Samantha Wei

Aetna Life Insurance Company

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Hartford, CT 06156

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January 9, 2018

Subject: Aetna Life Insurance Company - NAIC No. 00160054

Student Health Blanket Accident and Sickness Policy

SERFF Tracking Number: AETN-130853872

Dear Reviewers:

Following the recent 2018-2019 PA student health Insurance rate filing guidance, Aetna student health will submit the following items as rate manual filing with SERFF Tracking Number: AETN-131331937 as the first step of the rate filings expected. We will submit a new SERFF rate filing with the specific rates ("the specific named group filing") within 15 business days of finalizing a contract with an institution. Below each required documents for the rate manual filing will be addressed.

A. Cover Letter / PA Bulletin Information – Rate Manual Filing

1. Company name & NAIC number
2. Corresponding contract form number and SERFF ID numbers
3. Estimated effective date of coverage, including policy year start and end dates
4. Current number of covered lives and policyholders (as of November 1, 2016)
5. Rating areas

Comments:

1. Company name & NAIC number : Aetna Life Insurance Company - NAIC No. 00160054
   Corresponding contract form number and SERFF ID numbers:
   Policy: AL SH HPol-H 02
   Certificate of Coverage: AL SH HCert-H 02
   Schedule of Benefits: AL SH HSOB-H 02
   SERFF Tracking Number: AETN-131299256

2. Estimated effective date of coverage, including policy year start and end dates: The rates and policy are effective for school year 2018-19, which typically runs from July/August 2018- June/July 2019 and each school effective dates might vary and cannot be finalized until the renewals completed.
3. Current number of covered lives and policyholders (as of September 1, 2017): There are four policyholders with a total of 22,687 covered lives.
4. Rating areas: Not applicable.

B. **Actuarial Memorandum and Certifications:** It was submitted under supporting documentation as requested.

C. Rate manual and rate exhibits, including an Excel workbook that chronicles the step-by-step methodology (unredacted and, optionally, redacted)
   Comments: The rate manual was submitted under rate tab as requested.

We have tried to present this information in a manner that will facilitate your review of the rate filing submitted. If there is something more that we can do to improve the process or that you would like us to do differently in the future, please let us know. I can be reached via e-mail at weij@aetna.com.

Sincerely,

Jingwei (Samantha) Wei, FSA, MAAA

Aetna Student Health

617-959-3133

STUDENT HEALTH RATE MANUAL

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Student health introduction

Colleges and universities that provide or make available student health insurance coverage to their students and their dependents typically choose one vendor to be the underwriter/carrier of the coverage. While some similarities may be made to group insurance, student health care costs, and the concomitant insurance rates, are influenced by a variety of health cost drivers not generally applicable to group insurance and their effect on health care costs can vary dramatically from institution to institution.

We have identified five major drivers of student health care costs:

- Benefit Plan design
- Student Health Center Services
- Enrollment Process
- Demographics
- Cost of Medical Services

The range in variation in each of these drivers is described below; as is the differing impacts such variation can have on health care costs and premium rates.

Benefit Plan Design

It is intuitively clear that benefit plan design affects the cost of a student health insurance program. Generous plans have higher costs; limited plans, lower costs. But there also are complexities and subtleties. For example, there are cost implications for plans that have an annual deductible, if the deductible is waived or not waived with a referral from the student health center. Exclusions can play a key role in the determination of plan costs.

Student Health Center Services

The student health insurance program is a compliment to the services provided at the institution's student health center. It is a truism that most services provided at the health center are those that otherwise would be provided in the community and be covered under the insurance program. As a result, the capabilities of the health center, the scope and depth of its services, be it limited to certain primary care services or expanded beyond primary care to include certain specialty care, is going to directly affect the utilization of services in the community that would otherwise fall under the insurance program. Simply put, a robust student health center is going to generate fewer services in the community than a less comprehensive one. Also, a referral requirement from the health center will play a key role in determining where medical services are rendered.

How all of this affects the cost of health care under the insurance program depends not only on the scope and depth of services at the student health center, and the presence or absence of a referral requirement, but how medical services rendered at the student health center are financed. For some institutions, all services at the health center are financed by a student health fee that is totally separate from the student health insurance premium. For such schools, their respective student health insurance premium rates will vary based on the capabilities of the health center and the amount of medical services rendered there. At the other end of the spectrum, there are institutions which bill the health insurance plan for all services rendered at the health center. For these institutions, when compared to those who use a separate student health fee, their health insurance premium rate will be considerably higher because their premium rate essentially incorporates a student health fee as well as the cost of insurance. Other institutions tend to fall somewhere in the middle in that the student health center is financed by a combination of a separate, more modest, health fee and billings to the insurance program.

Enrollment Process

Most of the higher education institutions we underwrite have implemented a hard waiver enrollment process for their student health insurance program. The process automatically enrolls each student in the insurance program unless that student can furnish proof that he/she has comparable coverage. In general, the end result is that 20-25% of undergraduates and 35-65% of graduate/professional students will be enrolled in the insurance program. Because this process essentially eliminates choice on behalf of the student, those enrolled tend to represent a balanced risk pool (high utilizers are offset by low utilizers) that translates into reasonable, stable insurance premium rates. But, if the process is not strictly enforced, as some institutions are prone to do, enrollment can drop and the risk pool can be negatively affected which, in turn, translates into higher utilization under the insurance plan and higher insurance premium rates.

Demographics

Differences in demographics will cause significant differences in student health insurance rates. As the enrollment rates under a hard waiver process above suggests, an insured student population will have different demographics than the general student population because of the higher enrollment rates for graduate and professional students. As a general rule, graduate students (including professional students) have health insurance costs that are 160 - 200% higher than undergraduates, primarily because they are five to six years older (age 27 versus age 21) and have higher fertility rates. But the split of the general student population, as well as of the insured student population, between undergraduates and graduates can vary greatly from institution to institution and will have a dramatic effect on health insurance premium rates.

The percentage of international students in the general student population, as well as in the insured student population, also can vary widely from institution to institution and can have an effect on health insurance premium rates as international students have health insurance costs that are 20-25% lower than their domestic counterparts.

Finally, there is the student/dependent mix of the insured population. Dependent coverage requires a subsidy from the student portion of the program and the amount of subsidy is a direct function of the percentage of dependents on the insurance program. In determining rates that do not incorporate a differentiation in rate between student and dependent, projections of enrollment changes for dependent population will assume increased dependent enrollment.

Cost of Medical Services

Student health insurance rates, like commercial health insurance rates, will reflect prevailing charges of medical services which vary by geographic area and the level of negotiated provider discounts which are affected by the presence or absence of competing providers in the area. Additionally, for universities that own or are affiliated with medical centers, there may be favorable, directly negotiated discounts with the medical center that benefit the students in the form of lower health insurance premium rates.

General Guidelines

We underwrite health insurance programs offered by colleges and universities to their students and their dependents. We require that Aetna is being offered as the sole carrier. Students and their dependents generally bear the entire cost of the insurance premium, although the premium for some subsection of the student population, graduate assistants in particular, may be partially or fully subsidized by the institution. As determined by the college or university, enrollment in the health insurance program may be mandatory, mandatory with waiver process or voluntary and, within the program, may vary by the status of the potential insured: full-time versus part-time student, student versus dependent. Mandatory enrollment

means all eligible students are automatically enrolled and this requirement generally applies only to full-time students or to a subsection of the student population such as international students. Mandatory with waiver process means all eligible students are automatically enrolled but can waive participation in the program if they can provide proof of acceptable coverage. Voluntary enrollment means all eligible students can elect to enroll in the health insurance program.

The institution defines who is eligible to participate in the health insurance program. In general, for students, the institution will define eligibility as all students who are registered and actively participating in credit courses leading to a degree. Dependents will be defined consistent with the Affordable Care Act.

For health insurance programs where the enrollment process is voluntary, we do not impose any minimum participation requirement on a retroactive basis.

Student health Insurance Premium

Student Health Insurance Premium Rates are generally determined by an experience-rating process. No manual rate calculation is usually involved as we believe it is not practical to develop a manual rating system that can adequately address all the variances in risk profile that each school's student health insurance plan presents. Experience-rating is used for most schools.

Policy / School year experience is used in the experience-rating process when available. Use of the most recent 12 months of paid claims is generally not advisable because of the potential discontinuities that the annual enrollment process can introduce to the payment process, as well as the lack of reliability in the enrollment numbers for the more recent months.

The most recent policy year experience is used in the experience-rating process for schools with the larger insured populations and the two most recent policy years' experience is used for schools with the smaller insured populations.

In situations where the institution has no prior claims experience or the claims experience is either suspect or incomplete, we determine the student health insurance premium rates by what we call proxy pricing. We identify from our book of business a health insurance program of an institution (the proxy) that closely matches the institution to be rated in terms of benefit design, scope and depth of services at the health center, enrollment process and demographics. Using the proxy's claims experience and/or current premium rates and making pricing adjustments to account for any minor differences between the institution to be rated and the proxy's health cost drivers, we are able to determine appropriate premium rates for the institution's student health insurance program.

Rate Calculation-Renewals

Data Required:

- Current Policy Year Rate(s)
- Claims data for appropriate Policy Years
- Subscribers by Billing Tier (Premium Breakdown)
- Members
- Rate History/Plan Changes
- Broker Commission (if applicable)
- Large Claim Data & Diagnosis

Section I: Experience Rating Process for Accounts with a written premium >= $10,000,000

A. Determine Baseline Cost Ratio (BCR) –

A baseline cost ratio is established for the most recent policy experience period(s) by multiplying the current paid claims for each specific policy year (rating period) by the completion factor. (An adjustment may be made by the Underwriter, based on the specific claims experience of the account).

Any claims exceeding the pooling point (after projected completion of these claims) will have that amount(s) of claim in excess of the pooling point subtracted out of the overall projected completed experience. The overall projected claims will then be multiplied by the Pooling adjustment factor in (under pooling adjustment section below). Medical pooling is intended for unexpected, non-recurring claims. In instances where medical opinions suggest a strong likelihood of significant recurring claim dollars exceeding the pooling threshold for the 2018-2019 policy year, the Pooling adjustment factor (under pooling adjustment section below) may be adjusted accordingly for these expected recurring large claims.

Once the completed projected claims has been determined it is divided by the total premium collected (excluding taxes, fees and commissions) for the given policy period in order to establish the baseline loss ratio.
Example – To determine the 2018-19 policy year rates, you would use the Baseline Loss Ratio from the 2016-17 policy year.

B. Trend (T) – Trend (see Section medical and prescription drug trends) allowing for changes in unit cost and utilization of services, is then applied to the baseline loss ratio. An adjustment may be made by the Underwriter, based on the specific claims experience of the account, network utilization, and health center services offered.

C. Plan Design Change(s) (PDC) – If applicable (i.e. the program made plan changes), the appropriate credit or debit is applied. This adjustment was made during the intervening policy year between the experience period and the rating period.

D. Premium Increase (PI) - If applicable (i.e. the program had a premium increase or decrease), the appropriate credit or debit is applied.

E. Projected Loss Ratio (PLR) for Current Plan Year (CY) is determined –

((BCR * T) * PDC)) / PI = PLR CY

F. Trend (T) – Trend (see Section medical and prescription drug trends), allowing for changes in unit cost and utilization of services, is then applied to the projected loss ratio for the current plan year in order to determine the renewal year loss ratio. An adjustment may be made by the Underwriter, based on the specific claims experience of the account, network utilization, and health center services offered.

G. Future Plan Design Changes (FPDC) – If applicable (i.e. the program made plan changes), the appropriate credit or debit is applied. This adjustment is made to the plan during the rating period.

H. Loss Ratio (LR) – The projected loss ratio is then divided by the required Medical Cost Ratio for applicable size

I. Required Rate Change (RRC) -

(PLR CY * FPDC * T) = LR

(LR/MCR) – 1 = RRC%

J. Broker Commission (BC) – If applicable (i.e. they have a broker), incorporate BC% (defined as the Broker Commission expressed as a percentage of premium) or BCF (defined as the Broker Commission expressed as a per student dollar amount) if flat rate.

K. Patient Centered Outcome Research Fee (PCORF) - A PMPM amount calculated in accordance with the definition of such in the ACA

L. Reinsurance Contribution (RC) - A PMPM amount calculated in accordance with the definition of such in the ACA

M. Health Insurer Fee (HIF) - A percentage of premium amount calculated in accordance with the definition of such in the ACA

N. Premium Tax (PT) - A percentage of premium amount defined by the state for this line of business

O. Prior Year's Rate (PYR) - the student rate from the previous school year, excluding PCORF, RC, HIF, PT, and BC

P. Total Student Rate (TSR) – calculated as:

TSR = (PYR * (1+RRC%) + PCORF +RC + BCF) / (1 – HIF – PT – BC%)

Section II: Experience Rating Process for Accounts with a written premium <$10,000,000

1. Determine BCR – A base line cost ratio will be developed using prior plan experience by using the steps in Section I A.

2. The BCR that results will be trended forward one year, to the current plan year.

3. A blended BCR will be developed by weighting the prior plan year developed BCR, equally with the current plan year developed BCR.

4. Repeat steps B through P, in Section I.

Rate Calculation – New Business

Data Required:

- Current Policy Year Rate(s)
- Claims Reports for appropriate Policy Years
- Subscribers by Billing Tier (Premium Breakdown)
- Members

- Rate History/Plan Changes (Prior Two Years)
- Broker Commission (if applicable)
- Brochures past years
- Large Claim Data & Diagnosis
- Type of Enrollment

Section I: Experience Rating Process for Accounts with a written premium >= $10,000,000

A. Determine Baseline Cost Ratio (BCR) –

A baseline cost ratio is established for the most recent policy experience period(s) by multiplying the current paid claims for each specific policy year (rating period) by the completion factor (An adjustment may be made by the Underwriter, based on the specific claims experience of the account).

Any claims exceeding the pooling point (after projected completion of these claims) will have that amount(s) of claim in excess of the pooling point subtracted out of the overall projected completed experience. The overall projected claims will then be multiplied by the Pooling adjustment factor in (under pooling adjustment section below). Medical pooling is intended for unexpected, non-recurring claims. In instances where medical opinions suggest a strong likelihood of significant recurring claim dollars exceeding the pooling threshold for the 2018-2019 policy year, the Pooling adjustment factor (under pooling adjustment section below) may be adjusted accordingly for these expected recurring large claims.

Once the completed projected claims has been determined it is divided by the total premium collected (excluding taxes, fees and commissions) for the given policy period in order to establish the baseline loss ratio.
Example – To determine the 2018-19 policy year rates, you would use the Baseline Loss Ratio from the 2016-17 policy year.

B. Trend (T) – Trend (see Section medical and prescription drug trends,) allowing for changes in unit cost and utilization of services, is then applied to the baseline loss ratio. An adjustment may be made by the Underwriter, based on the specific claims experience of the account, network utilization, and health center services offered.

C. Plan Design Change(s) (PDC) – If applicable (i.e. the program made plan changes), the appropriate credit or debit is applied. This adjustment was made during the intervening policy year between the experience period and the rating period

D. Premium Increase (PI) - If applicable (i.e. the program had a premium increase or decrease), the appropriate credit or debit is applied.

E. Projected Loss Ratio (PLR) for Current Plan Year (CY) is determined –

((BCR * T) * PDC)) / PI = PLR CY

F. Trend (T) – Trend (see Section C for applicable policy year), allowing for changes in unit cost and utilization of service, is then applied to the projected loss ratio for the current plan year in order to determine the renewal year loss ratio. An adjustment may be made by the Underwriter, based on the specific claims experience of the account, network utilization, and health center services offered.

G. Future Plan Design Changes (FPDC) – If applicable (i.e. the program made plan changes), the appropriate credit or debit is applied. This adjustment is made to the plan during the rating period.

H. Network Adjustment (NA) – Based on overall utilization and school locale, the underwriter would adjust the overall projected claims by appropriate network credit.

I. Actuarial Adjustment/New Business (AA)– Adjust by Actuarial Adjustment Factors

J. Loss Ratio (LR) – The projected loss ratio is then divided by the required Medical Cost Ratio for applicable size program.

K. Required Rate Change (RRC)-

(PLR CY * T * FPDC * NA * AA) = LR

LR/MCR - 1 = RRC%

L. Total Student Rate (TSR)- is calculated exactly analogously to that described under "Renewal Rate Calculation Worksheet"

Section II: Experience Rating Process for Accounts with a written premium < $10,000,000

1. Determine BCR – A base line cost ratio will be developed using prior plan experience by using the steps in Section I A.

2. The BCR that results will be trended forward one year, to the current plan year.

3. A blended BCR will be developed by weighting the prior plan year developed BCR, equally with the current plan year developed BCR.

4. Repeat steps B through L, in Section I.

Accident & Sickness Claims Completion Methodology

Premium rates for student health insurance programs are determined from an experience rating process using policy year experience. Generally, it takes 14-18 months from the end of a policy year for medical claims (2-5 months for outpatient prescription drugs) to reach the ultimate (or completed) paid level for that experience period.

For student health insurance, renewal rating is done for the second subsequent policy year and is performed 2-8 months after the end of the most current policy year. Consequently, a Completion Factor is required to

convert medical claims paid-to-date to our best estimate of completed claims for that policy year (outpatient prescription drugs generally are considered to be complete at the time of the renewal calculation).

To determine the completion factor, we use the institution's prior claims experience as well as the claims experience of our entire book of student health business. We incorporate the experience of the entire block because we find using only one observation is not credible and produces inconsistent results. We believe this methodology produces an appropriate and consistent completion factor based on the individual institution's experience and the experience of our book-of-business.

In rating prospective business, we seldom are provided with the historical payment patterns of the claims that would allow us to incorporate that individual institution's experience into the development of an appropriate completion factor. In these instances, we use the same approach to develop a completion factor for prospective business as we do for renewal business, as described above, except that we rely entirely on the experience of our book-of-business.

Pooling Adjustments

Pooling Levels for school year 2018-19 will be based on 17/18 Premium Levels

Estimated 17/18 Premium	18/19 Pooling Level
<$1M	$100,000
$1M - $5M	$150,000
$5M - $10M	$200,000
$10M -$50M	$250,000
$50M - $75M	$300,000
>$75M	$400,000

The pooling level may be adjusted upwards by $50,000 for schools with a projected premium over $1,000,000, or upwards by as much as $100,000 for schools with a projected premium over $5,000,000. The pooling factors were evaluated based on a recent 24 months period.

Pooling Level	Pooling Charge for 17-18 School Year
$100,000	10.3%
$150,000	7.7%
$200,000	6.3%
$250,000	5.5%
$300,000	4.9%
$350,000	4.4%
$400,000	4.0%
$450,000	3.7%
$500,000	3.4%

Medical and Prescription Drug Trends

The Medical Trend factor is a trend factor derived from our Book-of-Business claims experience that is intended to be applied to current claims experience to project future claims experience for student health insurance programs. The unlimited trend factor is adjusted to reflect region-specific cost differentials.

We are a predominantly large case underwriter where, for many individual institutions, a majority of medical services are rendered at one or two major facilities and where these providers are either in the network or have a direct arrangement with Aetna Student Health. Facility costs represent the major portion of the medical costs of an institution's insurance program because the institution's health center typically

absorbs most of the primary care costs and acute conditions are dominant for this insured population. In experience rating these institutions, rather than using a trend based on average experience across our block of business, we develop institution-specific medical trend. We do this by incorporating the known and anticipated unit cost increases for a specific provider, combined with an assumed increase in utilization. Medical costs from all other providers are trended at the average medical trend factor. These medical trends are then weighted based on the percentage each provider represents relative to the total medical costs under the program.

The Outpatient Prescription Drug Trend factor is a trend factor derived from our Book-of-Business claims experience that is intended to be applied to current claims experience to project future claims experience for student health insurance programs

The Composite Trend for the medical and outpatient prescription drug programs is calculated by weighting the medical and prescription drug trends by the percentage each program represents relative to the total medical costs under the program.

A typical trend calculation is attached to illustrate how different factors inherent to our plan designs can affect trend.

Facility-Specific Medical Trends Development Example

	2016/2017
Unit Cost Increase	5%
Increase in Utilization	5.5%
Facility-Specific Trend	**10.8%**

	2017/2018
Unit Cost Increase	5%
Increase in Utilization	5.5%
Facility-Specific Trend	**10.8%**

This facility has a contracted 5% unit cost increase for the 16/17 policy year and a 5% unit cost increase for the 17/18 policy year. The assumed increase in utilization is 5.5% for the 16/17 policy year and 5.5% for the 17/18 policy year. Facility Specific Trend is a result of the unit cost increase multiplied by the utilization increase.

Example with Institution-Specific Trend for a Major Facility

	% of Medical plan	SY 2017-18	SY 2018-19
Main Facility	30%	9.8%	9.8%
All other providers	70%	11.0%	11.0%
Medical Trends	100%	10.6%	10.6%

Trends for school year 17/18 and 18/19

	% of total plans	School year 2017/18	School year 2018/19
Medical	87%	10.6%	10.6%
Drugs	13%	20.0%	20.0%
Total	100%	11.8%	11.8%

COMMENTS

The main facility has 9.8% medical trends for 17/18 and 18/19. This facility represents 30% of total medical costs.

All other providers, or 70% of the total, receive the unlimited trend factor of 11% for 17/18 and 18/19.

Final Plan Trend is calculated by weighting the medical and prescription drug trends where medical costs are 87% and prescription drug costs are 13% of the total plan.

Effective Trends for 17/18 and 18/19

10.6% Medical Trend X 87% of Total + 20.0% Drug Trend X 13% of Total = 11.8% Final Plan Trend

Underwriting Adjustments

For new business with no prior experience or incomplete data

Underwriting may use information such as carrier persistency, participation levels, network utilizations, administrative complexity, premium payment history and etc. to adjust. The adjustment should be no more than +/-2%.

Other adjustments

When there are changes in eligibility, for example changes from Voluntary to Hard Waiver, adjustment factors will be used to calculate savings/credits in premiums due to programs changes.

Medical service availability and level of on Campus health center may also be used in the underwriting adjustment. For example whether it is full service Health Center with pharmacy or health service under MD supervision (Services include minor surgery, X-rays, lab) , or Dispensary under RN supervision (Minor Treatment) or no Health center on campus.

Retrospective Premium Agreements

Some of our larger institutions require that a retrospective premium agreement apply to their student health insurance program. Generally, these agreements do not involve any risk sharing in the sense that neither the institution nor the insured student population is responsible for any additional premium payments if the loss experience is adverse in the policy year(s) to which the retrospective premium agreement applies. Rather, the intent of these agreements is to limit the amount of underwriting margin that will accrue to the carrier if the student health insurance program in a given policy year(s) performs at a lower medical cost ratio (MCR) than was expected.

In general, the premium for a student health insurance program is student-pay-all. However, most universities subsidize in part or in whole the premium for certain student groups (in particular, their graduate assistants) enrolled in the student health insurance program. To the extent that the institution has remitted premiums to the student health insurance program, the institution may apply part or all of any refund payable under the retrospective premium agreement in any manner as may be agreed to by the institution and Aetna. If the refund is in excess of the institution's portion of the premiums, the excess will be applied for the sole benefit of students.

Amounts payable under Retrospective Premium Agreements directly affect earned premium for purposes of Minimum Loss Ratio calculations. In the event that Aetna is obligated to return premiums, the amount of underwriting margin that accrues to the carrier is limited for that particular school. The requirements of the ACA with respect to MLR still apply and could still result in a rebate being payable.

Sample Agreement

[Customer XYZ]

2018-19 Student Health Insurance Plan

Retrospective Premium Agreement

Sample Agreement

This Letter of Agreement (the "Agreement"), effective as of [DATE], 2018, serves to document our mutual understanding and agreement of the circumstances under which [Customer XYZ] would be entitled to return of potential premium surplus, based on claims experience, under the Blanket Student Accident and Sickness Insurance Policy ([Policy # BPXXXXXX]) (the "Policy") between [Customer XYZ] (the "Policyholder") and Aetna Life Insurance Company (the "Company").

The retrospective premium arrangement described in this Agreement will apply only to the 2018-2019 Policy Year. In the event the Policy is terminated for any reason prior to the standard termination date for the 2018-2019 Policy Year, this Agreement will be null and void. The agreement will apply to the Student Health Insurance Plan, the Dependent and Continuation coverage (if applicable) on a combined basis. The premium/fees and claims associated with Advantage Dental (if offered), Vital Savings (if offered), Accidental Death and Dismemberment, Worldwide Emergency Travel Assistance, and Medical Evacuation and Return of Mortal remains will be excluded.

Retrospective Premium Calculation. For the aforementioned Policy Year and subject to the terms set for the below, the Company will perform a retrospective premium calculation, under its standard blanket student policies and procedures, twelve (12) months after the end of that Policy Year).

Estimated Calculation – [MONTH] 2020

Incurred Claims. Incurred claims for the Policy Year will be defined as follows: total paid claims to date for that Policy Year completed to ultimate by means of the appropriate completion factor

Earned Premium. Earned premium for each Policy Year will be defined as follows: premium billed and due and remitted for the coverage provided with respect to that Policy Year, excluding: (a) any payments made to brokers on behalf of the Policyholder; and (b) the estimated amounts collected for payment, by Aetna, to the federal government, for taxes and fees due under the Affordable Care Act; these taxes and fees include the Patient Centered Outcomes Research Fee, Reinsurance Contribution and Health Insurer Fee.

Incurred Loss Ratio. An incurred loss ratio for the Policy Year will be defined as follows: incurred claims divided by earned premium

Surplus: If the incurred loss ratio is less than [.XXX] (expressed to 3 decimal places), then a surplus is created; if the incurred loss ratio is equal to or greater than [.XXX], there is no retrospective premium adjustment.

Refund: If a surplus is created, the refund is equal to: (A) X (B) X (C) where

is the absolute difference between the incurred loss ratio and [.XXX] (to 3 decimal places)

is the earned premium for the 2017-2018 policy year

[0-100]%

Payment of Refund: The refund will be remitted to the Policyholder within 30 days of the date of calculation provided the Policy remains in force through Policy Year 2018-2019. If the Policy terminates earlier, there will be no refunds.

9. Use of Refunds. Any and all refunds will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna. If the sum of student contributions which have been made for student health insurance exceeds the sum of premiums which have been paid for student health insurance (after giving effect to any refunds), the excess will be applied by the Policyholder for the sole benefit of students. Aetna will not have to see to the use of such excess.

If you are in agreement with the terms of this Agreement, please sign both copies and return one to Aetna Student Health on or before [DATE], 2018. Failure to return an executed copy of the Agreement prior to that date shall render this Agreement null and void.

We appreciate your business and thank you for your prompt attention to this matter.

Signed: Aetna Student Health

Name: _____ ____/____/____

Date

Title: _____

Signed: [Customer XYZ]

Name: _____ ____/____/____

Date

Title: _____

Actuarial Memorandum

As requested by 2018-2019 PA Student Health Insurance Rate Filing Guidance, the actuarial memorandum provides narrative that supports the rate manual, including the credibility formula, factors and their application. The actuarial memorandum also includes the pricing assumptions which underlie the proposed premium rate development, as shown in the rate manual. The supporting exhibit and tables were provided in Excel format and include working formulas.

The final plan benefit designs, final rates, and RRJ will be filed with the Pennsylvania Insurance Department within 15 business days of finalization with an institution.
The summary information and the actuarial certification.

a. A summary of how pricing assumptions for the proposed rate filing compare to the current/most recent previous rating practice

Comments: compared with the approved school year 2017-18 rates filing the following updates have been made:

1) Pharmacy trends: Aetna student health evaluated the most recent two years pharmacy monthly costs and updated pharmacy trends as 20.0% based on the increased pharmacy cost and the supporting exhibit with rolling months costs was submitted.
2) Pooling charge: The pooling charges based on the recent claims were updated and the supporting exhibit was submitted.
3) PPACA fees: PCORF is set to be $2.40 PMPY for SY 18-19; HIF % is set to be 3.15% for SY 18-19.

b. Institutions of higher education in Pennsylvania with which the issuer has contracted to provide student health insurance for the 2017-2018 academic year

Comments: The following schools in Pennsylvania have contracted with Aetna student health for the school year 2017-18:

Drexel University
Carnegie Mellon University
University of Pennsylvania
Lafayette College

c. Rate change history for renewing products

School year 2016-17: 8.0%
School year 2017-18: -0.6%
School year 2018-19: will be provided in the Specific Named Group Filing

d. Other states where the issuer is doing student health business: Aetna student health conduct business nationwide.

2. Benefits

a. Benefit description and HIOS ID numbers, including identification of benefits in addition to EHBs

- The manual rate development of the claim costs and derivation of premiums for all ACA-specific benefits and provisions, including pediatric dental, pediatric vision, etc. should be justified.

Comments:

Benefit Description: The health benefits provided by the policies are for costs charged for in/outpatient hospital care, health care provider services, durable medical equipment, drugs, x-ray and lab tests, and like services which are medically necessary. These benefits are subject to various deductibles, coinsurance and copayments based on the specific provisions of the plans being offered.

Aetna student health will disclose the actuarial value of the coverage and metal level (or the next lowest metal level) and the coverage would satisfy and meet the minimum of 60% requirement according to the recent released 2017 NBPP.

HIOS Issuer ID: 33906

1) Pediatric Dental: ($15 PMPM) X (70%) X (% of members under age 19 on each plan)
    a. $15 PMPM average cost was derived from enterprise estimates of average dental claims for members under age 19
    b. 70% average benefit ratio based on book of business benefit metrics

2) Pediatric Vision: ($300/yr) X (0.6) X (% of members under age 19 on each plan)
    a. $300 Per Year average cost was derived from the enterprise estimates of average vision experience in prior periods
    b. 0.6 is the average utilization factor derived from population metrics

EHB benefits are covered in Aetna student health form filing

b. Benefit changes from the policy year experience period to policy year rate period, and development

Comments: The policy year benefit changes cannot be finalized until the Specific Named Group Filing.

c. Description of how students may seek services covered under the policy (on and away from campus) and the benefit structure for payment for student health services in- and out-of-network
Comments: the benefit structure for payment for student health services in- and out-of-network cannot be finalized until the Specific Named Group Filing.

3. Retention
a. Expense assumptions – uniform percent or variable, and basis
b. Contingency and risk margins – uniform percent or variable, and basis

Comments: Retention= 1- target loss ratio, and the target loss ratio varies by applicable account size. Because the administrative cost as a percentage of premiums is typically smaller for larger accounts with larger premiums and vice versa for smaller account. Higher target loss ratio is applied to larger account due to the greater cost savings and smaller retention %.

4. Risk pool identification and description
a. Consistent with 45 C.F.R. §147.145(b)(3), "A health insurance issuer that offers student health education, if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health factor."

Comments: Aetna student health comply with 45 C.F.R. §147.145(b)(3) and the risk pool is based on the school, not health factors.

5. Factors – identify the data used and describe the development of the following factors, if included in the rate manual
a. Area factors
b. Network factors: cannot be finalized until the Specific Named Group Filing
c. Enrollment method: cannot be finalized until the Specific Named Group Filing
d. Tiering – if tiered rates may be used, demonstrate how the tier relativities will be developed

Comments:
a Area Factors: Not applicable
b. Network factors: Cannot be finalized until the Specific Named Group Filing
c. Enrollment method: Cannot be finalized until the Specific Named Group Filing
d. Tiering – Spouse or dependent rate is not higher than student rate

6. Morbidity assumptions

Comments: Student Health Insurance Premium Rates are generally determined by an experience-rating process. No manual rate calculation is usually involved as we believe it is not practical to develop a manual rating system that can adequately address all the variances in risk profile that each school's student health insurance plan presents.

For more details, please see the Development of Student Health Insurance Premium in the attached Rate Manual.

7. Trend justification
a. Trend rates utilized in the pricing must be sufficiently justified, including data source(s) and all assumptions and adjustments.
b. Include explanation of whether trends are developed on an institution-specific basis or statewide or national basis.

Comments:
a The final trends applied to schools cannot be finalized until the Specific Named Group Filing
b The Medical Trend factor is a trend factor derived from our book-of-business claims experience that is intended to be applied to current claims experience to project future claims experience for student health insurance programs that have no significant inside limits (the unlimited trend factor). The unlimited trend factor is also adjusted to reflect region-specific cost differentials.
We are a predominantly large case underwriter where, for many individual institutions, a majority of medical services are rendered at one or two major facilities and where these providers are either in the network or have a direct arrangement with Aetna Student Health. Facility costs represent the major portion of the medical costs of an institution's insurance program because the institution's health center typically absorbs most of the primary care costs and acute conditions are dominant for this insured population. In experience rating these institutions, rather than using a trend based on average experience across our block of business, we develop institution-specific medical trend. We do this by incorporating the known and anticipated unit cost increases for a specific provider, combined with an assumed increase in utilization. Medical costs from all other providers are trended at the unlimited medical trend factor. Both the institution-specific medical trend and the unlimited medical trend factor are adjusted for any inside limits in the health insurance program. These medical trends are then weighted based on the percentage each provider represents relative to the total medical costs under the program.

The outpatient prescription drug trend factor is a trend factor derived from our book-of-business claims experience that is intended to be applied to current claims experience to project future claims experience for student health insurance programs that have no significant inside limits (the unlimited trend factor).

The composite Trend for the medical and outpatient prescription drug programs is calculated by weighting the medical and prescription drug trends by the percentage each program represents relative to the total medical costs under the program.

A typical trend calculation is provided in attached rate manual to illustrate how different factors inherent to our plan designs can affect trend.

8. National loss ratios
a. Provide federal medical loss ratios for student health business for the most recent three calendar years.

Comments: Student health statutory minimum MLR was aggregated on nationwide basis as required by 45 CFR 158.120(d)(5), not state level. Aetna student health school year 2015 and 2014 MLR report filed with HHS exceeded 80% since student health was required to file MLR report.

9. Credibility of data
a. A credibility formula - The determination of credibility percentages assigned to plan experience should be justified including all assumptions.
b. If the issuer plans to apply a cap and floor methodology to rate changes to smooth the impact of rate changes, describe how the issuer will apply this.
Comments:

a. Student health insurance premium rates are generally determined by an experience rating process. The most recent policy year experience is used in the experience-rating process for schools with the larger insured populations and the two most recent policy years' experience is used for schools with the smaller insured populations. Details can also be found in the attached rate manual.
   The credibility is determined as:

Lives	Credibility
0	0%
250	25%
500	100%

   The school specific rates cannot be finalized until the Specific Named Group Filing
b. Not applicable.

10. Manual data
a. If manual data are used, identify the data source, show all adjustments, and explain why the data and adjustments are appropriate for the student health insurance market.

Comments: Whether manual data is needed or not cannot be known until the Specific Named Group Filing

11. Completion factors
a. Discuss how completion factors are developed and whether they are developed on an institution-specific, statewide, or national basis.

Comments: Premium rates for student health insurance programs are determined from an experience rating process using policy year experience. Generally, it takes 14-18 months from the end of a policy year for medical claims (2-5 months for outpatient prescription drugs) to reach the ultimate (or completed) paid level for that experience period.

To determine the completion factor, we use the institution's prior claims experience as well as the claims experience of our entire book of student health business. We incorporate the experience of the entire block because we find using only one observation is not credible and produces

inconsistent results. We believe this methodology produces an appropriate and consistent completion factor based on the individual institution's experience and the experience of our book-of-business

12. Guaranteed renewability
a. Please note that according to 45 C.F.R. 147.145(b)(1)(iii), individuals in a student health plan cannot be non-renewed unless the individuals are no longer students or dependents of students; otherwise, 45 C.F.R. 147.106, Guaranteed Renewability of Coverage, applies. Please include such language in the filing.

Comments: Aetna student health confirm the compliance of 45 C.F.R. 147.145(b)(1)(iii) and the language is included in the submitted rate manual under general guidelines

13. Guaranteed availability
a. Please note that according to 45 C.F.R. 147.145(b)(1)(ii), individuals in a student health plan cannot be refused coverage unless the individuals are not students or dependents of students; otherwise, 45 C.F.R. 147.104, Guaranteed Availability of Coverage, applies. Please include such language in the filing.

Comments: Aetna student health confirm the compliance of 45 C.F.R. 147.145(b)(1)(iii) and the language is included in the submitted rate manual under general guidelines.

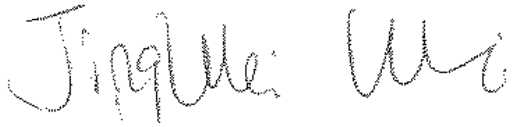
14. Final Rates
a. If the rate filing does not include the final plan benefit designs and final rates, a statement must be included in the Actuarial Memorandum that the final plan benefit designs, final rates, and RRJ will be filed with the Pennsylvania Insurance Department within 15 business days of finalization with an institution.
Comments: Aetna Student health confirmed that the final plan benefit designs, final rates, and RRJ will be filed with the Pennsylvania Insurance Department within 15 business days of finalization with an institution. The statement above is included in this Actuarial Memorandum

Actuarial Certification

I certify that, to the best of my knowledge and judgment:

1. The filing meets the guidance provided herein

2. The rate filing is in compliance with the applicable laws of the Commonwealth of Pennsylvania;
3. The rate filing is in compliance with applicable federal laws, including that:
a. Consistent with 45 C.F.R. §147.145(b)(2), all final plans will be developed to provide at least 60 percent actuarial value, as calculated in accordance with 45 C.F.R. §156.135, and
b. All final rates will be developed to meet an anticipated loss ratio, as calculated in accordance with 45 C.F.R. Subt. A, Subch. B., Pt. 158, such that it is anticipated that rebates will not be required
4. The rate filing complies with all applicable Actuarial Standards of Practice;
5. The benefits provided will be reasonable in relation to premiums; and
6. The premium schedule will not be excessive, inadequate, or unfairly discriminatory.



Jingwei Wei, F.S.A., M.A.A.A.

January 9th, 2018