

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name: Aetna Health Inc.
State: Kentucky
HIOS Issuer ID: 34822
Market: Individual
Effective Date: 01/01/2017
Rate Filing Tracking Number: AETN-130489964
Policy Form(s): HI IVL HPOL-2017 01-HIX, HI IVL HPOL-2017 01

Company Contact Information:

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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 premiums rate development for the products supported by the policy forms referenced above;
- 3) Request approval of the proposed monthly premium rates; and
- 4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with our Qualified Health Plan (QHP) application in Kentucky beginning January 1, 2017. The rates comply with all rating guidelines under federal and state regulations. This memorandum covers plans that will be available on and off the public Marketplace in Kentucky.

2. Proposed Rate Increase

Monthly premium rates for all Individual Market products in Kentucky are being revised for effective dates January 1, 2017 through December 31, 2017.

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) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Elimination of the reinsurance program;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;

- Updates to our pricing models used to determine the impact of cost sharing designs; and
- Updates to provider networks differentials

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 by network.
- Modification to cost sharing differs 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. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average increases, weighted by January 2016 membership, for products covered by this filing.

3. Experience Period Premium and Claims

Not applicable as Aetna has no historical experience.

A. Paid Through Date:

Not applicable as Aetna has no historical experience.

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

Not applicable as Aetna has no historical experience.

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

Not applicable as Aetna has no historical experience.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in February, 2016. 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.

5. Projection Factors

Not applicable as Aetna has no historical experience.

6. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

Aetna does not currently have historical Individual claims experience for the state of Kentucky, therefore the Ohio 2015 Individual claims experience was used as the credibility manual. The source data for our manual rate is the experience incurred from January 1, 2015 to December 31, 2015 and paid through March 2016 for Aetna Life Insurance Company in the Ohio Individual PPO market.

B. Adjustments Made to the Data:

The Individual experience used as the basis for the manual rate was adjusted for changes in population risk morbidity, benefits, and demographic and area normalizations.

1. Changes in Morbidity of the Population Insured:

Using 2014 CMS Risk Adjustment Reports, specifically the normalized plan liability risk score, normalized for age and gender, we have compared the Ohio Individual market to the Kentucky Individual market. For the Ohio credibility manual, we projected the Ohio Individual market estimates to the 2015 experience by using the ratio of Wakely study data from 2015 to 2014 to our Ohio Individual issuer experience. To project the 2017 Kentucky risk profile, we have used the 2014 CMS plan liability risk score, normalized for age and gender. Lastly, we have made an adjustment to Population Risk and offset this adjustment in Risk Adjustment because we anticipate that our 2017 Kentucky narrow network product offering will attract a healthier than average risk profile translating to a Risk Adjustment payment in 2017.

Exhibit 2 displays the assumptions used to project the change in population morbidity and illustrates the resulting projection factor.

2. Changes in Benefits

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

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

3. Changes in Demographics and Area Adjustment

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors.

The area adjustment represents the impact of moving from the average Ohio area experience in the credibility manual to the average Kentucky area factor in the 2017 projection period. The average Kentucky area factor in the 2017 projection period is based on the Kentucky network developed for

this product. The Kentucky network is narrower than the current network offered in the large group market, and providers have agreed to rates specific to this product. The area factors under this construct were developed by reviewing 2015 allowed charges (Kentucky Large Group insured and self-insured). The revised allowed charge levels on a per member per month basis were compared to allowed charge levels in Ohio, normalized for differences in demographics.

With this methodology, the area adjustment implicitly reflects any change in unit cost, and the trend factors applied to the Ohio experience exclude this component.

Exhibit 3 and 4 contain detail on the calculations of the impact of demographic and area mix shifts.

4. Trend (Cost/Utilization)

Medical trend factors are based on our Medical Economics Unit's analysis of a continuous normalized population, excluding catastrophic claims. Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

Pharmacy trends are based on commercial group Rx trend analysis. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. Pharmacy Trend is expressed in terms of allowed trend less rebates.

Exhibit 5 shows the anticipated annual trend from the experience period to the rating period.

C. Inclusion of Capitation Payments:

No services in the experience period were covered by capitation and no services provided in 2017 are expected to be covered by capitation arrangements.

7. Credibility of Experience

No credibility is assigned to the experience data. Aetna does not have experience in the base period to use in the rate development, therefore the 2017 rates are based on the manual rate.

8. Paid-to-Allowed Ratio

The projected paid to allowed ratio is [REDACTED]. Exhibit 6 illustrates the development of this number along with the projected membership distribution by metal tier.

9. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

Not applicable as Aetna has no historical experience.

B. Risk Adjustment – Experience Period

Not applicable as Aetna has no historical experience.

C. Risk Adjustment – Projection Period

For 2017, risk transfer payments are significantly dependent on the population that enrolls with Aetna Health Inc. as well as other issuers in the state of Kentucky. Using the Aetna nationwide experience of being a payer into the risk adjustment program, we expect that the population that will enroll with Aetna Health Inc. will be better than the market average thus resulting in a payment to the risk adjustment program in 2017. In setting the payment amount, we considered the 2017 changes in the HHS risk adjustment coefficients that increased Aetna's estimated transfer by an average \$ [REDACTED] PMPM over the

2015 results, based 2015 Wakely data for Aetna's Individual ACA book of business and the corresponding Individual market data.

As a result, we project a risk adjustment payable, net of the 2017 user fee of [REDACTED]. The overall projected net risk adjustment transfer is a premium increase of [REDACTED].

10. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 7.

The prospective general and administrative expenses are based on historical corporate Individual market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2017. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2017, as well as Federal income tax. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

11. Rate Development

This section provides an overview of the process used to develop premium rates and is a summary of the sections discussed above.

The following steps were performed to develop premium rates:

A. Develop Experience Manual Rate

As discussed in section #6A above, Aetna does not currently have historical Individual claims experience for the state of Kentucky, therefore the Ohio 2015 Individual claims experience was used as the credibility manual. Adjustments from the 2015 manual experience period to the 2017 projection period were discussed in section #6B above. Exhibit 11 demonstrates 2015 allowed claims to 2017 projected allowed claims.

B. Develop 2017 Benefit Plan Relativities

As discussed in section #16A below, 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. The paid-to-allowed ratio is applied to 2017 projected allowed claims developed in section A above.

C. Add Risk Adjustment Transfer Payment

As discussed in section #9C above, Aetna nationwide experience of being a payer into the risk adjustment program, we expect that the population that will enroll with Aetna Health Inc. will be better than the market average thus resulting in a payment to the risk adjustment program in 2017.

D. Add Retention Expenses

As discussed in section #10 above, we add retention expenses to our claim cost including User Exchange Fees, commissions, general expenses, premium taxes, Patient Centered Outcomes Research Fund fees, target profit and Federal Income tax.

E. Calculate Composite Premium

We calculated the total composite premium by adding projected claims, retention expenses including target profit and risk adjustment.

F. Calculate Premium by Rate Cell

The total composite premium is then divided by the allowable rating factors (plan design, tobacco, age, and geographic area) across the block of business by rate cell to calculate a base rate. The base rate and allowable rating factors will be used in our 2017 premium rates. The rating factors used meet all federal and state regulatory requirements.

12. Projected Loss Ratio

The expected 2017 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 8.

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 Kentucky through Aetna Health Inc. 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.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs and catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

15. Market-Adjusted Index Rate

Exhibit E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustments (Risk Adjustment and Exchange User Fees) were discussed, previously. The risk adjustment on Worksheet 1 of the URRT is 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 8. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value, Cost Sharing, and Tobacco:

The factors in Column 2 and Column 3 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 levels of cost sharing have on the use of medical services, which is based in part on the induced utilization factors used in the Risk Adjustment program. These adjustments are first normalized to result in an [REDACTED] when applied to the projected 2017 membership.
3. The non-tobacco adjustment is the reciprocal of the average tobacco factor, as illustrated in Exhibit 12.

B. Distribution and Administrative Costs:

Exhibit E-2, Column 4, 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 Risk Adjustment User Fee, and Exchange User Fee, which are reflected in the Market-Adjusted Index Rate. These expense and profit assumptions do not vary by plan.

C. Provider Network, Delivery System, and Utilization Management:

The factors in Column 5 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

D. Benefits in addition to EHBs:

The factors in Column 6 adjust for the impact of benefits in addition to EHBs.

The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). Hence, all factors in Column 6 are 1.00.

E. Catastrophic Plan Eligibility:

No adjustment has been made for the impact of catastrophic membership eligibility.

F. Experience Period Plan Adjusted Index Rates:

Not applicable as Aetna has no historical experience.

17. Calibration

A. Age Curve Calibration:

The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit 10.

We project a premium-weighted average age factor for the 2017 membership using the prescribed age curve. The age that most closely corresponding to the weighted average age factor and the age calibration factor is the reciprocal of the weighted average age factor shown in Exhibit 10.

B. Geographic Factor Calibration:

Exhibit 4 displays the projected membership by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor. The 2017 Individual Rate Manual displays the rating area factors used for this rate filing.

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:

$$\text{Calibrated Plan Adjusted Index Rate} * \text{Age Factor} * \text{Area Factor} * \text{Tobacco Factor}$$

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



Member Age	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Calibrated Plan Adjusted Index Rate	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Age Factor	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Area Factor	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Tobacco Factor	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Final Rate	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[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.

Please see the 2017 Individual Rate Manual for all 2017 rating factors including age, plan, area and tobacco factors.

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

21. Membership Projections

Exhibit 9 summarizes the membership projections by plan and plan variation. Membership projections are based on the size of the projected Kentucky Individual market in 2017 in our service area and assumed penetration of the market.

Projected enrollment in cost sharing reduction subsidy plans are based on current % of members enrolled in these variants as of January 2016 across Aetna's national book of business.

Terminated Plans and Products

Exhibit 15 provides a plan and product crosswalk from 2016 to 2017. The crosswalk includes the list of single risk pool plans and products that have terminated prior to January 1, 2017, products that have experience in the single risk pool experience period, and products that were made available in 2016 and 2017. 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.

22. Plan Type

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

23. Warning Alerts

There are no Warning Alerts on Worksheet 2.

24. Benefit Design

This filing includes the following standard plans: one Catastrophic, two Bronze, three Silver, and one Gold.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized in the AV screenshots and Exhibit A-2 (Summary of Benefits). All benefit and cost sharing parameters comply with Kentucky benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

25. Marketing

All of these plans will be made available through the public Marketplace and 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.

26. 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.

27. Renewability

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

28. Company Financial Condition



29. Rate Filing Disclosure Items Noted in 806 KAR 17:150

A. The effect of mandated benefits:

1. For benefit plans offering pharmacy benefits, coverage for amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic disorders in accordance with KRS 304.17A-139(4)

Aetna was new to the individual Kentucky market beginning in 2016, so specific cost and utilization data is not available. These items would be included in the manual rates used as the basis for the claim cost development.

2. Hearing aids and related services in accordance with KRS 304.17A-132;

Aetna was new to the individual Kentucky market beginning in 2016, so specific cost and utilization data is not available. These items would be included in the manual rates used as the basis for the claim cost development.

3. Anesthesia and hospital or ambulatory surgical facility services in connection with dental procedures in accordance with KRS 304.17A-149

Aetna was new to the individual Kentucky market beginning in 2016, so specific cost and utilization data is not available. These items would be included in the manual rates used as the basis for the claim cost development.

4. Medical and surgical benefits with respect to mastectomies pursuant to KRS 304.17A-134

Aetna was new to the individual Kentucky market beginning in 2016, so specific cost and utilization data is not available. These items would be included in the manual rates used as the basis for the claim cost development.

B. Claim Cost Development

1. Methodology

The methodology used to develop premium rates, including claim cost is described above in Section #11.

2. Specific Assumptions

See Section #11 for further details on specific assumptions.

3. Experience by month, including exposures or members, earned premium, paid claims, incurred claims, and incurred loss ratio, for the past three (3) years for this product, or for a similar product if this filing is for a new product.

Aetna was new to the individual Kentucky market beginning in 2016, so experience data is not available.

- C. Development and printout of the following shall be shown by age, gender, and tier combination using the lowest industry factor and the lowest area factor, and separately using the highest industry factor and highest area factor.

1. (i) Base premium rates

See exhibits 13A and 13B.

- (ii) Index rates

See exhibits 13A and 13B.

- (iii) Corresponding highest premium rates

See exhibits 13A and 13B.

- (iv) If offered, any applicable GAP premium rates for the standard plan option.

Aetna is not offering the standard plan option.

2. If the filing contains more than one (1) product type, a development and printout as identified and described in clause a of this subparagraph for each product type separately.

This filing is limited to the HMO plan type.

3. If the filing contains proposed rates for more than one (1) class of business, a development and printout as identified and described in clauses a and b of this subparagraph for each class of business separately.

This filing does not contain proposed premium rates for more than one class of business.

- D. For an insurer that has existing GAP enrollees:



- E. Factors used for each case characteristic, including age, gender, industry or occupation, and geographic region, with a separate summary of the maximum factor and the minimum factor for each case characteristic.

Please see Tables 1-4 in the Individual Rate Manual.

- F. Anticipated Pricing Loss Ratio and Administrative Expenses

Please see Exhibit 8 for the projected Federal MLR and the traditional anticipated pricing loss ratio. Please see Exhibit 7 for the related retention portion of the projected premium.

- G. Detailed discussion of the manner in which the projected amount of net assessments and payments under KRS 304.17B-021 and 304.17B-023(3) used in establishing the proposed rates in the filing as required by KRS 304.17A-095.

H. Information regarding how fees are paid to providers as follows:

1. Justification of fees paid to providers in relation to the rate requested, including any assumption used regarding provider discounts in the rate filing.
2. Average discount to providers during experience period and average discount for physician payments, hospital payments, laboratory payments, pharmacy payments, mental health payments, and other payments for the rate filing period.

As detailed in section #6 above, Aetna developed cost relativities to Ohio using allowed charge data, and modeled unit cost and steerage savings for the network construct of this product. Exhibit 14 summarizes the expected savings. Please note that billed charges are not carried through the network steerage model, thus an anticipated discount is not explicitly listed. The anticipated allowed charges in this exhibit are used to develop area relativities only, as the basis is our 2015 claim experience across market segments.

See Exhibit 14 for the illustration regarding Kentucky 2015 Commercial experience, Allowed Basis Savings and Individual Network adjusted allowed PMPMs.

I. If a trend rate is used, include the time period to which the trend applies, not to exceed twelve (12) months, and the applicable annual trend rate and the periodicity of the factor.

The individual premium rates are effective for the 2017 calendar year, so no additional trend will be applied to the premium rates.

J. Prospective certification

Please see attached form HIPMC-R34.

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 other Aetna employees, along with work products produced at their direction, for the following items:

- URRT Methodology and Data Definitions
- Experience Period MLR Rebates
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Pediatric Dental Claim Cost
- CSR Recoveries/Accruals – CY2015
- Reinsurance Recovery – CY2015
- Risk Adjustment Payable/Receivable – CY2015

- Components of Retention/Administrative Fees
- Value of Network Arrangements
- Experience Period Data – Individual – AET

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] 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 Kentucky, 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) and 147.102),
 - b. Developed in compliance with the applicable Actuarial Standards of Practice,
 - c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
 - d. Neither excessive, deficient, nor unfairly discriminatory.
3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.
4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.

