are only available on a renewal basis off the Maine Marketplace.

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 Section D. All benefit and cost sharing parameters comply with Maine benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

24. Marketing

As described above, several 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.

25. 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.

Additionally, with respect to determining the applicable premium risk class due to tobacco-use status, the underwriting criteria will be consistent with the communicated federal thresholds. Tobacco use will be determined by use of tobacco on average of four or more times per week (excluding religious or ceremonial uses) within no longer than the past six months.

26. Renewability

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

27. Company Financial Condition

As of December 31, 2015, the capital and surplus held by Aetna Health Inc. of Maine was approximately \$13 million.

This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2015.

The Company issues commercial and Medicare Advantage coverage for multiple business segments, including to large employer, small employer, and individual purchasers.

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

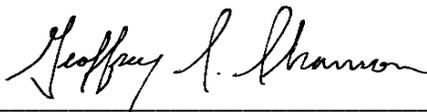
While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation 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, Geoffrey S. Shannon, am an Associate 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 Maine, the rules of the Bureau of Insurance, 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.

Furthermore, these rates are not excessive, inadequate, nor unfairly discriminatory.

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.



Geoffrey S. Shannon, ASA, MAAA
Aetna Health Inc.

July 15, 2016

Date