



Aetna Life Insurance Co.
151 Farmington Avenue – RS12
Hartford, CT 06156-7400
(860) 273-1343
Fax: (860) 902-8517

September 9, 2016

Ms. Mary Hooper, ASA, MAAA
Life & Health Actuary
Maine Bureau of Insurance
Gardiner Annex
124 Northern Avenue
Gardiner, Maine 04345

**Subject: AETNA HEALTH INC. (AHI) – SUPPLEMENTAL ACTUARIAL MEMORANDUM - FINAL
Maine Individual HMO Rate Filing - Effective January 1, 2017 through December 31, 2017
SERFF #: AETN-130553497; NAIC #: 95517; HIOS #: 73250ME004, 73250ME007**

This **final** rate filing is being submitted for review and approval according to Title 24-A, §2736 **and per final disposition from the Superintendent**. The Aetna Whole Health product is offered through Aetna Health Inc. Effective January 1, 2017^{C-5}, it will be available for new business and renewals in the following Maine counties:

- York
- Cumberland
- Sagadahoc
- Franklin
- Knox
- Lincoln
- Oxford
- Androscoggin
- Waldo

C-2: Scope and Purpose of Filing & D-18: Marketing Method:

This filing covers plans offered on- and off-Marketplace to Individuals located in Maine. The benefit plans and associated rates will be available for quotation or renewal effective January 1, 2017. They will be marketed through external broker relationships and direct sales, including Navigators operating on behalf of Maine's Marketplace.

The basis for the development of rates in this offering is a blend of calendar year 2015 experience, paid through March 2016, for Aetna's Maine Small Group and Individual segments. This experience is adjusted for the specific geography, benefit, and network features inherent in the Individual Whole Health product, and for certain demographic and morbidity differences between the existing Small Group and expected Individual populations.

All plans are in compliance with state-specific benefit requirements as well as the requirements of PPACA. Additionally, these plans conform to the federal metallic tiers of coverage, having achieved an actuarial value consistent with the thresholds established for each tier – 60%, 70%, 80%, and 90%, respectively – within the allowable range of deviation of two percentage points.

Associated rates have been developed with consideration of the market changes and rating requirements effective in the Individual market pursuant to the Patient Protection and Affordable Care Act of 2010 and subsequent federal and state regulation.

The descriptions and analyses presented in this rate filing reflect Aetna's understanding of regulations and guidance issued prior to **September 1, 2016**. The rates requested in this submission assume that members who purchase through the federally-facilitated Marketplace will remain eligible for federal subsidies. We reserve the right to amend or withdraw this rate filing should this change.

C-3: Description of Benefits:

The information on corresponding Aetna Whole Health forms on which these rates are based is:

SERFF #	HIOS Product Code	Form IDs	Status
AETN-130562087	73250ME007	Form HI IVL HPOL CB 2017[HIX] 01 SOB HI IVL SOB CB 000 01[HIX]	Offered to new business on & off Marketplace
AETN-130562039	73250ME004	FORM-HI IVL HPOL-2017-01 SOB-HI IVL SOB NM 000 01	Renewal & new business off-Marketplace

In general, the benefits provided are for in- and out-patient hospital care, health care provider services, rehabilitative therapy, prescriptions, x-ray and lab tests, emergency care, and like services that are medically necessary. Pediatric Dental coverage is also included under all plans. These benefits may be subject to various co-pays, deductibles, and co-insurance based on the specific provisions of the plans being offered. Additional details of the benefits and cost-sharing for each plan design can be found in sections C and D of this filing.

This rate filing also conforms to all benefit provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010, including:

- ✓ Elimination of cost sharing for preventive care on non-grandfathered benefit plans;
- ✓ Elimination of lifetime benefit maximums;
- ✓ Elimination of annual dollar maximums for essential benefits;
- ✓ Expansion of dependent age eligibility for children, to age 26;
- ✓ Waiver of pre-existing limitations for children under age 19.
- ✓ Benefit provisions required by the Women's Health mandate

C-4: In-Force Business, Annualized Premium, & & D-10: Average Premiums with Rate Increases:

Current membership is 639 members, with an annualized premium of \$2,380,217. This converts to an annual average premium per individual policy of \$6,486 and per member of \$3,725. The average annual rate increase reflected in the rate filing is **11.2%**, with a minimum rate change of **10.1%** and a maximum rate change of **12.2%**. These rate changes do not include the impact of individual-specific aging nor movement between geographic rating areas.

D-7: Morbidity Basis:

The morbidity basis for this rate filing is the actual 2015 experience results for Aetna's off-Marketplace Individual offering in Maine, blended with existing non-grandfathered Small Group PPO and HMO business, as shown on the "Historical Experience" exhibit in Section A. This blending is necessary as Individual membership for 2015 was only roughly 10% credible with just over 200 members.

As outlined in Section B, Small Group results have been adjusted to reflect the specific geography, product, and benefit features of Aetna Whole Health and for certain demographic and morbidity differences between the existing Small Group and expected Individual populations.

This revised filing also reflects an additional 250 basis points, or 2.5%, deterioration to the expected 2017 Individual population morbidity, as laid out in Section B. While this does include consideration for the Anthem Grandfathered and Transitional membership that will enter the ACA market effective January 1, 2017, it is primarily the result of further analysis of 2015 Risk Adjustment and Transitional Reinsurance data published June 30th by CMS. Aspects of this data that were reviewed include:

- Final 2015 CMS Market-level Reinsurance and Risk Adjustment results
- Final 2015 CMS Maine Risk Adjustment results, Individual vs Small Group
- Final 2015 CMS Transitional Reinsurance results by Maine carrier

Overall, this information regarding the specifics of Maine's Individual and Small Group populations in 2015 led us to the conclusion that there are additional morbidity nuances not identified in the initial rate filing submission, and have addressed that shortfall with this adjustment.

D-8: Mortality Basis:

Mortality is not applicable to this rate filing.

D-9: Issue Age Range:

Premiums are billed on an issue age basis as of the effective date of the quote or renewal. The issue age range is all ages.

D-6: Limitation on the Application of Approved Trend Factors:

This rate filing encompasses a full twelve (12) months of effective dates. Due to the open enrollment process inherent in the Individual market, rates are set at a level premium for the entire calendar year.

D-11: Medical Trend Assumptions:

Please refer to Section A, 'Maine Historical and Projected Trends' exhibit to view Commercial Group trend for 2015. The historical breakdown of unit cost and utilization is based on actual provider billing and Aetna claim payment practices. As such, they are subject to fluctuations for several reasons including: changes in provider billing practices, changes in Aetna claim payment practices, and changes in the mix of services and procedures delivered by the medical profession. These unit cost and utilization trends should not be viewed in isolation nor should they be compared to other external data sources or views of market-based price and utilization changes.

Projected trends utilize historical trend results as a starting point. They are then adjusted for a variety of considerations, such as:

- historical anomalies, such as extreme winter weather or a severe flu season,
- credibility of a Market versus regional and national indicators/results,
- anticipated changes in provider contracts and network changes,
- the introduction and use of new technology,
- economic conditions,
- formulary changes,
- patent expirations,
- new pipeline drugs,
- other general market share shifts, and
- the influence of these on member utilization.

Specific to the differences between actual 2015 trend and projected 2017 trend, the following should be noted:

- Managing inpatient hospital use is an important part of containing overall healthcare costs. As a situation allows, members are encouraged to instead access care in outpatient settings. However, given historical Inpatient utilization, we believe the 2015 utilization of -12.8% to be an anomaly and expect future utilization to be about 1%.
- The decrease to Outpatient utilization, which is made up of ambulatory and emergency services as well as diagnostic services (xray and lab), is also not considered sustainable, especially as economic indicators

continue to improve. Similar to inpatient, we would expect outpatient use to rise about 1% in Maine for 2017 versus 2016. In comparison, national outpatient utilization is approaching 5% annually.

- Pharmacy unit cost trend results for 2015 were driven by the high generic utilization specific to Maine. Continuing conversion from brand to generic medications offset the increasing impact of Specialty medications, which currently total over 40% of overall pharmacy costs. However, given the few brand medicines projected to lose patent security in the near future, Aetna's unit cost trend for 2017 reflects this increasing Specialty impact against a leveling-off of brand-to-generic conversion.

D-12, 13: Maine versus National Experience:

Only experience from 2015 Maine Individual members and non-grandfathered Maine Small Employers has been used to calculate Maine 2017 Individual rates. National experience was not utilized. Please refer to the "Maine Historical Experience" exhibit in Section A for the experience data, by legal entity. In the calculation of projected trend, regional and national trends were used as a check for reasonability only.

D-14: History of Rate Adjustments:

Aetna's Individual offering in Maine was a new as of January 1, 2015; therefore, the only rate adjustment was as of January 1, 2016, which was +0.5% annually based on a weighted average membership distribution.

D-15: Renewability Clause & D-19: Prohibited Rating Practices:

Consistent with Title 24-A, §2736-C, 2.B, 2.C, &2.D, PPACA requires that Individual health plans are guaranteed issue and guaranteed renewal. In addition, the rates in this filing will not be medically underwritten, nor will the premium level vary due to the gender, health status, claims experience, nor policy duration.

D-17: Rating Attributes:

As established under PPACA and corresponding regulation, the allowable rating variables applied to Individuals for 2017 consist of:

- ~ the age of each member
- ~ tobacco usage for each member
- ~ an area adjustment based upon the Individual's residence
- ~ the relative value of the benefit plan chosen

Further details on rate development and the rating factors associated with these variables can be found in Section C, Premium Rate Manual exhibits. They are in compliance with the permitted rating rules in Maine, as laid out in Title 24-A, §2850-B, 3.

D-16 & E-3: Large Blocks of Individual business – Expenses:

Retention is projected at **15.97%** of premium, including investment income, reflecting these components:

Expense Component	Cost PMPM	% of Premium
<i>PMPM Basis</i>		
General & Administrative Expense	\$40.74	9.99%
Broker Commission	\$6.21	1.52%
ACA Risk Adjustment Program Fee	\$0.13	0.03%
ACA PCORF	\$0.17	0.04%
ME Vaccine Assessment	\$2.08	0.50%
Subtotal PMPM:	\$49.33	12.08%

% of Premium

ACA Exchange User Fee	n/a	0.00%
Federal Income Tax	n/a	1.05%
State Premium Tax	n/a	0.89%
Risk & Profit (AFIT)	n/a	1.95%
Subtotal %:	n/a	3.89%
Total Retention as a % Premium:		16.0%
'Pure' Medical Loss Ratio:		84.0%

Please note: The expense breakdown in the Part III Actuarial Memorandum excludes the Reinsurance Contribution and Risk Adjustment Program User Fee. Thus total expenses are reduced by those amounts.

The "Pure" Medical Loss Ratio above can be converted to an estimated federal MLR as follows:

$$\text{Numerator} = \text{Expected Incurred Claims} + \text{Quality Improvement Expenses} = 84.0\% + 0.94\% = 87.17\%$$

$$\text{Denominator} = \text{Expected Earned Premium} - \text{Federal /State Taxes \& Fees} = 100.0\% - 2.52\%$$

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.

D-25: Rate/Benefit Relationships:

The table below provides a comparison of rate and premium levels versus cost-sharing differentials for the benefit plans that will be offered to Individuals in 2017. The Plan Rate reflects the Calibrated Plan Adjusted Index Rate, as noted in section C, Rate Manual, and exhibit E-2. It is unadjusted for age, area, and tobacco use.

The right side of the table displays the deductibles and out-of-pocket maximums each plan. Overall, the premium changes are in line with the differences in deductible and out-of-pocket, especially when considering other plan features.

Plan	Plan Rate	Annual Premium	Premium Change	Deductible	Deductible Difference	OOP Max	OOP Max Difference
ME AWH Gold \$5 Copay PD	\$408.43	\$4,901		\$3,750		\$6,000	
ME AWH Silver \$10 Copay PD	\$283.93	\$3,407	(\$1,494)	\$5,750	\$2,000	\$6,850	\$850
ME AWH Bronze \$35 Copay PD	\$237.75	\$2,853	(\$554)	\$6,400	\$650	\$7,150	\$300

Specifically, the Gold Whole Health plan covers certain Specialist office visits as well as generic drugs (after a health assessment) at 100%. Additionally, brand pharmaceuticals are covered at copay only, no deductible. These features drive a higher induced demand which increases the relative value of the Gold plan versus the next richest plan, Everyday Plus Whole Health.

As it pertains to the premium differential between the Basic and Catastrophic Whole Health plans, the Catastrophic premium rate reflects an additional adjustment of (15%), reflecting the limited age band allowed to purchase this option. Without this credit, the cost difference would be less than the \$100 out-of-pocket maximum difference.

E-5: Actuarial Value of Plans:

Please refer to Section D - 2016 Individual Plans & Actuarial Value exhibits, for 2017 benefit summaries and corresponding Actuarial Value results. These plans will make up the single risk pool for Aetna Health Inc. (AHI) Individual in 2017.

For the location of Actuarial Value inputs in the Forms, please refer to the table below:

Actuarial Value Input	Location in Form
Medical Deductible	Page 3
Medical Coinsurance	Throughout entire schedule – depending on plan feature
Combined Medical & Rx OOP Max	Page 3
Pharmacy Deductible	N/A
Integrated Medical & Rx deductible	Page 3
Inpatient copay per day	Page 7 Coinsurance
Maximum # of days charged for IPH copay	N/A
Emergency room services	Page 8
All inpatient hospital services (incl. MHSA)	Pages 7,16, 17
Primary care visits for illness/injury (excl. preventive)	Page 6
Specialist visit	Page 6
MHSA outpatient services	Pages 16, 17
Imaging (complex only)	Page 18
Rehabilitative Speech Therapy	Page 20
Rehabilitative Occupational & Physical Therapy	Pages 19,20
Preventive care/screening/immunizations	Pages 5
Laboratory outpatient & professional services	Page 18
X-rays & diagnostic imaging (non-complex)	Page 18
Skilled nursing facility	Page 8
Outpatient facility fee/Ambulatory surgery	Pages 8
Physician's surgical services for outpatient surgery	Pages 8
Pharmacy – generics	Page 23
Pharmacy – preferred brand	Page 23
Pharmacy – non-preferred brand	Page 23
Pharmacy – specialty	Pages 24
Cost-share cap on Specialty Rx	Page 24
Medical Deductible	Page 3

D-21 & D-22: Actuarial Certification:

I, Geoffrey S. Shannon, am a member of the American Academy of Actuaries and am qualified in the area of health insurance. I certify to the best of my knowledge and judgment that this entire rate filing is in compliance with the applicable laws of the State of Maine and with the rules of the Bureau of Insurance. Aetna does not medically underwrite nor vary premium rates due to the gender, health status, claims experience, group size, industry, nor policy duration of an eligible group or members of a group. Furthermore, all rates are quoted on a guaranteed issue/guaranteed renewability basis, and are used as a single risk pool.

Covered benefits, and associated pricing adjustments, are consistent across all benefit plans. All plan designs that will be offered in 2017, as shown herein, meet the metallic tier requirements of the Patient Protection and Affordable Care Act (P.L. 111-148).

In my opinion, these rates are not excessive, inadequate, nor unfairly discriminatory. I further certify that the rates included in this manual reflect any rate impact associated with all new form filings that have been approved since the last rate filing was submitted.

Sincerely,

A handwritten signature in black ink that reads "Geoffrey S. Shannon". The signature is written in a cursive style with a large initial 'G' and 'S'.

Geoffrey S. Shannon, ASA, MAAA
New England Actuarial
Aetna Inc.