MEMORANDUM

August 8, 2016

Commissioner Nick Gerhart
Iowa Insurance Division
330 Maple St
Des Moines, IA 50319

Re: **Rate Review Summary for Aetna Health of Iowa, Inc. 1/1/2017 Individual ACA Rate Filing**

Binder:	**AETN-IA17-125058974**
SERFF:	**AETN-130506410**
Plan Filing Actuary:	**Ben Bosco**
Filing Actuary Email Address:	**bxbosco@aetna.com**

Dear Mr. Gerhart:

We have completed our review of the individual filing for Aetna Health of Iowa, Inc. (Aetna Health) and offer, for your consideration, the following report summarizing our review and conclusions.

The summary information used herein was taken, for the most part, directly from the actuarial memorandum or subsequent documentation provided to us by Aetna Health. We have summarized and paraphrased portions of the information to some extent, but have generally relied on Aetna Health's specific language in order to avoid inadvertently changing the meaning of any of the statements made therein through rephrasing.

Appendix C: Analysis of this document includes our conclusions with regard to the appropriateness of the rate filing for the reviews required to conduct an effective rate review process, as well as some additional analysis of our own.

For the complete objections and Aetna Health's responses, please see Appendix B: Objections below.

Overview of Filing and Rate Review

This filing includes benefit plans that will be marketed to individuals in Iowa for coverage beginning January 1, 2017. The average increase for these plans is 22.58% for the POS-CB product and 37.42% for the HNOnly-HMO product.

The base period experience includes 591,024 member months. Aetna Health is projecting 432,492 member months.

Rate Change History

Previously, Aetna Health requested rate increases ranging from 12.6% to 18.9%. The increase in medical premium is due to increasing medical costs, changes to taxes and fees, changes to reinsurance recoveries, etc.

Past Projections and Assumptions

	Effective January 1, 2017	Effective January 1, 2016	Difference
Morbidity Adjustment	0.985	1.044	-0.06
Other Adjustment	1.037	0.994	0.04
Unit Cost Trend	1.055	1.053	0.00
Utilization Trend	1.024	1.035	-0.01
Projected Risk Adjustments PMPM	-$34.15	-$3.05	-31.10
Projected Reinsurance Recoveries PMPM	$0.00	$13.40	-13.40
Projected Administrative Expense PMPM	$45.88	$41.77	4.11
Projected Profit PMPM	$18.68	$12.50	6.18
Projected Taxes PMPM	$29.55	$33.66	-4.11
Projected Premium PMPM	$478.92	$384.65	94.27

Index Rate Development

Base Experience

The experience period claims are from the Individual ACA experience, both On and Off Exchange, from Coventry Health Care of Iowa (now renamed to Aetna Health of Iowa Inc.).

Credibility

Aetna health assigned no credibility to the experience data since they excluded experience from the IHAWP program as well as experience from counties that they are exiting.

Manual Rate

The source data for the manual rates is the Individual ACA On and Off Exchange experience incurred from January 1, 2015 to December 31, 2015 and paid through February 29, 2016 for Coventry Healthcare of Iowa in the Iowa (HMO / POS) market. Aetna Health excluded experience associated with the IHAWP Marketplace Choice Plans as well as experience from 23 counties they are exiting.

The experience used as the basis for the manual rate was adjusted for expected 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.

Paid to Allowed

The projected paid to allowed ratio is 69%. The exhibit below illustrates the development of this number along with the projected membership distribution by metal tier. Paid to allowed ratios are based on 2015 experience that is adjusted for the impact of any plan benefit changes based on Aetna Health's internal pricing models and trend deductible-leveraging.

Metallic Tier	Projected Membership Distribution	Projected Paid to Allowed Ratio
Platinum	0	N/A
Gold	28,657	80%
Silver	238,526	72%
Bronze	115,717	64%
Catastrophic	49,592	63%
Total	432,492	69%

Trend

Medical trend factors are based on the Medical Economics Unit's prospective view of national utilization combined with projected local market unit costs, 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 a blend of local market and 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. The trends used are shown below.

Service Type	Unit Cost	Utilization
Facility Inpatient	5.9%	0.1%
Facility Outpatient	5.5%	3.6%
Physician	2.9%	3.3%
Capitation	0.0%	-1.4%
Medical	4.8%	2.6%
Pharmacy	10.2%	0.6%
Total (Med + Rx)	5.5%	2.4%

Cost Sharing Changes

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.

Changes in Benefits

The experience data includes experience for Single Risk Pool products. The projection factors reflect the impact of any changes in 2017 State Benchmark EHBs and any new state mandated benefits.

Changes in Enrollee Risk Profile

The experience period data includes claims for single risk pool policies in force in 2015. The projected change in the morbidity of the population is based on an internal analysis of the 2015

members' standard silver plan liability risk score, normalized for age and gender. This analysis divided Aetna Health's market into cohorts of new members, members renewing from a 2015 ACA plan, and members enrolling from both grandfathered and grandmothered transitional plans. Aetna Health then modeled renewals and new market entrants for 2016 and 2017 from information sources, such as 2016 Marketplace enrollment data and Wakely 2015 Risk Adjustment reports, as well as internal analysis of special enrollment period members. The projected normalized average risk was developed from the market model, and compared to the average 2015 normalized scores.

Other

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

Risk Adjustment

Risk Adjustment transfer is accrued at the issuer and market level based on 2015 Wakely data. The transfer is allocated to the member-level based 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.

Aetna Health started with 2015 Risk Adjustment accruals to determine the current risk transfer relative to the market. They applied estimated changes in the risk relative to the market for 2017 that may be triggered by a shift in metal plan distribution/rating area or geographic cost/demographic distribution to determine the 2017 relativity to market. The difference between the projected relative risk and the market's is multiplied by the projected market average premium, which Aetna Health trended at 18% annually. As a result, Aetna Health projects a risk adjustment payable, net of the 2017 user fee of $0.13 PMPM.

Non-Benefit Expenses

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 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.

The profit and risk load is consistent with the target used in pricing the 2016 plans.

Retention Components	% of Premium	PMPM
G&A	8.51%	$ 40.76
Commissions	1.07%	$ 5.12
Administrative Expense Load	9.58%	$ 45.88
Profit & Risk Load	3.90%	$ 18.68

Taxes and Fees

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2017, as well as Federal income tax. The risk adjustment user fee 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 non-benefit expenses and taxes and fees are shown in the table below.

Retention Components	% of Premium	PMPM
Premium Tax	1.20%	$ 5.75
User Exchange Fee	2.83%	$ 13.55
State Based Exchange Fee	0.00%	$ -
HIT	0.00%	$ -
PCORI	0.04%	$ 0.19
Federal Income Tax	2.10%	$ 10.06
Total Taxes and Fees	6.17%	$ 29.55

FINAL PLAN RATES

The age factors are based on the HHS Default Standard Age curve.

Aetna Health projects a premium-weighted average age factor for the 2017 membership using the prescribed age curve and the projected age distribution based on issuer January & February 2016 membership and projected changes in the market. The age that most closely corresponds to

the weighted average age factor and the age calibration factor is the reciprocal of the weighted average age factor.

The geographic calibration factor is the reciprocal of the projected average area factor.

ACTUARIAL VALUES (AVS)

The AV Metal Values on Worksheet 2 were based on the AV Calculator (AVC). 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.

OP Facility Benefit Plan Fit Process:

OP facility has two subcategories of OP surgical - hospital and OP surgical- freestanding. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent coinsurance was then calculated for each copay/deduct combination. It was adjusted to account for the portion of cost less than the deductible that was at 0% coinsurance in the model as compared to the portion subject to coinsurance. It was validated that these adjusted equivalence factors did not vary materially based on the underlying continuance table used. The average coinsurance of the row was calculated based on the weightings of the internal subcategories.

Specialist Benefit Plan Fit Process:

Using internal cost data, Aetna developed a distribution of Specialist visits by type of specialist. The benefit for each specialist was then weighted based on proportion of visits to calculate the expected average copay entered into the AVC.

ER Benefit Plan Fit Process:

Using internal cost data, Aetna developed a distribution of ER visits. ER copay visit costs were then converted to equivalent coinsurance using the AVC continuance table average unit costs. If copay and coinsurance, the copay equivalent to coinsurance was multiplied by the actual coinsurance as the aggregate equivalent coinsurance for the row. The average coinsurance was determined as the weighted average of the copay equivalent coinsurance < visit limit band, 0% from visit limit to deductible level, and ER equivalent coinsurance > deductible band. For deductible/copay plans, copays were converted to effective coinsurance and then reconverted back to copays for consistency with rest of plan.

MEDICAL LOSS RATIO (MLR)

MLR

2017 Projected Claims PMPM	$384.69
Required Premium PMPM	$478.93

MBR to MLR Build-up	($)	(%) of prem.
QIA	$0.00	0.0%
Risk Adjustment	$0.13	0.0%
HIF Tax	$0.00	0.0%
State Premium Tax	$5.75	1.2%
PCORF and Reinsurance	$0.18	0.0%
FIT	$10.06	2.1%
Exchange User Fee	$13.55	2.8%
Total Taxes & Fees	$29.67	6.2%
Adjusted Premium	$449.26	
Adjusted Claims	$384.69	
Calculated MLR		85.63%

INITIAL CONCERNS AND RESOLUTION

This filing included induced demand factors that were much different than the HHS factors for risk adjustment. We requested substantial support for these factors to ensure health status was not being considered. Finally, it was decided to accept the factors, but we recommend that the State provide guidance concerning induced utilization in the future.

The documentation did not include the development of the manual rate. This was provided and was not unreasonable.

There were a number of items that we requested further documentation of, which was provided.

CHANGES MADE TO FILING DURING REVIEW

1. The description of the base experience was incorrect in the original memo and was updated.

No changes were made due to CMS Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year.

CONCLUSION

We have reviewed the Aetna Health product filing and find that the methods and assumptions used in developing the rates are based on generally accepted actuarial standards and meet the HHS guidelines for MLR calculation.

The overall annual average rate change from 1/1/16 to 1/1/17 associated with this filing for Aetna Health of Iowa, Inc. (AHI's) individual business is 22.58% for the POS-CB product and 37.42% for the HNOnly-HMO product.

AHI included the applicable ACA fees including the appropriate fees for the reinsurance and risk adjustment programs. The development of the consumer adjusted index rate was according to the federal instructions and we feel the calibrations are supported and are not unreasonable.

AHI's projected medical loss ratio was calculated according to the federal instructions and achieves the federally prescribed rebate threshold of 80.0%.

We find the filing to be complete and included substantial details documenting the assumptions and methods used in setting the rates. Based on the methodologies and assumptions used, we believe that the final rates are not unreasonable, are based on actuarial principles, and follow the HHS instructions. Thus we recommend that you approve this filing as: Not unreasonable.

RELIANCE AND QUALIFICATIONS

We are providing this letter to you solely to communicate our findings regarding the filing under consideration. Distribution of this letter to parties other than the Division by us or any other party does not constitute advice from or by us to those parties. The reliance of parties other than the Division on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our opinion, as presented above, we made use of information provided by the company without independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on the data provided by the company without independent investigation or verification, we have reviewed the information for consistency and reasonableness. Where we found the data to be inconsistent or unreasonable we have requested clarification.

The actuarial methodologies utilized in order to arrive at our opinion were those which were considered generally accepted within the industry.

I am a member of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion.

If you have any questions, do not hesitate to call me at 520-908-7246.

Sincerely,

Donna C. Novak, FCA, ASA, MAAA, MBA

CC: Klete Geren

APPENDIX A: RATE DEVELOPMENT

Benefit Category	**IP**	**OP**	**Prof**	**Other**	**Cap**	**Rx**
Util Desc	days	services	services	services		scripts
Util/1,000	287.41	1,598.90	12,783.39	1,063.23	12,000.00	13,117.26
Avg Cost/Service	$3,704.23	$991.45	$99.75	$329.83	$7.50	$50.15
PMPM	$88.72	$132.10	$106.26	$29.22	$7.50	$54.82
						$418.63
Population Risk	0.985	0.985	0.985	0.985	0.985	0.985
Other						
Mandate/Benchmark Chg	1.000	1.000	1.000	1.000	1.000	1.000
Area Shift	0.996	0.996	0.996	0.996	0.996	0.996
Network Adj	1.035	1.035	1.035	1.035	1.035	1.035
New Cap	1.000	1.000	1.000	1.000	1.000	1.000
Pooling Impact	1.000	1.000	1.000	1.000	1.000	1.000
Deductibel Suppression	1.000	1.000	1.000	1.000	1.000	1.000
Change in Demo	1.008	1.008	1.008	1.008	1.008	1.008
Rx-Formulary						1.045
Rx-PBM Discount						1.000
Rx-Pref Ntwk Savings						1.000
Rx-Select Home Del						1.031
Rx-ESI to CMK						1.057
Rx-ASRx						1.000
Total Other	1.039	1.039	1.039	1.039	1.039	1.184
Total Unit Cost	1.059	1.055	1.029	1.055	1.000	1.102
Implicit Ind Utilization	0.986	0.986	0.986	0.986	0.986	0.986
Utilization	1.015	1.050	1.047	1.050	1.000	1.020
Total Utilization Trend	1.001	1.035	1.033	1.035	0.986	1.006
Util/1,000	283.40	1,687.75	13,420.78	1,122.32	11,484.33	13,060.74
Avg Cost/Service	$4,314.59	$1,146.61	$109.67	$381.44	$7.80	$72.14
Projected PMPM	**$101.90**	**$161.27**	**$122.66**	**$35.68**	**$7.46**	**$78.51**
						$507.47

APPENDIX B: OBJECTIONS

Responses Posted June 15, 2016

Objection #1:

In regards to the experience period premium and claims, the Actuarial Memorandum states that "These claims are from SG employers with eligible 1-50 eligible employees, both ACA and transitional policies, from Coventry Health Care of Iowa." We assume that this is a typo and that the experience is from the Individual ACA On and Off Exchange experience for Coventry Healthcare of Iowa as stated in the credibility manual rate development section. If that is the case, please explain the experience on which the manual rate is based and why it would provide greater credibility than the individual experience, and correct the description in section 3A accordingly.

Response:

Corrected memo [IA_18973_IVL_URRTPartIII_ActlMemo_v2.pdf] loaded to SERFF. Section 3A now states "These claims are from the Individual ACA experience, both On and Off Exchange, from Coventry Health Care of Iowa (now renamed to Aetna Health of Iowa Inc.)."

The experience on which the manual rate (section 6) is based is almost the same as the base experience from section 3A, except that we have excluded IHAWP Marketplace Choice experience as well as experience from 23 counties that we are exiting in 2017. The manual provides greater credibility than the individual experience because the membership associated with IHAWP and the 23 counties that we are exiting in 2017 do not reflect the existing membership we expect to insure in 2017. The membership we expect to insure in 2017 is directly related to the manual rate, basically our base experience excluding IHAWP and 23 counties. We do not expect our 2017 risk profile and corresponding experience to look anything like it did in 2015 (where a significant amount of experience is connected to the IHAWP Marketplace Choice Plan) and for this reason, the manual rate will provide greater credibility for 2017 ratemaking.

Objection #2:

Please provide documentation of all changes to the source data for the manual rate resulting in the $507.47 allowed amount in a way that parallels the URRT development of the allowed amounts. This should include a base period summary of the manual rate data.

Response:

See table in Rate Development section above.

a. Section 6c of the Actuarial Memorandum states that the experience data was incorporated to account for moving to fee for service payment approaches. The adjustments to the source data for the manual rate should include the adjustment to account for capitation payments.

Response:

Capitation claims included in exp data and projected (trended) forward to include expected claim cost for capitated claims. Underlying assumption is that best estimate for experience capitated claims will be close to FFS claims. See also response to question #7.

b. The summary of the manual rate should include the number of member months included and the formula used for the credibility calculation used to assign credibility to the data underlying the manual rate.

Response:

Our manual rate experience includes 432,492 mmos.

Formula: When experience data does not accurately reflect the expectation for membership to be insured in the projection period, experience credibility set to 0%. When manual data perfectly reflects member-for-member the expectation of insured in the projection period (exclusion of IHAWP and 23 counties), experience credibility set to 0%.

c. Please describe all adjustments made to manual data to bring it in line with the projected population, State market, and provider contracts.

Response:

Please refer to table buildup from beginning of question #2. Our projected population is not expected to change from 2015 manual rate.

d. Are you no longer offering the IHAWP Marketplace Choice Plans?

Response:

Correct, we stopped offering IHAWP Marketplace Choice Plans beginning in 2016.

e. Please isolate the impact of removing the experience from the IHAWP Marketplace Choice Plans and the 23 counties that you are exiting in 2017.

Response:

Please refer to explanation above on manual rate development. Since manual is simply the base experience after removing IHAWP and 23 counties, looking at the base compared to the manual side-by-side presents the impact of removing the experience from the IHAWP Marketplace Choice Plans and the 23 counties that you are exiting in 2017.

Question #3:

Please provide quantitative support for the development of the morbidity adjustment.

Response:

The following table contains December 2015 Wakely data, normalized silver Plan Liability Risk Score (PLRS) calculated as the standard silver PLRS divided by the standard silver PLRS demographic factor. Each annual factor represents our issuer BASE experience and is a weighted average of ACA renewals, previously non-grandfathered renewals, and members new to us:

	Base	Manual
2015	3.024	2.570
2016	3.142	2.670
2017	2.977	2.531

In determining the "Manual" PLRS factors, actuarial judgment was used that the PLRS would be roughly 15% better (factor of 0.85) than the base, representing an improvement in morbidity due to loss of IHAWP and exiting 23 counties.

Thus, the morbidity adjustment is the change in morbidity from the experience period to the projection period, 2017 PLRS / 2015 PLRS = 0.985

Question #4:

Please provide a breakout of all adjustments included in the "Other" adjustment on the URRT (1.019 for medical services, 1.161 for drugs), showing that they amount to an overall factor consistent with the URRT. Be sure to provide the magnitude of each adjustment described in section 5 of the Actuarial Memorandum and show they build up to the ultimate factors used in the URRT.

Response:

Base Period Experience Projection factors, including all Section 5 adjustments and corresponding magnitudes by cost category, consistent with URRT Wksh 1

Benefit Category	**IP**	**OP**	**Prof**	**Other**	**Cap**	**Rx**
Population Risk	0.985	0.985	0.985	0.985	0.985	0.985
Other						
Mandate/Benchmark Chg	1.000	1.000	1.000	1.000	1.000	1.000
Area Shift	0.996	0.996	0.996	0.996	0.996	0.996
Network Adj	1.035	1.035	1.035	1.035	1.035	1.035
New Cap	1.000	1.000	1.000	1.000	1.000	1.000
Pooling Impact	1.000	1.000	1.000	1.000	1.000	1.000
Deductible Suppression	1.000	1.000	1.000	1.000	1.000	1.000
Change in Demo	1.008	1.008	1.008	1.008	1.008	1.008
Rx-Formulary						1.045
Rx-PBM Discount						1.000
Rx-Pref Ntwk Savings						1.000
Rx-Select Home Del						1.031
Rx-ESI to CMK						1.057
Rx-ASRx						1.000
Total Other	1.039	1.039	1.039	1.039	1.039	1.184
Total Unit Cost	1.059	1.055	1.029	1.055	1.000	1.102
Total Utilization Trend	1.001	1.035	1.033	1.035	0.986	1.006

Objection #5:

For each Essential Health Benefit (EHB) not covered in the base period data (including the transitional plan experience), please provide the additional cost per-member-per-month (PMPM) with an actuarial explanation of how the additional cost was developed.

Response:

The EHB factors reflect any changes in EHB from 2015 to 2017. There are no changes, so the factors are set to 1.0, as seen in the table above in row "Mandate/Benchmark Chg."

Objection #6:

Were trend assumptions adjusted for large claims?

Response:

Yes, we exclude catastrophic claims from the trends assumptions.

Objection #7:

Page 4 of the Actuarial Memorandum states that "No services provided in 2017 are expected to be covered by capitation arrangements." Yet the credibility manual rate contains $7.46 PMPM for capitation payments. Are these capitations expected to continue into 2017?

Response:

Capitation claims included in exp data and projected (trended) forward to include expected claim cost for capitated claims. Underlying assumption is that best estimate for experience capitated claims will be close to FFS claims. See also response to question #2a.

Objection #8:

Please provide quantitative support for the risk adjustment payment of $34.15 PMPM corresponding to the narrative provided in section 9c of the Actuarial Memorandum.

Response:

Wakely's 2015 estimation of our issuer's all-in (base experience) relative transfer was used as a starting point. Our base experience view was expected to have a payable of $9.2M with nearly 600k mmos. However, accounting for the loss of IHAWP, the payable was actually closer to $10.1M. We then approximated our payable after exiting 23 counties by applying a claim experience adjustment factor, reducing the expected manual rate risk adjustment payable to be

$9M with 430k mmos, or about $21 PMPM. Given the statewide market average premium (MAP), we determined our issuer relative transfer in 2015 for our manual rate of (1 - 21/346) = 0.939. Each annual relative transfer is assumed to remain static, while the MAP increases at an assumed trend rate of 18%:

	Issuer	MAP
2015	0.939	$346
2016	0.939	$408
2017	0.939	$481

Risk Transfer = (0.939 – 1.000) * $481 = -$29.17 + $0.15 fee (2016 fee)

An additional adjustment was made to the final risk adjustment payment: after CMS released updated 2017 Coefficient factors, our Wakely data and transfer tool suggested our payable would be $5.75 PMPM larger, but we capped the increase at $5 PMPM; lastly, we added in the 2017 RA fee of $0.13 PMPM.

Thus, the 2017 estimated risk adjustment transfer is:

-$29.02 - $5.00 - $0.13 = -$34.15 PMPM

Objection #9:

Please provide quantitative support for the Exchange User Fee in Exhibit E1.

Response:

Exhibit E-1 Exchange User Fees = 1 + (Exchange User Fee PMPM / Paid to Allowed in Projection Period / Projected Index Rate)

- Exchange User Fee PMPM = $13.55 = Blended Exchange User Fee * Single Risk Pool Gross Prem PMPM (see URRT Wksh1 cell V43)

- Blended Exchange User Fee = 2.83% = 81% members on-HIX * 3.5% exchange user fee + 19% members off-HIX * 0% exchange user fee

- Paid to Allowed in Projection Period = see Section 8 of memo or URRT Wksh1 cell V33

- Projected Index Rate = see Exhibit E-1, cell D9

Objection #10:

Please provide quantitative documentation of the development of your network and medical management factors. This should demonstrate that they were normalized. In particular, explain why the network adjustment factors in Exhibit E-3 differ from the projected network factors in Exhibit 7 by a factor of 0.9933.

Response:

For confidentiality reasons this detailed information is not provided in our report.

Please note that the Exhibit 7 network factors are not normalized. The factor of 0.9933 (cell K17) is a member-weighted average of the raw projected network factor, and it is used to normalize each network factor found in Column J of Exhibit E-3.

In other words, Exhibit 7 non-normalized network factor / 0.9933 = Exhibit E-3 normalized network factor

Objection #11:

Since your final induced utilization factors are significantly different than the federal factors used in the ACA Risk Adjustment, please provide substantial support for the additional utilization adjustment and clearly demonstrate that it doesn't reflect morbidity. Specifically, provide support for your Plan Design Adjustment for your Gold plans.

Response:

Refer to Exhibit E-3, column F (Utilization Adjustment) and Column G (Plan Design Adjustment). The Utilization Adjustment is consistent with the federal factors used in the ACA Risk Adjustment, as it is comprised of I) the HHS Scale split by metal tier and II) CSR utilization adjustments (see below for both tables):

I) HHS Scale

Platinum	1.150
Gold	1.080
Silver	1.030
Bronze	1.000
Catastrophic	1.000

II) CSR Adjustment (silver products only)

	Metal similar	Memb dist	HHS Scale util adj
Standard	Silver	25%	1.0
73% CSR	Silver	10%	1.0
87% CSR	Gold	25%	1.08/1.03
94% CSR	Platinum	40%	1.15/1.03
		Weighted avg =	1.059

The HHS Scale and CSR Adjustment factors are then multiplied together and normalized based on membership distribution found in Exhibit E-2, and it is clear that these utilization adjustments do not reflect morbidity.

For the Plan Design Adjustment, we take the pricing relativity of a specific plan, which encompasses not only benefit and plan design differences but also utilization differences mentioned earlier. Our benefit relativity model normalizes out the impact of morbidity. This pricing relativity becomes an implicit induced utilization factor after dividing by a ratio equal to the metal AV of specific plan over metal AV of base plan, so that metal AV differences are removed. These implicit induced utilization factors still contain the utilization adjustments from above so we divide out the HHS Scale factor and the CSR adjustment if applicable, leaving ourselves with just the plan design adjustment, which we normalize in Exhibit E-3. The final step is making an adjustment due to the eligibility impact of catastrophic plans.

In support of our Plan Design Adjustment for Gold plans, we start with a pricing relativity of 1.419. Since the gold plan metal AV is 0.780 and the base plan metal AV is 0.681, the gold plan implicit induced utilization factor equals 1.238 = 1.419 / (0.780 / 0.681). No CSR utilization adjustment is necessary since this is a gold plan. From here, we divide out the HHS Scale factor of 1.08 and the CSR adjustment is not applicable. What we have calculated at this point is the raw plan design factor of 1.146. The normalization factor of 0.995 is determined by taking a weighted average of all raw plan design factors, so the normalized gold plan design factor is 1.153. Lastly, we are offering a catastrophic plan, and the eligibility impact is 0.85. Thus, the final adjustment of (1/0.985) is a weighted average of the eligibility impact for catastrophic plans, bringing us to the final Plan Design Adjustment for our Gold plans of 1.153/0.985 = 1.170.

Objection #12:

Please explain how geographic region factors were developed.

Response:

The process derives relative cost by provider based on all-in fully insured and self-insured experience from the full commercial population as compared to what Medicare would have paid. The relative costs are then representative of true contracting differences between providers and do not reflect morbidity. Utilizations used to aggregate costs by rating area came from Iowa IVL/HIX and SG 2-50 ACA combined experience. From the raw data study using the process outlined above, results were normalized… Then, we applied actuarial judgment to Rating Area 4 to reflect projection period expectations.

Objection #13:

Please provide the calculation of the MLR in Exhibit 11 since the formulas were not included.

Response:

Calculations added to [IA_AHI_IVL_18973_Exhibits v2.xlsx] file loaded to SERFF.

Objection #14:

Please explain how the premium tax rate of 1.2% was derived (Exhibit 10).

Response:

Based on the AHI legal entity, the Iowa state premium tax is 1.00% and our assumption for assessments and fees is 0.20%.

APPENDIX C: ANALYSIS

General Information

1) What are the main drivers of the rate change?

   The main driver of the rate change appears to be the experience of the sponsor, rather than explicit trends or other adjustments.

   Payments for risk adjustment have increased from $3.05 pmpm to $34.15 pmpm, accounting for 6.9% of the rate increase.

   The temporary reinsurance program ended in 2016. Loss of reinsurance offsets accounts for 2.9% of the rate increase.

   Profit margin post- tax increased from 3.3% to 3.9%.

2) Are variations in rate increases by product or plan explained?

   Variations in rate increases are attributed to updates to provider cost estimates, modification to cost sharing, and model updates to calculations of induced demand.

3) Were past rate increase assumptions (e.g. trends, projected allowed claims PMPM, etc.) consistent with actual experience?

   Past rate increase assumptions appear to be consistent with actual experience.

Experience Period Allowed Claims to Projected Index Rate

1) Experience Period Premium and Claims

   a) Was the paid through date provided for the base period data?

      The base period data reflects incurred claims from January 1, 2015 through December 31, 2015 paid through February 29, 2016. We find two full months of runout reasonable.

   b) Were the services in the "Other Medical" category explained including the measurement units used?

      Other medical services are an estimated portion of Hospital Outpatient claims including ambulance services, DME, and prosthetics. Utilization is measured per service.

2) Projection Factors

a) Is the magnitude of the adjustments consistent with the URRT?

The adjustments for utilization and cost trend are consistent with the URRT.

b) Were the data, assumptions, and magnitude of the morbidity adjustment explained?

After an objection, Aetna Health provided quantitative support for their morbidity adjustment. The BASE PLRS was developed using 2015 Wakely data. Aetna Health used actuarial judgment to determine the PLRS for the "Manual" would be roughly 15% better than the base due to loss of IHAWP and exiting 23 counties. We believe the adjustment is not unreasonable.

c) Were all of the changes in the "Other" category described including the magnitude, data used, assumptions used and methodology used?

In an objection response, Aetna Health broke-out all of the adjustments included in the "Other" adjustment on the URRT. These adjustments include an area shift, network adjustment, and a change in demographics. The magnitude of these adjustments total 1.019, which we believe is well supported and is not unreasonable.

d) Were changes due to age, gender, or region (included in the "Other" category) documented and reasonable?

The demographic changes for age, gender, and region are reasonably developed using the projected membership distributions and are well documented.

e) Were changes in utilization use to cost-sharing adjustments reasonable when considering the direction of the difference between the base period paid-to-allowed factor and the projection period paid-to-allowed factor?

The downward adjustment to utilization for cost-sharing appears reasonable in comparison to the reduction in paid-to-allowed between the base and projection periods.

f) Were the changes in cost for changes in benefits reasonable (i.e., benefits from base period that are not an essential health benefit (EHB) and benefits that are EHBs that were not in the base period)?

No changes in benefits were made.

g) Were medical cost trend changes by major service categories reasonable;

i) Compared to past history and prior estimates?

The trends are reasonable compared to prior estimates in addition to being reasonable on their own.

ii) Considering changes in provider contracting?

The trends include known and anticipated changes in provider contract rates.

iii) Compared to other carrier filings for the same period?

The trends are reasonable when compared to other carriers in the market.

iv) Compared to industry publications?

The included trends are not unreasonable when compared to industry publications.

v) When comparing resulting cost per service compared to other carrier filings for the same period?

The resulting costs per service are reasonable compared to other carrier filings.

h) Were changes in utilization of services by major service categories reasonable;

i) Compared to past history and prior estimates?

The trends are reasonable compared to prior estimates in addition to being reasonable on their own.

ii) Compared to other carrier filings for the same period?

The trends are reasonable in comparison to other carrier filings.

iii) Compared to industry publications?

The included trends are not unreasonable when compared to industry publications.

iv) Compared to other carrier filings when comparing resulting utilization per 1,000 for the same period?

The resulting utilization per 1,000 is reasonable in comparison to other carrier filings.

i) How were trends adjusted due to fluctuation in large claim amounts?

Catastrophic claims were excluded from the trends assumptions.

3) Credibility Manual Rate Development

a) Was the development of the manual rate reasonable and well documented including:

i) Source of manual data;

The source of the manual data is the Individual ACA On and Off Exchange experience incurred from January 1, 2015 to December 31, 2015 and paid through February 29, 2016 for Coventry Healthcare of Iowa in the Iowa (HMO/POS) market. Experience associated with the IHAWP Marketplace Choice Plans as well as experience from 23 counties Aetna Health is exiting is excluded.

ii) Adjustments to manual data to ensure it is consistent with the population being rated; and

The projected population is not expected to change from 2015 manual rate.

iii) Projections of manual data for trend and other adjustments.

See projection factors above.

b) If there were capitation payments, how were they accounted for?

Capitation claims included in experience data and projected (trended) forward to include expected claim cost for capitated claims. Underlying assumption is that best estimate for experience capitated claims will be close to FFS claims.

c) Is the experience included on worksheet 1 of the URRT specific to the company? (i.e. confirm that the experience for the manual rate should be included in the manual rate section and not the experience section).

All relevant experience was included appropriately as part of the experience section.

d) What credibility methodology was used?

No credibility was assigned to the experience data. Alternate experience was used for the credibility manual rate. The experience data does not accurately reflect the expectation for membership to be insured in the projection period, so the experience credibility was set to 0%.

e) What is the resulting credibility?

The credibility assigned is 0%.

f) Is the methodology reasonable when considering ASOP #25?

The methodology may be reasonable when considering ASOP #25. However, we are unsure how credibility was estimated for the data used for the manual rate.

4) Paid to Allowed Ratio

a) Was the paid to allowed ratio;

i) Reasonable compared to the base period data?

The URRT WS1 indicates base period incurred to allowed ratio of 0.705, which is reasonably close to the projected paid to allowed ratio of 0.691.

ii) Developed using carrier data from the appropriate block of policies?

The projected paid to allowed ratios are based on 2015 experience adjusted for the impact of plan benefit changes based on an internal pricing model and weighted based on projected enrollment by metal tier.

iii) Reasonably close to the weighted average actuarial values from the actuarial value calculator?

The projected paid to allowed ratio is reasonably close to the weighted average actuarial values from the actuarial value calculator of 0.673.

5) Risk Adjustments

a) What did the actuary base the relative risk of the carrier's block and the market on?

The relative risk of the carrier's block and the market is based on Wakely's 2015 estimation of Aetna Health's base experience was used as a starting point.

b) Is the carrier's market share large enough that it represents the market?

The carrier's market share is not large enough that it represents the market.

c) Were projected risk adjustment transfer amounts appropriate considering the size of the carrier and the source of the carrier's population?

Quantitative support for the risk adjustment transfer was provided in an objection response. The 2015 Wakely estimation was adjusted to account for Aetna Health exiting 23 counties and also to account for CMS's released updated 2017 Coefficient factors. We believe the adjustment is well supported and is not unreasonable.

d) Were projected risk adjustment fees appropriate (as a PMPM) and entered correctly in the URRT?

The projected risk adjustment fees of $0.13 PMPM are appropriate and entered correctly.

e) Are risk adjustment, and risk corridor included as adjustments to incurred claims in the MLR development?

Risk adjustment is appropriately included as an adjustment to incurred claims in the MLR development.

f) Are the net risk adjustment values consistent between the memorandum, URRT, and MLR development?

The net risk adjustment values are consistent.

g) Are the reinsurance and health insurer fees appropriate? For Small Group policies, carriers can assume a health insurer fee for months in 2018.

Yes, there will be no reinsurance or health insurance fees in 2017, and none have been entered in the URRT.

6) Non-Benefit Expenses

a) Are administrative cost and profit margins (PMPM and as a percentage of premium) reasonable compared to other carriers?

Both administrative costs and profit are reasonable compared to other carriers in the market. Both are close to average.

b) If administrative costs are not reasonable considering other carriers, are they consistent with historic actual administrative costs?

Administrative costs are reasonable considering other carriers.

c) Are sales and marketing expenses reasonable?

Commissions of 1.07% are not unreasonable.

d) Are administrative costs related to programs that improve health care quality reasonable and comparable to other carrier filings?

No costs related to health care quality improvement were included, which is not unreasonable.

e) Are applicable taxes and licensing or regulatory fees appropriate?

Applicable taxes and licensing or regulatory fees appear appropriate. We requested quantitative support for the Exchange User Fee, which was provided and is not unreasonable. In addition, we requested the development of the 1.2% premium tax rate, which includes a 1% Iowa state premium tax and 0.20% for assessments and fees.

f) Are taxes and fees consistent with adjustments made to premium in the development of the federal MLR?

The development of federal MLR is consistent with taxes and fees.

g) Are the insurer's profit margins appropriate considering its Risk-based Capital (RBC) level?

Exhibit 10 shows that the total pricing retention includes both profit and risk load (3.9%) and FIT (2.10%). This implies that 3.9% represents post-tax profit and pre-tax profit is around 6.0%. This is not unreasonable when considering their REDACTED RBC level (REDACTED) in 2015.

h) Are non-benefit expense values consistent with those included on the URRT? (Profit values on URRT are pre-tax)

Non-benefit expense values are consistent with the URRT.

7) Projected Loss Ratio

a) Are projected MLRs appropriate and determined according to ACA?

The projected MLR is calculated according to the federal instructions and the MLR is above the minimum threshold for this market.

b) Are state MLR requirements fulfilled?

State MLR requirements are fulfilled.

Projected Index Rate to Consumer Adjusted Premium Rates

1) Index Rate

a) Was a market wide risk pool used including on exchange and off-exchange non-grandfathered plans in the market used?

The experience period used in manual rating includes all Individual ACA On-and-Off exchange experience for non-grandfathered plans in Iowa.

b) Were transitional plans included in the base experience?

Transitional plans were appropriately included in the base experience.

c) Were transitional plans included in the projection period to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period?

The morbidity adjustment accounts for individuals transitioning to ACA-compliant plans during the projection period.

d) Does the index rate only include the EHBs?

The index rate includes only EHBs.

2) Market Adjusted Index Rate

a) Was the Market Adjusted Index Rate developed with consideration of adjustments for AV and cost sharing, after adjusting for the risk adjustment and exchange user fee?

The Market Adjusted Index Rate is not adjusted for AV and cost sharing after adjusting for risk adjustment and exchange user fee.

b) Were the adjustments made considering the ratio of allowed to paid, which is factored in later?

The adjustments were made considering the ratio of allowed-to-paid.

3) Plan Adjusted Index Rates

   a) Were the following adjustments the only ones made to the Market Adjusted Index Rate:

      i) Actuarial value and cost sharing;

      ii) Provider network;

      iii) Benefits in addition to EHBs;

      iv) Non-Tobacco User

      v) Impact for catastrophic plan eligibility; and

      vi) Adjustment for distribution and administrative costs.

      Only allowable adjustments were made to the Market Adjusted Index Rate.

4) Are AV, cost sharing, and induced utilization factors provided separately and are they reasonable?

   The AV and cost sharing adjustment is comprised of three separate adjustments for AV, cost sharing, and induced utilization. Because the final induced utilization factors are significantly different than the federal factors used in the ACA risk adjustment, we requested substantial support to ensure health status is not being considered. We recommend that the State provide guidance on the induced utilization next year.

5) If an adjustment was made for induced utilization, are cost sharing factors normalized to a weighted average of 1.0?

   The induced utilization is normalized.

6) Was an adjustment made for non-tobacco user status and is it reasonable?

   The adjustment made for tobacco is the reciprocal of the average tobacco factor and is reasonable.

7) Were the rating factors for networks and medical management appropriate and supported by the documentation?

   The included network rating factors were appropriately normalized and the resulting adjustments are not unreasonable.

8) Are differences between plans based on benefit richness (AV) appropriate and done in a way that the morbidity of those selecting lower cost sharing plans is ignored?

   This filing included induced demand factors that were much different than the HHS factors for risk adjustment. We requested substantial support for these factors to ensure health status was not being considered, but the answer did not satisfy us. Finally, it was decided to accept the factors, but we recommend that the State provide guidance concerning induced utilization in the future.

9) Are differences between plan administrative costs explained and appropriate?

   Administrative costs are applied consistently as a constant percentage (1.202).

10) Are adjustments for catastrophic plan only applied to the catastrophic plan?

    A 15% reduction is applied to only catastrophic plans.

11) Calibration

    a) Was the age calibration based on prior or projected age distributions and was it appropriate considering and adjustment to the base data for age? That is, if there was an adjustment for aging, the projected age distribution should be used in the age calibration.

       The age calibration is appropriately based on the projected age distribution.

    b) Was normalization of the URRT premium rate to the base rate reasonable considering the changes in age curves and geographic rating?

       Normalization of the URRT premium rate to the base rate is reasonable considering the age curve and geographic rating.

    c) Was the calibration uniform for all plans?

       Calibration was uniform across all plans.

12) Consumer Adjusted Premium Rate

    a) Was the appropriate age curve used?

       The HHS Default Standard Age curve was used.

b) Are the tobacco factors with in the required 1.5:1 range?

The tobacco factors are within the prescribed range.

c) Were the appropriate geographic regions used?

The appropriate geographic regions were used.

d) Were the rating factors for geographic regions supported and appropriate?

The development process derives relative cost by provider based on all-in fully insured and self-insured experience from the full commercial population as compared to what Medicare would have paid. We believe the factors are not unreasonable.

e) Did the geographic factors only consider differences in cost and utilization by geographic are due to differences in practice patterns and cost and not consider differences in morbidity?

Aetna Health indicated the relative costs are representative of true contracting differences between providers and do not reflect morbidity.

f) Are the final rates appropriate when compared to each other?

The final rates are reasonable in comparison with one another.

g) Are the final rates appropriate compared to other carriers in the same region and metal level?

The final rates appear reasonable compared to other carriers in the same region and metal level.

Actuarial Value

1) Was the URRT AV close to the one in the Plans and Benefits template?

The URRT AV was reasonably close to the Plans and Benefits template.

2) Was the AV for each metal plan in fact within the appropriate range?

All AVs are within the appropriate range for the metal level.

3) If the plan was a unique plan design:

   a) Was the plan design in fact unique?

      The designs are unique, where specified.

   b) Were adjustments to the AV from the AVC or the AVC input made appropriately?

      All adjustments to AVC inputs appear to have been made reasonably.

   c) Was the actuarial certification and documentation appropriate? If an alternative method was used, was this indicated in the filing, and is the alternative method appropriate?

      The actuarial certification was provided and appears reasonable.

4) For sample plans can the AV be duplicated using the actuarial value calculator (AVC)?

   Sample plan AVs can be duplicated using the federal AVC.

Membership

1) Were large projected shifts in membership adequately explained?

   A shift in membership (591,024 in experience period to 432,492 in projection) is explained based on the carrier exiting a number of markets.

Solvency

1) Is the incurred but not paid reserve reasonable compared to the run out period?

   The incurred but not paid appears reasonable based on the run out period.

2) Are there other reserves? If so, were changes in those reserves considered in the rating process?

   It appears there are no other reserves to be considered in the rating process.

3) To verify the issuer's capital and surplus is appropriate, we reviewed the historic risk-based capital.

   For confidentiality reasons this detailed information is not provided in our report.

Warning Alerts

1) Is the filing actuary's explanation for the warning alerts valid?

   The actuary's explanation for a warning alert for total premium in the experience period is reasonable.