Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	**Aetna Health, Inc. & Aetna Health Ins. Co.**
State:	**Delaware**
HIOS Issuer ID:	**67190**
Market:	Small Group
Effective Date:	01/01/2019
Rate Filing Tracking Number:	**AETN-131453896**
Policy Form(s):	**HI SG SOB-HMO-14041892 03, HI SG HCOC-2018 03, HO SG HCOC-2019 03, HO SG SOB-HMO-14041892 03**
Form Filing Tracking Number:	**AETN-131409294, AETN-131409348**

Company Contact Information:

Name: [redacted]
Telephone Number:
Email Address:

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 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 conjunction with our Qualified Health Plan (QHP) application in Delaware beginning January 1, 2019. The rates comply with all rating guidelines under federal and state regulations. This memorandum covers plans that will be available off the public Marketplace in Delaware.

2. Proposed Rate Increase

This filing includes new benefit plans that will be marketed to small groups in Delaware for coverage effective beginning January 1, 2019.

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, 2017 through December 31, 2017 and paid through February 28, 2018.

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 small group business in Delaware. Our internal projections indicate that no MLR rebate is expected to be paid in 2018 (for 2017 experience) for the Small Group MLR Pool in Delaware. As such, no adjustment was made to premiums to account for expected rebates.

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 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.

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

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 2018. 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 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.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for
Community-rated policies issued to small employers in 2017.

We considered the expected relationships between the morbidity of each of these populations and the likely population that will be covered by Small Group Single Risk Pool policies in 2019.

B. Changes in Benefits:
The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The projection factor reflects the pro-rated impact of any additional benefits, as well as any changes in 2018 State Benchmark EHBs, and newly mandated benefits.

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 changes in the age/gender mix and area mix using internally-developed factors. Exhibits 5 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:
The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts.

E. Trend Factors (Cost/Utilization):
Medical trend factors are based on our Medical Economics Unit's local trend and network experience, 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 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.

Exhibit 8 shows the anticipated annual trend from the experience period to the rating period.

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, 2017 to December 31, 2017 and paid through February 2018 for Aetna community-rated policies in the Delaware 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 current ACA Small Group market. The similar dynamics include: no individual medical underwriting and rating by gender, limits on age-rating, and caps for rating on the number of dependents, as well as plans benefits and cost-sharing.

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, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend, as discussed in the exhibits referenced above.

C. Inclusion of Capitation Payments:
No adjustments to the experience period data have been made for capitation arrangements because we expect little to no capitation services to be provided in 2019.

7. 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.

8. Paid-to-Allowed Ratio
The projected paid to allowed ratio is [redacted]. Paid to allowed ratios are based on 2017 experience that is adjusted for the impact of any plan benefit changes based on our internal pricing models and trend deductible-leveraging.

9. Risk Adjustment
A. Risk Adjustment – Experience Period
Risk Adjustment transfer is accrued at the issuer and market level based on 2017 Wakely data and our internal projections of how our risk relative to market has changed. 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 resulting member transfers are summed to the HIOS plan level and adjusted for 2017 Risk Adjustment fees of [redacted] PMPM in Worksheet 2.

B. Risk Adjustment – Projection Period

We started with 2018 Risk Adjustment accruals to determine our current risk transfer relative to the market. The difference between our projected relative risk and the market's is trended for one year.

In addition, the projected risk adjustment transfer includes changes that were outlined in the 2019 Notice of Benefit and Payment Parameters. The 2019 projected market average premium used in the payment transfer formula is also reduced by [redacted] to remove administrative cost

As a result, we project a risk adjustment payable, net of the 2019 user fee of $0.15 PBMPM. The resulting PMPM adjustment, net of risk adjustment user fees, is [redacted].

10. Non-Benefit Expenses and Profit & Risk
The retention portion of the projected premium is illustrated in Exhibit 10.

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, 2018 projections, and projected changes in expenses, inflation, and membership for 2019 for our National book of Small Group business.

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 Company's 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. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2019 as well as Federal income tax and State Premium taxes. 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.

11. Projected Loss Ratio

The expected 2019 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 11.

12. 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 Delaware through Aetna Life Insurance Co. 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.

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, 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).

Small Group Market Trend Adjustments: Exhibit 12 illustrates the quarterly trend factors, the adjustment for changes in the Health Insurer Fee, 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, leveraging, and also account for changes in the Health Insurers Fee. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2019.

14. Market-Adjusted Index Rate

Exhibit E-1 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 been have each been converted to percent of allowed claims in this Exhibit.

15. Plan-Adjusted Index Rates

Exhibit E-2 illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The 2019 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 adjustments:

- We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. 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.

1. 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 2019 membership.

B. Distribution and Administrative Costs:
Exhibit E-2, Column 3, reflects the adjustment for projected administrative costs, including sales, marketing, and profit & risk. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Risk Adjustment User Fee which is 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. The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). Hence, all factors in Column 5are 1.00.

E. Catastrophic Plan Eligibility:
This filing does not include catastrophic plans.

16. Calibration
Exhibit C-1 shows an example of how calibration is applied to all plan adjusted index rates.

A. Age Curve Calibration:
The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit C-2. Exhibit C-2 demonstrates the determination of the Plan-Level Average Age Factor. Plan membership is based on issuer's similar January 2018 plan membership and projected changes in the market.

To Age-Calibrate the Plan-Adjusted Index Rates, We project a premium-weighted average age factor for the 2019 membership using the prescribed age curve and the projected age for each plan, as illustrated on exhibit C-2, The overall Age Calibration factor is developed in Column B of Exhibit C-1. This factor is based on the weighting of plan-adjusted Index rate and membership weighted by each plan's average age factor membership. The Age-Calibrated Plan Adjusted Index Rate is determined multiplying each Plan Adjusted Index Rate by the Plan-Level Average Age Factor and then dividing by the weighted over-all average age factor.

The age that most closely corresponds to the premium weighted overall average age factor is the average age for the single risk pool.

B. Geographic Factor Calibration:
Exhibit C-2 summarizes the rating area definitions and factors, and displays the projected premium by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor, and is applied in column F of Exhibit C-1

Projected area factors are shown in Exhibits 6 and C-2. Unit cost trend studies were used to evaluate whether there were significant changes to network costs that would require changes from previously filed rating area factors.

C. Small Group Premium Rates:
The development of the average projected trend factor is discussed above.

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 * 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 14.

18. Composite Premiums
Small employers will not be able to elect to have rates set using a composite approach as permitted by Delaware.

19. AV Metal Values
The AV Metal Values on Worksheet 2 were based on the 2019 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.

20. 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.

21. Membership Projections
Exhibit 15/C-2 summarizes the membership projections by plan. Membership projections are based on historical experience, enrollment in ACA-compliant plans through January 2018, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans. (We assume that total enrollment will be similar to our current enrollment.)

Terminated Plans and Products
Exhibit 16 provides a plan and product crosswalk from 2017 to 2019. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2018 and 2019.

22. Plan Type

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

23. Warning Alerts
There are no warning alerts on Worksheet 2 of the URRT.

24. Benefit Design
This filing includes one Bronze plan.

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 A-1 All benefit and cost sharing parameters comply with Delaware benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

25. Marketing
Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Plan Finder and our own website. Marketing and distribution approaches may change from time to time at management's discretion.

26. Underwriting
Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

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

28. Company Financial Condition
As of December 31, 2017, the capital and surplus held by Aetna Health, Inc. & Aetna Health Ins. Co. was approximately $525 million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2017. The Company issues commercial and Medicare Advantage coverage in various states for multiple business segments, including to large employer, small employer, and individual purchasers.

Reliance
While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and 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:

- Experience Period MLR Rebates
- Risk Adjustment Transfer
- Actuarial Value, Modifications, and Benefit Relativities
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend

- Administrative Fees
- 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, [redacted], am a Fellow 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 Delaware, 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.

June 14, 2018

_____ _____

[redacted]

Date