

State: Pennsylvania **Filing Company:** Aetna Health Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: IVL HMO (AHI on&off)
Project Name/Number: AHI IVL HMO 2016/

Filing at a Glance

Company: Aetna Health Inc.
Product Name: IVL HMO (AHI on&off)
State: Pennsylvania
TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI: HOrg02I.005D Individual - HMO
Filing Type: Rate - G.I. (Guaranteed Issue)
Date Submitted: 05/06/2015
SERFF Tr Num: AETN-129971237
SERFF Status: Assigned
State Tr Num: AETN-129971237
State Status: Received Review in Progress
Co Tr Num:

Implementation Date Requested: 01/01/2016
Author(s): Bruce Campbell, Beatriz Girasulo, Josephine Williams, James Lescoe, Khanh Nguyen, William Derech, Xiaofang Liu, Cynthia Parenteau, Tim Howard, Alison McDonough, Van Jones, Glenn Latona, Selena Jin
Reviewer(s): Art Lucker (primary), Jim Laverty (AH)
Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:
 Proposed 5.6% increase on 2016 on and off exchange individual HMO rates.
Binder Name: PA_IVL_64844_Combined_QHP Binder_2016
SERFF Tracking Num: AETN-PA16-125041583

State: Pennsylvania
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO
Product Name: IVL HMO (AHI on&off)
Project Name/Number: AHI IVL HMO 2016/

Filing Company: Aetna Health Inc.

General Information

Project Name: AHI IVL HMO 2016
 Project Number:
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact: 5.6%

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type: Individual
 Filing Status Changed: 05/07/2015
 State Status Changed: 05/07/2015
 Created By: Van Jones
 Corresponding Filing Tracking Number: AETN-130055091,
 AETN-130054978, AETN-130047703, AETN-130047645,
 AETN-130047733, AETN-130047724

Deemer Date:
 Submitted By: Van Jones

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

Includes rates for Individual products to be offered effective January 1, 2015.

Filing Description:

The purpose of this filing is to request approval of the monthly premium rates for the policy forms referenced above. The development of these rates reflects the impact of the market changes and rating requirements resulting from PPACA and subsequent regulation.

These rates are for plans issued in the individual market in conjunction with our Qualified Health Plan (QHP) application in Pennsylvania beginning January 1, 2016. The rates comply with all rating guidelines under federal and state regulation. The filing covers plans that will be available on and off the Federally Facilitated Exchange (Exchange) in Pennsylvania.

Company and Contact

Filing Contact Information

Van Jones, Director, Actuarial
 3721 TecPort Drive
 Harrisburgh, PA 17106
 vajones@cvty.com
 717-671-6824 [Phone]

Filing Company Information

Aetna Health Inc.	CoCode: 95109	State of Domicile:
980 Jolly Road	Group Code: 1	Pennsylvania
Blue Bell, PA 19422	Group Name:	Company Type:
(999) 999-9999 ext. [Phone]	FEIN Number: 23-2169745	State ID Number:

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

SERFF Tracking #:

AETN-129971237

State Tracking #:

AETN-129971237

Company Tracking #:**State:**

Pennsylvania

Filing Company:

Aetna Health Inc.

TOI/Sub-TOI:

HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005D Individual - HMO

Product Name:

IVL HMO (AHI on&off)

Project Name/Number:

AHI IVL HMO 2016/

Supporting Document Schedules

Satisfied - Item:	Transmittal Letter (A&H)
Comments:	
Attachment(s):	AHI HMO Cover Letter 2016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum - redacted version
Comments:	
Attachment(s):	AHI IVL Memo and Cert 2016 PA Redacted.pdf
Item Status:	
Status Date:	



Van Jones
Aetna Health Inc.
3721 Tecport Drive
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Phone: 717-541-5780

May 6, 2015

Ms. Rashmi Mathur
A&H Actuarial
Bureau of Accident & Health Insurance
Office of Insurance Product Regulation and Market Enforcement
1311 Strawberry Square
Harrisburg, PA 17120

Re: Aetna Health, Inc (a PA corp)

SERFF Tracking Number: AETN-129971237

Policy Forms: HI PA IVL-NM-HIX2016Contract V001, HI PA IVL-HIX2016Contract V001,
HI PA IVL-NM-OFF2016Contract V001, HI PA IVL-OFF2016Contract V001,
HI PA IVL-CB-HHIX-Contract V001, HI PA IVL-CB-HContract V001, HAPA
INDPOL-IDX 2016, HAPA INDPOL-OFFIDX 2016

HIOS Product IDs: 64844PA010, 64844PA011, 64844PA012, 64844PA009, 64844PA008

SERFF Form Filings: AETN-130055091, AETN-130054978, AETN-130047703, AETN-130047645,
AETN-130047733, AETN-130047724

Dear Ms. Mathur:

We enclose, for your Department's review, a rate filing for the above-referenced forms that provide Comprehensive Medical Expense coverage to residents of the Commonwealth of Pennsylvania.

The purpose of this filing is to provide details of the premium rate development and the resulting proposed monthly premium rates for Individual policies which will be offered for coverage effective January 1, 2016 and later in the Commonwealth of Pennsylvania.

The benefit plans included in this filing comply with all state-specific benefit requirements and rating regulations, as well as those associated with Federal Health Care Reform H.R. 3590 – the Patient Protection and Affordable Care Act (PPACA). Additionally, these health benefit plans conform to the allowed tiers of coverage, defined as Bronze, Silver, and Gold as defined by PPACA and applicable regulations. All plans achieve an actuarial value consistent with the allowable range of deviation and the thresholds established for each tier – 60%, 70%, and 80%, respectively.

We request that the rates and benefits information contained in this submission be considered proprietary and confidential to Aetna, as this information is not publicly available, and as such, disclosure could result in irreparable harm to Aetna.

Attachments:

- Actuarial Memorandum and Certification
- Supporting Exhibits
- Rate Template / Rate Tables
- Unified Rate Review Template

Please contact me with any concerns at 717-671-6824, or at vajones@cvty.com.

Sincerely

A handwritten signature in black ink that reads "Van A. Jones". The signature is written in a cursive, flowing style.

Van A. Jones, FSA, MAAA
Director, Actuarial
Aetna Health Inc.

Actuarial Memorandum and Certification

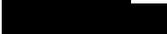
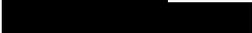
General Information

Company Identifying Information:

Company Legal Name: Aetna Health Inc. (a PA corp)
State: Pennsylvania
HIOS Issuer ID: 64844
Market: Individual
Policy Form(s): **HI PA IVL-NM-HIX2016Contract V001**
HI PA IVL-HIX2016Contract V001
HI PA IVL-NM-OFF2016Contract V001
HI PA IVL-OFF2016Contract V001
HI PA IVL-CB-HHIX-Contract V001
HI PA IVL-CB-HContract V001
HAPA INDPOL-IDX 2016
HAPA INDPOL-OFFIDX 2016

Effective Date: 01/01/2016
Rate Filing Tracking Number: AETN-129971237
Form Filing Tracking Number: AETN-130055091
AETN-130054978
AETN-130047703
AETN-130047645
AETN-130047733
AETN-130047724

Company Contact Information:

Name: 
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 rate development applicable to the products supported by the policy forms referenced above;
- 3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
- 4) Provide summaries of the benefit details for the products/plan designs referenced by 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.

As stated more fully below, the rates requested in this submission assume that members who purchase through the federal-facilitated marketplace will remain eligible for federal subsidies. We reserve the right to amend or withdraw this rate filing if the Supreme Court holds otherwise in the pending case of King v. Burwell.

These rates are for plans issued in conjunction with our Qualified Health Plan (QHP) application in Pennsylvania beginning January 1, 2016. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available on and off the public Marketplace in Pennsylvania.

Plans included in this filing reflect the merger of Aetna Health Inc. (a PA corp), and HealthAmerica, Pennsylvania Inc. (HAPA). For 2016, all plans will be issued by Aetna Health, Inc. (AHI). For certain benefit plans, the benefit administration will be provided systems that previously support HAPA products and forms filings will be specific to the benefit administration system utilized.

2. Proposed Rate Increase

Monthly premium rates for all Individual Market products in Pennsylvania are being revised for effective dates January 1, 2016 through December 31, 2016.

A. Reason for Rate Increase(s):

Revised rates for these products reflect the following:

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services);
- Revisions to our assumptions about population morbidity and the projected population distribution;
- Changes to the reinsurance program;
- Changes in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Changes in our pricing models used to determine the impact of cost sharing designs; and
- Changes in provider networks and contracts.

B. Variation in Rate Changes by Plan/Product:

Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs based on network.
- Changes in cost sharing differ by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs in the large group market. These changes impact our estimates of the relative costs of the plan designs that will be offered.
- Updates to family deductible and out of pocket maximum provisions on HSA-compatible plans to comply with new federal regulations.

The weighted average increase across plans based on current ACA-compliant membership, inclusive of the impact of benefit and cost sharing changes, is 5.6%. The minimum increase is 0.63% and the maximum increase is 8.75%.

3. History of Rate Adjustments

- January 1, 2014 Initial introduction of these products
- January 1, 2015 Rate decreases for AHI and HAPA averaged 19.6% and 3.9%, resp.

4. 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, 2014 through December 31, 2014 and paid through February 28, 2015. HealthAmerica of Pennsylvania, Inc (HAPA) is merging with Aetna Health, Inc. (AHI) effective 1/1/2016 and the 2014 experience of both HAPA and AHI for both ACA and pre ACA individual risks are included in the experience period premium and claims.

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

Experience period premiums are date-of-service premiums from actuarial experience databases for non-grandfathered individual business in Pennsylvania. Internal projections indicate that no MLR rebate is expected to be paid in 2015 (for 2014 experience) for the Individual MLR Pool in STATE. As such, no adjustment was made to premiums to account for expected rebates.

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

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

Allowed claims for the HAPA experience come directly from the claim records for hospital, physician and prescription drug services. However, for prescription drugs, the allowed claims are credited for average manufacturer rebates. For markets with capitated services, the capitation rate is used for incurred claims; allowed claims are then the same as the incurred claims.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

Incurred Claims are captured in both reporting systems as the total amount of claims paid including the enhanced benefits for reduced cost-sharing variant plans sold on the Exchange. We reduce the amount reported on Worksheet 1 of the URRT, by the estimated HHS payments for member cost-sharing based on the simplified approach as described by 45 CFR Part 156.430. These estimated are developed and applied to completed experience period at the policy level.

As noted above, the experience period reflects two months of paid claim run-off. [REDACTED]

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 (if material) of these provider risk sharing provisions.

5. Benefit Categories

The AHI internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions dated February 21, 2015. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, included day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes 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.

For the HAPA reporting systems, claim tagging is used to fit all fee-for-service medical claims into four categories: Hospital Inpatient, Hospital Outpatient, Physician Services, and Other Medical. Other medical services are an estimated portion of Hospital Outpatient claims including ambulance services, durable medical equipment, and prosthetics. The utilization for these services are counted by service type and rolled up into one utilization number for the total category. Inpatient utilization is counted as days; outpatient and other medical utilization is counted as services; and physician utilization is counted as visits. Capitated services are paid on a per member per month (PMPM) basis and have no utilization values attached. Although pharmacy is also capitated, the experience utilization by prescriptions is included.

6. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The experience period data includes claims for both single risk pool policies issued in 2014 and non-grandfathered individual policies issued prior to January 1, 2014. The projected change in the morbidity of the population is based on modeling that considers changes in the two subsets of experience, current members and anticipated new entrants to the single risk pool, along with the anticipated change in the morbidity for each.

B. Changes in Benefits:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for both Single Risk Pool products that have essentially identical benefits and coverage issued outside the Single Risk Pool which does not cover all EHBs. The projection factor reflects the pro-rated impact of these additional 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:

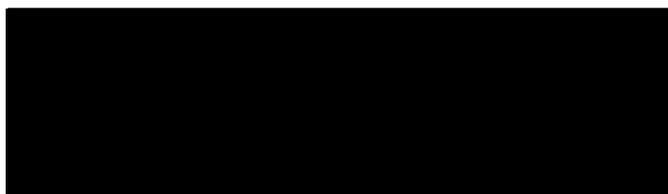
Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibit B contains detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

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

E. Trend Factors (Cost/Utilization):

Anticipated annual trend from the experience period to the rating period for the product line is as follows:



a. Medical Trend

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.

b. Pharmacy Trend

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

7. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

The source data for the manual rate is the experience incurred from 1/1/2014 to 12/31/2014 and paid through February 2015 for AHI and HAPA as well as Aetna Life Insurance Company and HealthAssurance of Pennsylvania in the Pennsylvania small group market (2-100, HMO / PPO, ACA & Pre-ACA non-grandfathered). The small group market experience is considered an appropriate source for the manual rate due to similarities in covered benefits and market dynamics to the post-2014 ACA Individual market. 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.

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.

C. Inclusion of Capitation Payments:

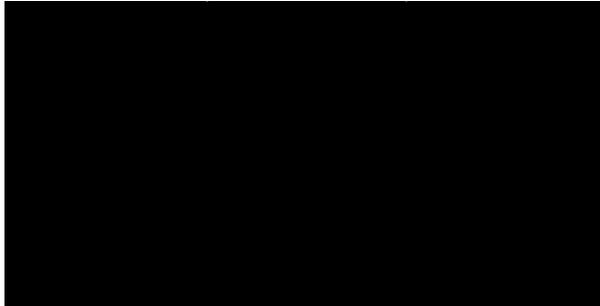
The manual experience includes capitation for the same services that are expected to be capitated for the products in this filing in 2016. We have adjusted the manual experience for known or anticipated changes in capitation contracts and projected changes in demographics where capitation rates vary based on demographics.

8. 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.

9. Paid-to-Allowed Ratio

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately [REDACTED]



10. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

Reinsurance recoveries in the experience period incurred claims were calculated by assuming 100% recovery of paid claim amounts less HHS cost-sharing payments between \$45,000 and \$250,000. Plan information is known on paid claims and thus, recoveries are listed in the appropriate HIOS ID on Worksheet II.

B. Reinsurance – Projection Period

We estimate 2016 reinsurance recoveries by relying on an internally developed model using Pennsylvania small group claims data incurred during calendar year 2014, trended forward with a factor of [REDACTED] to 2016. We are assuming average coverage in Pennsylvania of [REDACTED] deductible, [REDACTED] out-of-pocket limit and [REDACTED] coinsurance, and using federally established parameters of [REDACTED] of paid claims between [REDACTED] and [REDACTED], adjusted for 2016 enrollment assumptions and adjusted for the Pennsylvania geography. We expect the transitional reinsurance program to reduce average claims for these products by approximately [REDACTED] in 2016 excluding the impact of the Reinsurance Contribution.

The net impact of Reinsurance, after considering the Reinsurance Contribution of [REDACTED] PMPM for 2016, is [REDACTED]. This cost is allocated by plan as a percent of claims cost.

C. Risk Adjustment – Experience Period

Risk Adjustment is estimated as a per member per month amount by metallic tier and allocated by plan within each metal tier for purposes of completing Worksheet II.

D. Risk Adjustment – Projection Period

We develop a market base rate that represents the average market morbidity expected in 2016. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level. As a result, we project a net risk adjustment payable of the user fee of [REDACTED] PMPM.

E. Risk Corridors

The risk corridors program is intended to protect carriers from significant deviation between actual results and carriers' projections, and as such, does not impact the required premium on a prospective basis.

11. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is █████%. This was developed from the following items and approximated as shown:

1. Taxes and Fees of █████% comprised of:
 - a. Premium Taxes of █████%
 - b. Patient Centered Outcomes Research Fund of \$████ per member per year, converted to █████%
 - c. Health Insurer Fee of █████%, including a gross-up for income taxes
 - d. Exchange User Fee of █████%. This assumes a business mix of █████% on exchange at █████% and █████% off exchange.
 - e. Federal Income Tax of █████%, assuming █████% tax rate
2. General Administrative Expenses, including sales, marketing, and any commission expense, of approximately █████% of premium
3. After-tax Target Profit of █████

The Risk Adjustment Program User Fee and the Reinsurance Contribution have been reflected in the risk adjustment and reinsurance components of incurred claims. The Exchange User Fee is applied as an adjustment to the Index Rate at the market level.

These prospective expenses are based on historical expense levels, current-year projections, and projected changes in expenses, inflation, and membership. The profit target has increased from our 2015 target. This increase is to bring the profit target in line with our AHI's long-term corporate objectives for this business.

12. Projected Loss Ratio

The projected MBR for this filing calculated in the traditional way is █████%. The expected 2016 MLR for this filing, as defined by PPACA and before any credibility adjustment, is █████%.

13. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Individual market in Pennsylvania through AHI. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

14. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits (non-EHBs).

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, 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).

15. Market-Adjusted Index Rate

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

16. 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 Plan Adjusted Index Rates are displayed in Column 7. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value, Cost Sharing, and Tobacco:

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

1. We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The combination of these two analyses is a projection of the relative paid to allowed ratio which also reflects the impact of out of network coverage.
2. We applied an adjustment for the impact different of cost sharing levels 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 normalized to result in an aggregate factor of 1.0 when applied to the projected 2016 membership.
3. We remove the aggregate impact of tobacco rating. A █% load is applied to all tobacco users age 21 and older. Approximately █% of enrollees are expected to be tobacco users aged 21 and older. The average tobacco factor is calculated as █. The non-tobacco adjustment (to derive a rate for non-tobacco users) is the reciprocal of this value, or approximately █.

B. Distribution and Administrative Costs:

Column 3 reflects the adjustment for projected administrative costs, including sales, marketing, and any commission expense, and profit & risk. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Reinsurance Contribution, Risk Adjustment User Fee, and Exchange User Fee, which are reflected elsewhere. Products offered in Region 8 have distribution and administrative costs that differ from other regions. The profit and risk do not vary by plan, however, marketing, sales, commission and administrative costs differences reflect material differences in the expected savings of the benefit and marketing strategy being introduced in region 8 in 2016.

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

All benefits offered meet the definition of an EHB.

E. Catastrophic Plan Eligibility:

This filing does not include catastrophic plans.

F. Experience Period Plan Adjusted Index Rates

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates for the experience period. Since these values were not explicitly developed as part of our 2014 rate filings, we have approximated the values that would have been filed. The approach used to develop these values starts with the 2014 plan-specific base rates (the premium rate that would have been charged for a member with 1.0 age, area, and tobacco factors), and multiplies them by the average age and area factors that were projected in the 2014 filing.

17. Calibration

A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit D.

We project a premium-weighted average age factor for the 2016 membership of [REDACTED] using the prescribed age curve. The age most closely corresponding to the weighted average age factor is [REDACTED]. We determine a calibration factor of [REDACTED] by taking the reciprocal of the weighted average age factor. The projected age distribution is based on the national enrollment for the combined Aetna and Coventry small group business in 2014.

B. Geographic Factor Calibration:

Exhibit C shows the rating areas by county and the experience and projected area factors. Exhibit C also displays the projected membership by area and the projected average area factor of [REDACTED]. The calibration factor is the reciprocal, or [REDACTED].

C. Quarterly Trend Calibration:

Not applicable.

18. Consumer-Adjusted Premium Rate Development

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:

Calibrated Plan Adjusted Index Rate * Age Factor * Area Factor * Tobacco Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

As an example of this calculation, consider a family living in Dauphin County that enrolls in the PA Coventry Silver \$10 Copay OAHMO PD plan. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6, and no family member uses tobacco. The rate for this family is calculated as:

[REDACTED]

The family's final monthly rate is the sum of the member rates, or \$ [REDACTED]. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example.

19. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

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 and Cost Sharing Reduction Subsidy Estimates

Exhibit A summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience and enrollment in ACA-compliant plans through March 2015. We assume that total enrollment will be similar to our current enrollment.

Cost sharing reduction subsidy estimates are determined by calculating the difference in the Metal AV for the standard plan variation and the CSR variation, and multiplying the value by the plan's projected allowed claims PMPM, the membership projected in the CSR.

22. Terminated Products

The following products will be closed to new sales prior to January 1, 2016:

[REDACTED]

[REDACTED]

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period. Also, some terminated products columns of Worksheet II reflect a HIOS ID of 64844PA005. This HIOS ID was created for use in Worksheet II to identify terminated HAPA plans in a manner that avoids HIOS upload conflicts if plans with HAPA HIOS IDs were listed in an AHI URRT.

A mapping of 2014 ACA-compliant plans to 2016 plans is provided in Exhibit G.

23. Plan Type

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

24. Warning Alerts

Some plans in this filing were offered on the Marketplace in 2014. We have reported the estimated cost share reduction subsidies on Row 65 of Worksheet 2. The Validation Report incorrectly indicates that these amounts should be zero for 2014.

25. Benefit Design

This filing includes the following standard plans: [REDACTED]. All Region 8 Benefits include coverage for pediatric dental benefits; plans offered outside the Exchange in Regions 1-7 and 9 will also include pediatric dental benefits.

Please refer to the corresponding policy forms for detailed benefit language. All benefit and cost sharing parameters comply with Pennsylvania benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

26. Marketing

As described above, some of these plans will be made available through the public Marketplace. In addition, plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including directly to consumers through direct mail, telemarketing, and the internet and indirectly through brokers and general agents. Marketing and distribution approaches may change from time to time at management's discretion.

27. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the Marketplace as verification of eligibility.

Additionally, with respect to determining the applicable premium risk class due to tobacco-use status, the underwriting criteria will be consistent with the communicated federal thresholds. Tobacco use will be

determined by use of tobacco on average of four or more times per week (excluding religious or ceremonial uses) within no longer than the past six months.

28. Renewability

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

29. Company Financial Condition

As of December 31, 2014, the capital and surplus held by Aetna Health Inc. (a PA corp) was approximately [REDACTED]. This amount is disclosed in the Company's statutory financial statement dated December 31, 2014. The Company issues commercial and Medicare Advantage coverage in various states for multiple business segments, including to large employer, small employer, and individual purchasers.

30. Reliance

While I have reviewed the reasonableness of the assumptions in support of both the preparation of the Part I Unified Rate Review Template and the assumptions in support of the rate development applicable to the products discussed in this filing, I relied on the expertise of the following noted individuals, along with work products produced at their direction, for the following items:

- URRT Methodology and Data Definitions
- Experience Period MLR Rebates
- Actuarial Value, Modifications, and Benefit Relativities
- Medical Cost and Utilization Trend
- Impact of Reinsurance
- Rx Cost and Utilization Trend
- Pediatric Dental Claim Cost
- Components of Retention/Administrative Fees
- MH Net Trend and Outpatient Pre-Cert Adj
- Experience Period Data – Individual
- Experience Period Data – Small Group



31. 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 Pennsylvania, 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.

2. The Projected Index Rate is:
 - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
 - 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.

The projected index rate assumes that members are eligible to receive federal subsidies. As of the date below, the Supreme Court of the United States is considering whether those subsidies are lawful (King v. Burwell). I would not be able to certify that the proposed rates are adequate if the Supreme Court rules that the subsidies are not lawful. Accordingly, Aetna reserves the right to withdraw and/or amend this rate submission in the event of such a Supreme Court ruling.



May 6, 2015



Date

Aetna Health, Inc.