State: *Pennsylvania* **Filing Company:** *Aetna Health Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *2Q 2016 PA SG AHIC filing*
Project Name/Number: *2Q 2016 PA SG AHIC filing/*

Supporting Document Schedules

Satisfied - Item:	Transmittal Letter (A&H)
Comments:	
Attachment(s):	2Q16-4Q16 AHIC SG PA Cover Letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Part III Act Memo
Comments:	x
Attachment(s):	2Q16-4Q16 PA SG AHI-AHIC Memo and Cert - REDACTED.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Part II Narrative
Comments:	
Attachment(s):	2Q16-4Q16 PA SG HMO Part II Narrative.pdf
Item Status:	
Status Date:	

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Mailstop U12N
Blue Bell, PA 19422
Phone: 215-775-0283
AdamsA@aetna.com

September 29, 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 Insurance Company - PA Small Group Rate Manual – 04/01/2016

Dear Ms. Mathur:

The purpose of this filing revision is to provide details of the premium rate development and resulting proposed monthly premium rates for Small Group policies which will be offered off-Exchange in the State of PA for effective dates of April 1, 2016 and later. This filing is being provided to comply with regulatory rate filing requirements, and is not intended to be used for other purposes.

The health benefit plans proposed in this filing are new benefit plans and are in compliance with all state-specific benefit requirements and rating regulations, as well as the benefit plan requirements of the Patient Protection and Affordability Act (P.L. 111-148). Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, Gold, and Platinum. All plans within a tier are expected to achieve an actuarial value consistent with the thresholds established for each tier – 60%, 70%, 80%, and 90%, respectively – approximated within the allowable range of deviation defined as 2 percentage points.

This rate filing is intended for new business issued through the State of PA off-Exchange marketplace effective April 1, 2016.

All products and associated proposed monthly premium rates contained within this rate filing will be available to existing business upon their request. Existing business that is not considered grandfathered under PPACA regulation will be converted to the plans and rates in this filing upon renewal.

We have tried to present this information in a manner that will facilitate your Department's review. If there are changes we can make to improve the process or you would like us to present the information differently in the future, please let us know.

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Please feel free to contact me at the above listed telephone number and/or e-mail address if you have any additional questions.

Since AHI, AHIC, ALIC, and AHASPA consider this submission to contain proprietary information, we ask that it be kept confidential to the extent possible.

Sincerely,

Andrew Adams, F.S.A., M.A.A.A.
Mgr, Actuarial
Aetna

Enclosures

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	**Aetna Health, Inc. (and Aetna Health Ins. Co.)**
State:	**Pennsylvania**
HIOS Issuer ID:	**64844**
Market:	Small Group
Policy Form(s):	**HI AShortTermVisDenDeduct 03; HI RRXDRUGPLAN V005; HO AShortTermVisDen 04; HO ARecCharge V003**
Effective Date:	04/01/2016
Rate Filing Tracking Number:	**AETN-130242320 & AETN-130242341**
Form Filing Tracking Number:	**AETN-130047878; AETN-130047985**

Company Contact Information:

Name:	[redacted]
Telephone Number:	[redacted]
Email Address:	[redacted]

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.

These rates are for plans issued in Pennsylvania beginning April 1, 2016. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in Pennsylvania.

2. Proposed Rate Change

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

A. Reason for Rate Change(s):

Revised rates for these products reflect the following:

- Administrative expenses have been increased to include broker commissions. This change will increase rates from their previously approved levels by 4.6%;
- There are 5 new narrow network plans being added to the product portfolio. These new plan designs are mirrors of previously filed and approved broad network plans, but are only available in Fayette county (Region 4). These plans reflect anticipated cost savings from facilities in that county;

3. History of Rate Adjustments

- January 1, 2014 Initial introduction of these products
- January 1, 2015 -12.3% avg rate change for HNOption plans; -5.4% avg rate change for HMO plans; -3.1% avg rate change for POS plans

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 January 31, 2015.

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

C. Allowed and Incurred Claims Incurred During the Experience Period:
Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

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

As noted above, the experience period reflects one month of paid claim run-off. [redacted]

Exhibit Z summarizes the experience data and documents the impact of the IBNP reserves, by date-of-service for each month within the experience period.

5. Benefit Categories
Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions 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 and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including

visit-based mental health services. Other includes home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

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.

6. Projection Factors

A. Changes in the Morbidity of the Population Insured:

[redacted]

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.

D. Other Adjustments:

[redacted]

E. Trend Factors (Cost/Utilization):

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

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

[redacted]

7. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

[redacted]

B. Adjustments Made to the Data:

[redacted]

C. Inclusion of Capitation Payments:

[redacted]

8. Credibility of Experience

[redacted]

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]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]

10. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

[redacted]

B. Reinsurance – Projection Period

[redacted]

C. Risk Adjustment – Experience Period

[redacted]

D. Risk Adjustment – Projection Period

[redacted]

11. Non-Benefit Expenses and Profit & Risk

[redacted]

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 change is to bring the profit target in line with our long-term corporate objectives for this business.

12. Projected Loss Ratio

[redacted]

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 Small Group market in Pennsylvania through Aetna Health, Inc. (and AHIC). The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d). Rates for plans that may be renewed outside

the Single Risk Pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing.

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).

Small Group Market Trend Adjustments: The following table illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. [redacted]

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

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:

[redacted]

- [redacted]
- [redacted]

[redacted]

B. Distribution and Administrative Costs:
Column 3 reflects the adjustment for projected administrative costs and profit. 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. These expense and profit assumptions do not vary by plan.

C. Provider Network, Delivery System, and Utilization Management:
The factors in Column 4 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

D. Benefits in addition to EHBs:
[redacted]

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. For Small Group plans, we also multiply by the average trend factor that was expected to be charged based on the anticipated distribution of effective dates from the January 1, 2014 filing.

17. Calibration
A. Age Curve Calibration:
The age factors are based on the HHS Default Standard Age curve.

[redacted]

B. Geographic Factor Calibration:
[redacted]

C. Quarterly Trend Calibration:
[redacted]

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 * Trend Factor

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

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

19. Composite Premiums

[redacted]

20. 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.

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

22. Membership Projections

[redacted]

[redacted]

23. Terminated Products
The following products will be closed to new sales prior to January 1, 2016:

- 64844PA001 (Aetna Health Maintenance Organization)

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.

A mapping of 2014 ACA-compliant plans to 2016 plans is provided in Exhibit I. The exhibit also identifies plans that have been terminated and will not be offered in 2016.

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

25. Warning Alerts
The Experience Period Plan Adjusted Index Rate on Worksheet 2 differs from the Experience Period Premium PMPM on Worksheet 1 since the Experience Period Premium reflects the actual enrollment mix for all non-grandfathered business in the market in 2014 while the average Plan Adjusted Index Rate reflects the projected (vs. actual) ACA mix for single risk pool experience and a zero rate for non-single risk pool experience.

For the same reason, Total Premium (TP) differs between Worksheets 1 and 2.

The Projected Plan Adjusted Index Rate on Worksheet 2 differs from the Gross Premium Average Rate on Worksheet 1. This difference results from the value on Worksheet 1 being the rate that corresponds to claims incurred in the 12 months starting April 1, 2016, while the average on Worksheet 2 is the average rate for the market for coverage that begins between April 1, 2016 and December 31, 2016.

For the same reason, Total Premium (TP) differs between Worksheets 1 and 2.

26. Benefit Design
This filing includes the following standard plans: 9 Bronze, 38 Silver, 29 Gold, and 5 Platinum.

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.

27. Marketing
Plans will be marketed through brokers and general agents.

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

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

30. Company Financial Condition

As of December 31, 2014, the capital and surplus held by Aetna Health, Inc. of PA was approximately $447 million. 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.

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:

[redacted]

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.

September 29, 2015

_____ _____

[redacted] Date

Aetna Health, Inc.
Pennsylvania Small Group
HMO and QPOS

Summary
Aetna is filing rates for Small Group plans in Pennsylvania. This filing proposes to raise average premium rates by 9.0% for HMO plans and 10.1% for QPOS plans.

Who is affected?
The rates will apply to policies that start or renew from April 2016 through December 2016. Approximately 68,000 members are enrolled in plans to which the new rates will apply. Some plans in this market may not be available for renewal. Members in those plans will be able to enroll in the new plans included in this filing.

Why We Need to Increase Premiums
Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 9.6%, excluding the effect of benefit changes described below. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care.

For Small Employers in Pennsylvania, some examples of increasing medical costs we have experienced in the last 12 months include:

- The cost for an inpatient hospital admission has increased 11%.
- Costs for pharmacy prescriptions have gone up 10%.
- Physician admissions have increased 4%

What Else Affects Our Request to Increase Premiums
Several requirements related to the Affordable Care Act (ACA) also impact these rates. These include:

- "Keep What you Have" and its impact on the population that will enroll in the plans covered by this filing
- Enhanced network access standards – which limit our ability to control the cost and quality of medical care
- Changes to required taxes and fees

Will Premiums for All Small Groups Increase 9.0% for HMO plans or 10.1% for QPOS plans?
No, the 9.0% and 10.1% are averages based on our current enrollment by plan. Some premiums will increase by less. Others will increase by more than the average. The exact rate change will depend on what benefit plan the group chooses, when the group's contract renews, where in Pennsylvania the group is located, and the number and ages of family members.

Changes in the premium that members pay will also depend on changes in employer contributions.

How does this request align to Minimum Loss Ratio Requirements (MLR)?
These rates are expected to produce an MLR equal to or above the 80% requirement for Small Group business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to members in accordance with the law.

Aetna makes significant investments that benefit our members that the government does not allow us to use in this calculation. These investments include customer service, health quality activities like disease management programs, and the development of new information technologies.

What is Aetna doing to keep premiums affordable?

Aetna is taking a number of steps to keep our products as affordable as possible and to address the underlying cost of health care. These actions include:

- Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care and not the quantity of services.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
- Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

Aetna is dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's Plan for Your Health website aims to educate all consumers on how to take advantage of their health care benefits.