Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For UnitedHealthcare of Ohio, Inc.
State of Kentucky Rate Review

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FEDERAL Rate Justification PART III – Actuarial Memorandum & Actuarial Certification

Purpose

The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT).

This document contains information that consists of confidential, proprietary trade secrets under state and federal law. Under federal law, this information is exempt from disclosure under Exemption 4 of the U.S. Freedom of Information Act, 5 U.S.C. §552, is a trade secret or confidential commercial or financial information as defined in 45 CFR §5.65, and protected from disclosure under 45 CFR §§5.1 – 5.69, and 45 CFR §154.215 (i)(2). The attached document contains confidential, proprietary information and trade secrets. This information is protected from disclosure by KY Rev. Stat. §61.878(1)(c), Section 4 of 200 KY. Admin. Regs. 1:020, and the Kentucky Uniform Trade Secret Act, KY Rev. Stat. §§ 365.880 to 365.900.

General Information

Company Identifying Information

Company Legal Name: UnitedHealthcare of Ohio, Inc.

State: Kentucky

HIOS Issuer ID: 45920

Market: Small business, 1-50

Effective Date: 1/1/2017 - 12/31/2017

Company Contact Information

Primary Contact Name: Jamie Shallow

Primary Contact Telephone Number: 920-661-1071

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Proposed Rate Increase(s)

UnitedHealthcare of Ohio in Kentucky issues group major medical products. The overall estimated impact over the prior 12 months on 2017 rates including trend due to changes proposed in this filing is 7.9%. Please refer to Unified Rate Review Template (URRT) worksheet 2 for additional information on the rate change by plan.

Reason for Rate Change

UnitedHealthcare is filing rate changes effective 1/1/2017 for existing benefit plans that meet the coverage and rating requirements of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA). Proposed changes include the following:

- **Introduction of new 2017 ACA Portfolio:** Effective 1/1/2017, we will introduce 5 new plans, carry over 42 plans from the 2016 ACA portfolio and terminate 3 plans. This set of plans will be called our 2017 ACA plan portfolio.

- **Changes that vary by plan**
  - Some plan designs have changes to cost-sharing requirements solely to maintain its existing metal level.
  - The plan relativity factors are being repriced to be consistent with our most recent pricing model. In order for this repricing to be revenue neutral in aggregate, a -8.5% change to Base Rate is required.

- **Annual Pricing Trend:** Effective 1/1/2017, the annual pricing trend will change from 8.7% to 9.1%.

Experience Period Premium and Claims

Experience Period, Paid Through Date

The experience period is 1/1/2015 to 12/31/2015, paid through 2/29/2016. The experience includes only non-grandfathered policies.

Experience Period – Premiums

Total earned premium in the experience period was $9,709,788. The 2015 MLR rebate is $0, therefore total premium (net of MLR Rebate) is $9,709,788.

Experience Period – Allowed and Incurred Claims

Incurred claims were developed by first starting with actual claims paid through 2/29/2016 sorted by incurred date. Allowed claims by benefit category were obtained from UnitedHealthcare claim paying system reports. Estimates of incurred but not paid were added to these paid claims. The following is a description of the reserve methodology:

The UnitedHealthcare Reserving process utilizes the Reserve Production System (RPS) to record reserves into the PeopleSoft general ledger. Fee for service and paid claim data is loaded into RPS and becomes the basis for the monthly reserve calculations at the various business unit, location, and line of business levels. The assignment of the paid claims into RPS packages is based on the mapping rules maintained by the Corporate Actuarial department. RPS calculates a preliminary best estimate Incurred But Not Reported (IBNR) for each reserving model (package) primarily using standard completion factors based on historical claim experience. The Claims Reserving Team adjusts the preliminary IBNR based on specific knowledge of the entity (i.e. catastrophic claims, pended claims, etc.) to calculate the final IBNR. In months where adjudicated claims experience is not complete enough for an estimate using completion factors, a seasonally adjusted PMPM is used to estimate incurred claims.

A description of the Sarbanes Oxley controls, audited by Deloitte & Touche, in place regarding the reserving process includes:

- Market Paid claim Tie-outs: To verify completeness and accuracy of financial data in RPS, paid claim data is tied out between source system (RPS) and PeopleSoft general ledger.
- Market Expense Tie-outs: RPS reserve changes on the income statement are tied to the PeopleSoft general ledger to ensure that information is accurate subsequent to computing the reserve.

Benefit Categories

Claims were assigned to benefit categories by our claim department using standard industry definitions of services.

- **Inpatient Hospital:** Includes non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- **Outpatient Hospital:** Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, ambulance, home health care, DME, other services provided in an outpatient facility setting and billed by the facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.
- **Other Medical:** Includes non-capitated, fee-for-service costs for physician procedures, inpatient stay, or and outpatient procedure related to Mental Health / Chemical Dependency (MHCD).
- **Capitation:** Includes all MHCD services provided under capitated arrangement.
- **Prescription Drug:** Includes drugs dispensed by a pharmacy, not dispensed by facility (i.e. via inpatient, outpatient), and not physician administered drugs. This amount is net of rebates received from drug manufacturers.

Projection Factors

Insured Population Morbidity Changes

No adjustments for population morbidity changes were made.

Benefit Changes

The estimate of the cost of added essential health benefits (EHB) was developed using UnitedHealthcare national experience. For plans which are not in compliance with the ACA in the experience period, adjustments are made in order to project expected claims. These are included in the "Other" adjustments column on Worksheet 1, Section II. The total estimated impact for benefit changes is approximately 2.0% and primary drivers of this increase include the following:

- The addition of pediatric dental coverage – approximately 0.75%
- The addition of pediatric vision coverage – approximately 0.25%
- Increasing DME coverage to unlimited coverage – approximately 0.90%
- Increasing autism treatment to unlimited coverage – approximately 0.10%
- Increasing transplant services to unlimited coverage – approximately 0.11%
- The addition of private duty nursing coverage – approximately 0.34%
- Other EHB requirements – approximately 0.34%

These adjustments total to approximately 2.7% for plans not in compliance with the ACA. In the experience period, 74% of the member months are attributed to pre-ACA plans. Therefore, the total adjustment needed is 2.7% x 74% = 2.0% for benefit changes.

Demographics Changes

An adjustment for aging of the population has been included in the "Other" adjustments column on Worksheet 1, Section II. An annual aging adjustment of approximately 1% was developed based on national UnitedHealthcare experience. The demographic aging assumption is half of this adjustment at 0.5%, to reflect the aging of the population between the effective date of the policy and the midpoint of the experience period. When combined with the benefit changes adjustment of 2.0%, this produces the "Other" adjustment of 2.5% in Worksheet 1, Section II of the URRT. Please refer to the State Actuarial memorandum for more detailed explanations of these adjustments.

Other Adjustments

No other adjustments were made.

Trend Factors (Cost, Utilization)

The annualized net claims trend rate used in adjusting the claims from the experience period to the projection period is 8.0%. This is comprised of a unit cost assumption of 4.0%, utilization assumption of 2.6% and leveraging assumption of 1.2%. This 8.0% trend rate reflects the assumed claims trend over the 24 months between the experience period midpoint and the projection period midpoint. The allowed claims trend to adjust allowed claims from the experience period to the projection period is 6.7% and consists of the unit cost and utilization components.

The pricing trend used to adjust rates for each effective date in 2017 is 9.1%. This represents the expected trend rate going forward. This is comprised of a unit cost assumption of 5.4%, utilization assumption of 2.1%, and leveraging assumption of 1.4%.

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, benefit leveraging, and business mix identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected net of business mix (employer mix, benefit mix, demographic mix, etc.). Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence mix of procedures.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

Credibility Manual Rate Development

Experience Data Used – Source and Appropriateness

The UnitedHealthcare of Ohio (UHC of OH) experience includes 26,618 member months. We generally assign full credibility at 25,000 member years, or the equivalent of 300,000 member months. For the credibility manual, we assigned partial credibility to the combined Kentucky small group experience sold by UnitedHealthcare Insurance Company (UHIC), UnitedHealthcare of Kentucky (UHC of KY), and UnitedHealthcare of Ohio (UHC of OH) (collectively, UnitedHealthcare) and blended the experience with the fully credible Indiana small group experience sold by UHIC. UnitedHealthcare's Kentucky block of small group business includes approximately 101,000 member months and is not considered fully-credible. UnitedHealthcare's Indiana block of small group business includes approximately 566,000 member months and is considered fully-credible.

Data Adjustments

UnitedHealthcare's Kentucky block of business was assigned a partial credibility factor of 58.1%. Adjustments made to the manual data are the same adjustments as described in the Projection Factors section above.

Experience Credibility

The UHC of OH experience of 26,618 member months (2,218 average members) is considered not credible and has been given a credibility weight of 0%. As such, full credibility has been placed on the credibility manual, which is based on UnitedHealthcare experience in Kentucky blended with the UnitedHealthcare experience in Indiana.

Paid To Allowed Ratio

The paid to allowed ratio is 0.723. The paid to allowed average factor for the projection period is based on the actual paid to allowed in the experience period, adjusted for expected leveraging and migration to new plans.

For each plan, the projected member months were multiplied by the 2017 calendar year index rate. This is the projected allowed claims for the plan.

The projected allowed claims amount was multiplied by the expected paid-to-allowed relationship (AV and cost-sharing structure) for each plan in order to calculate the total incurred claims, payable with issuer funds.

The incurred claims for all plans were added together and divided by the total allowed claims for all plans in order to calculate the paid to allowed ratio.

Risk Adjustment and Reinsurance

Projected Risk Adjustments (PMPMs)

Based on the study by a national actuarial consulting firm for a market-majority of carriers within Kentucky, the UnitedHealthcare book of business has a relative risk score that is roughly equivalent to the statewide average. Due to the risk adjustment on ACA rates, we need to normalize our claim cost to the statewide average. This normalization accounts for 0.0% of the claim cost. Risk transfer of $0.00 PMPM is assumed to be received and risk adjustment user fee of $0.15 PMPM is assumed to be paid, therefore total projected risk adjustment is a net payer of $0.15 PMPM.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Since the state of Kentucky chose not to combine its individual and small group markets, reinsurance recoveries are not applicable to this rate filing. No reinsurance premiums are assumed to be charged in 2017.

Non-Benefit Expenses and Risk Margin

Administrative Expenses

The administrative expense assumption of 11.6% is a long-term estimate of administrative expenses, including commissions, management fees, and other SG&A. This load does not vary by product or plan. Prior to the 7/1/2015 rate filing, expense items were spread evenly to many geographic markets and market segments (small group, large group, ASO, etc.) within UnitedHealthcare. Consistent with the 7/1/2016 filing and in an effort to be more consistent with financial reporting methods, an activity based cost allocation method is being used to illustrate administrative expenses in rate filings. This method more accurately reflects the expense items that are associated with its specific geographic market and segment.

I relied on UnitedHealthcare's Finance Department to provide the Non-Benefit Expenses and Risk Margin information, including administrative expenses, taxes and fees.

Profit & Risk Margin

The profit and risk load is 4.3%.

Taxes and Fees

The taxes and fees assumptions are shown in the table below.

Premium Taxes and Fees Allocation	Estimated % of Premium	Estimated PMPM
Federal / State Income Tax on Profit & Risk Load	2.99%	$13.26
Premium Tax	0.00%	$0.00
ACA Taxes: Insurer Fee	1.92%	$8.52
ACA Taxes: Reinsurance Fee	0.00%	$0.00
ACA Taxes: PCORI Fee	0.05%	$0.20
ACA Taxes: Risk Adjustment User Fee	0.03%	$0.15
ACA Taxes: Exchange User Fee	0.00%	$0.00
All Other Taxes & Fees	1.30%	$5.76
Total	**6.30%**	**$27.89**

The Risk Adjustment User Fee listed in this table is reflected in the Projected Risk Adjustment section.

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 84%. If the actual loss ratio is below the 80% MLR requirement for small business, rebates will be paid as the law requires. Please refer to the below exhibit for a demonstration of the estimated 2017 MLR calculation.

Estimated Federal MLR Calculation		
Claims		
(A)	Projected Claims*	$344.85
(B)	QI-IT Initiatives, Fraud, Medical Management	$4.43
(C)	Total Projected Claims for MLR (A + B)	$349.28
Premium		
(D)	Avg Single Risk Pool Gross Premium*	$443.08
(E)	Total Taxes and Fees	$27.89
(F)	Total Premium for MLR (D - E)	$415.19
MLR (C / F)		**84%**

* See URRT Worksheet 1

Single Risk Pool

The Single Risk Pool is established according to the requirements in 45 CRF part 156, §156.80(d).

The Single Risk Pool reflects all covered lives for every non-grandfathered product/plan combination in the state and market. The Single Risk Pool is specific to UnitedHealthcare of Ohio in the Kentucky small group market.

Index Rate

The index rate for the experience period is equal to the allowed claims PMPM. No adjustments were made for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees.

The index rate for the projection period of $498.76 is the weighted average of the projected allowed claims applicable for each effective date. The projection period (1/1/17 – 12/31/17) projected allowed experience claims PMPM is trended to the midpoint of each quarter in 2017. The weighted average was based on the projected member months with effective dates for policy periods beginning in each quarter of 2017. The calculation is shown below.

Projected Allowed Claims PMPM (for 1/1/2017 Renewals)		$476.76		
Projected Allowed Trend - Annualized		7.6%		
Quarterly Allowed Trend		1.9%		
Renewal Quarter	**Renewal Quarter Distribution**	**Index Rate By Renewal Quarter**	**Weighted ACA Reins. Fees & Risk Adj. Pmts**	**Market Adj. Index Rate By Renewal Quarter**
2017Q1	19.7%	$478.11	$0.21	$478.31
2017Q2	8.4%	$488.93	$0.21	$489.13
2017Q3	18.7%	$497.44	$0.21	$497.64
2017Q4	53.2%	$508.43	$0.21	$508.64
Total	**100.0%**	**$498.76**	**$0.21**	**$498.96**

No benefits in excess of essential health benefits were projected. No adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees were made to the index rate calculation above; only to the Market Adjusted Index Rate. The trend assumption reflects the assumed changes in cost and utilization going forward in 2017, and is consistent with the 2017 pricing trend. Please refer to the Trend section for additional information.

Market Adjusted Index Rate

The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). Since the index rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program and risk adjustment program were grossed up by the paid to allowed average factor in order to be on an allowed basis.

For a demonstration of the Market Adjusted Index Rate calculation, please refer to the exhibit above in the *Index Rate* section, as well as the attachment Index Rate Bridge.

Plan Adjusted Index Rate

Experience Period

The experience period Plan Adjusted Index Rates are included in row 55 of worksheet 2 of the URRT. They are non-zero values if the plan was available for purchase as of the initial ACA compliant filing with an effective date of 1/1/2015. The experience period Plan Adjusted Index Rate was developed starting with the Index Rate submitted in the 1/1/2015 rate filing, adjusted for the allowable market level adjustments (net Risk Adjustment, net Reinsurance Recoveries and Marketplace User Fees) to develop the Market Adjusted Index Rate. The paid to allowed ratio from the same filing was then applied to the Market Adjusted Index Rate to calculate the overall projected incurred claims estimate. The result was then divided by the projected loss ratio to calculate the overall projected premium. Lastly, the ratio of the allowable adjustments[1] factor of the specific plan to the overall allowable adjustments factor was applied to develop the Plan Adjusted Index Rate for each plan in the experience period.

[1] Allowable adjustments include AV and cost-sharing, provider network, delivery system and utilization management as defined in the 2017 Unified Rate Review Instructions.

Projection Period

The Plan Adjusted Index Rates are provided in URRT part I and are calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following plan adjustments are included:

- Actuarial value and cost sharing values are developed with the method identified in the sections below and applied to each plan accordingly.
- Provider network, delivery system and utilization management adjustment is developed based on the underlining provider network features, contract terms, and utilization and cost patterns due to the network features.
- Distribution and administrative costs adjustment is developed based on the method described in the "Non-Benefit Expense and Profit & Risk" section. The same adjustment has been applied to all plans to develop the Plan Adjusted Index Rate.
- The formula to develop the Plan Adjusted Index Rate is as below:
    - *Plan Adjusted Index Rate = (Market Adjusted Index Rate x (1+ provider network savings) x Actuarial Value and Cost Sharing)/(1- Distribution and Administrative Cost).*

For a demonstration of the Plan Adjusted Index Rate calculation, please refer to the attachment Index Rate Bridge.

Calibration

The member weighted average age factor and geographic factor have been developed to calibrate the Plan Adjusted Index Rate.

Age Curve Calibration

The Age Curve Calibration factor is calculated as the member weighted average age factor (based on ACA compliant national standard age curve) in the UHC experience period. The factor is calculated to be: 1.4105. Based on the standard age curve, the nearest age is age 44.

Geographic Factor Calibration

The Geographic Area Calibration factor is calculated as the member weighted average rating area factor (based ACA compliant rating area factors) in the UHC experience period. The factor is calculated to be: 0.7416.

Tobacco usage is not a rating factor been adopted by UnitedHealthcare. So, the tobacco calibration is not applicable.

The calibration factors are applied uniformly to all plans.

Consumer Adjusted Premium Rate Development

Each projected Plan Adjusted Index Rate is adjusted for the following factors in order to arrive at a premium rate:

- Age curve and geographic factor calibration
- Rating Area
- Age
- Effective date adjustment (quarterly trend)

For a sample calculation for the Consumer Adjusted Premium Rate, please refer to the attachment Index Rate Bridge.

AV Metal Values

All Actuarial Values (AV) were based on the 2017 Actuarial Value Calculator. Some adjustments were made to plan designs in order to appropriately model the design in the AV calculator. When possible, data from the AV Calculator was used to make the adjustments. If the necessary data from the AV Calculator was not available, adjustments were developed based on UnitedHealthcare's historical experience and proprietary pricing model. The adjustments are outlined below.

- **Non Standard Inpatient and Outpatient Cost Sharing**

  Several plans have different cost-sharing between Inpatient Facility and Inpatient Professional Services coinciding with different cost sharing between Outpatient Facility and Outpatient Professional. Due to the limitations of the AVC, this is done by modeling two tiers in the AVC and blending results to produce the correct AV score. The two tiers are as follows:

Tier 1: Inpatient Facility and Outpatient Facility claims (50% coinsurance applies)

Tier 2: Inpatient and Outpatient Professional Services (80% coinsurance applies)

The scenarios are split up such that Inpatient and Outpatient 50% coinsurance does and does not apply because the AV calculator's claim categories are not aligned with the categories of claims that would and would not be subject to the 50%. In particular, Inpatient Professional and Facility claims are all consolidated under one category of Inpatient in the AVC, but the plan is administered such that only Inpatient Facility claims are subject to the 50% coinsurance. Similarly, for the Outpatient Facility Fee the AVC contains both Outpatient Facility and Outpatient therapeutics. Only Outpatient Facility claims are subject to the 50% coinsurance.

When both Inpatient and Outpatient cost sharing differ between Facility and Professional services the tier weighting is 71% and 29%, which is based on historical UHC experience (since this information is not available in the AVC claims distributions).

In similar fashion some plans also utilize this Narrow Network tiering functionality in the AVC to account for situations in which Inpatient and Outpatient Per Occurrence Copays (POC) apply simultaneously. In certain situations the POC only applies to IP Facility and OP Surgery Facility. For example, plan AL-GD has POCs of $250 + 80% for IP Facility and $250 + 80% for OP Surgery Facility. In this case the same 71%/29% narrow network weights are input into the AV Calculator's Tier 1 and Tier 2.

In other situations the POC applies to IP Facility and OP Surgery Facility and Therapeutics. For example, plan AL-F3 has POCs of $500 + 80% for IP Facility, $250 + 80% for OP Surgery Facility and $250 + 80% for OP Therapeutics Facility. In this case a 74%/26% split is input into the AV Calculator's Tier 1 and Tier 2 narrow network weights, which is based on the same UHC historical experience as noted above. The POCs for the facility portion are represented in tier 1 with an effective coinsurance amount as described in the next section. The Professional Services cost share is input into the Tier 2 categories of the AVC.

- **Per Occurrence Copays and Effective Coinsurance Inputs**

According to the User Guide of the Actuarial Value Calculator in the FAQ section, the tool will not allow both copays and coinsurance to apply. In order to apply copays in conjunction with coinsurance, the copay is applied as an effective coinsurance rate in order to calculate an AV score appropriate for the plan designs in question.

For example, Plan AL-FM, to convert the $400 Emergency copay amount to effective coinsurance, we divided the flat dollar copay by an average unit cost calculated using the Silver continuance table included in the AV calculator (e.g. $2,524). Note: for Gold plans we used $2,278 and for Bronze plans we used $2,646 because each metallic level has different continuance tables.

For Plan AL-FM, the Emergency Room cost share was determined to be equivalent to 67.3% coinsurance.

a. $400 copay (rounded) = 15.8% (i.e. 400/2,524)
b. Copay is applied first so (rounded) = 20% x (2,524 – 400)/2,524 = 16.8%

Final Emergency Room cost share = 100% - 15.8% - 16.8% = 67.3%

In the case where the cost sharing feature is a per occurrence copay (POC), meaning the POC applies to each instance the service is utilized in addition to the deductible and coinsurance (until the maximum out of pocket limit is reached), an effective coinsurance is calculated. The AVC is run with **both** this effective coinsurance, as well as the POC in the coinsurance and copay inputs. This mimics the feature of the POC applying until the deductible is met followed by the effective coinsurance, which accounts for the copay applying after the deductible. In this portfolio POCs apply to IP Facility, ER, Imaging, and OP Surgery.

An example of a POC of $250 on Imaging for Silver plan AL-GD with 80% coinsurance is calculated similarly to the ER effective coinsurance above. The $250 is first divided by the average unit cost for Imaging using the Silver continuance table included in the AV calculator (e.g. $852). The effective coinsurance portion of the POC is determined to be 56.5%. This is input into the calculator along with the $250 copay portion.

a. $250 copay (rounded) = 29.3% (i.e. 250/852)
b. Copay is applied first so (rounded) = 20% x (852 – 250)/852 = 14.1%

Imaging Effective Coins = 100% - 29.3% - 14.1% = <u>56.5%</u>

Note that for OP Surgery, only an effective coinsurance is entered into the AVC because it will not account for a copay to be input.

The following table illustrates the average unit costs by service and by metal level used to calculate the effective coinsurance as described above.

	Actuarial Value Calculator			
Service Category	Platinum	Gold	Silver	Bronze
Medical Services	**Average Unit Cost per Visit**			
ER	1,972.23	2,278.47	2,523.74	2,646.46
IP	21,247.27	22,617.63	23,239.34	22,699.77
MRI	782.44	827.14	852.04	892.04
OPSurg	8,209.55	8,176.59	8,587.25	8,756.91

- **Copay limits on PCP/Specialist (combined)**

Some plan designs feature a combined limit of 3 copays on PCP and Specialist visits. After 3 visits, the benefits change to deductible/coinsurance. However, the AV Calculator is limited to scoring plan designs with a PCP-only copay limit. To work around this issue, the Narrow Network Option tiering is utilized. The utilization weight allotted to each tier is based on UHC experience for plan design and visit limit counts using PCP and specialist cost per service distributions. The Tier 1 inputs represent the limited office visit cost sharing and office visit benefits exceeding the limit are represented in Tier 2.

In certain situations, such as for plan AC-TI, where different cost-sharing exists between Inpatient Facility and Inpatient Professional Services as well as limited combined PCP and Specialist visits, a slightly different approach is used. These designs utilize the Narrow Network Option tiering in the calculator according to the Inpatient Facility versus Inpatient Professional Services method described above (see

Non Standard Inpatient and Outpatient Cost Sharing section). To account for the office visit limits two separate instances of the plan is run in the calculator. The first run exhibits the limited office visit cost sharing features. The second run only differs in that office visit benefits exceeding the limit are used.

To blend the two runs together the utilization weights based on UHC experience for plan design and visit limit counts using PCP and specialist cost per service distributions are used. An example below illustrates this multiple AVC run approach.

	Run 1 (OV copays limited)		Run 2 (OV exceeding limits)	
	Tier 1	Tier 2	Tier 1	Tier 2
Narrow Network Util	71%	29%	71%	29%
IP Services	50%	80%	50%	80%
SNF	50%	50%	50%	50%
OP Facility	50%	80%	50%	80%
PCP Cost Share	$30	$30	80%	80%
Spec Cost Share	$60	$60	80%	80%
Prelim AV	**73%**		**70%**	
Limited Visit Util	51%		49%	
Final AV	**71.4%**			

- **Navigate Plus (gate keeper plans)**

Some of the plan designs contain a "gate keeper" plan feature, which has a larger member cost share for specialist visits that are not by referral. The plans were run through the model using the two-tiered structure approach with specialist referral benefits in tier one and non-referral benefits in tier two. The tiered network weights are 97%/3% to account for members who self-refer, which is UnitedHealthcare's interpretation of a standard population.

- **Navigate Premier**

There are currently two Navigate Premier plans in the portfolio, AL-F3 (non-HSA) and AL-F4 (HSA). Navigate Premier plans are unique in that the plan design is as follows:

  - Premium designation[1] (PD): cost sharing differs on PCP and Specialist based on provider (lower cost share for premium designated providers, and higher cost share on non-premium designated (non-PD) providers)
  - Per Occurrence Copay (POC) on ER and Imaging services (same method as previously described)
  - Per Occurrence Copay on IP Facility and OP Facility (similar method as previously described, with an exception due to specialist portion of claims categories subject to premium designation)

Plan AL-F3 (non-HSA) has three separate AV results which are blended together with respective weights to arrive at a final actuarial value. This level of sophistication is required because not all specialties used

[1] Premium designated providers are in UHC's preferred provider class because they meet quality and efficiency standards. Premium designated plans attempt to steer members to preferred providers by offering lower cost sharing when utilizing these providers.

for the UHC premium designation program align with the benefit categories in the AV calculator. Therefore, the weightings of cost sharing will be needed to determine the appropriate level cost sharing for Specialist Visit, All Inpatient Hospital Services (incl. MHSA) and Outpatient Surgery Physician/Surgical and Therapeutic Services in addition to the tier 1 and tier 2 utilization percentages. Another overlapping layer of sophistication is due to Per Occurrence Copays applying to only the Facility portion of Inpatient and Outpatient Services. A Table of UHC benefit categories with detailed descriptions is shown below.

Deductible/Coinsurance/MOOP	$2000/80%/$6350

UHC Benefit Category	Cost Sharing Premium Designation	Cost Sharing Non-Premium Designation*	Comment
Emergency Room Services	$250 + 80% coins	N/A	
Inpatient Facility	$500 + 80% coins	N/A	AVC benefit category does not separate Facility from Professional. IP costs consist of Facility, PCP, PD-Specialists and Non-PD Specialists.
Inpatient Professional - PCP	ded + 80% coins	ded + 60% coins	
Inpatient Professional - Specialists Elig for PD prgm	ded + 80% coins	ded + 60% coins	
Inpatient Professional - Specialists NOT Elig for PD prgm	ded + 60% coins	N/A	
PCP Visit	$45	$90	
Specialist Visits - Elig for PD prgm	$100	60% coins	Not all specialties are eligible for the Premium Designation program.
Specialist Visits - NOT Elig for PD prgm	60% coins	N/A	
MHSA OP Services	$45	N/A	
Imaging	$250 + 80% coins	N/A	
Rehab Speech Therapy	$45	N/A	
Rehab Occupational and Physical Therapy	$45	N/A	
Preventive Services	100%	N/A	
Lab Outpatient and Professional Services	ded + 80% coins	N/A	
X-rays and Diagnostic Imaging	ded + 80% coins	N/A	
SNF	ded + 80% coins	N/A	
Outpatient Facility Fee - Surgery	$250 + 80% coins	N/A	AVC benefit category does not allow copay input for OP Facility.
Outpatient Facility Fee - Therapeutics	$250 + 80% coins	N/A	
Outpatient Professional - PCP	ded + 80% coins	ded + 60% coins	The AVC has a single category for all OP Professional Costs which consists of PCP, PD-Specialists and non-PD Specialists.
Outpatient Professional - Specialists Elig for PD prgm	ded + 80% coins	ded + 60% coins	
Outpatient Professional - Specialists NOT Elig for PD prgm	ded + 60% coins	N/A	

* If Non-Premium Designation does not apply, then members pay the Premium Designation cost share.

A condensed version of the AVC inputs for copays and effective coinsurances for the various scenarios are shown below. As mentioned earlier, this will require three separate AV calculations blended to arrive at a final AV of 71.0%.

	Run 1 PD Specialist both tiers				Run 2 Non-PD Specialist both tiers				Run 3 Non-PD PCP & Specialist both tiers			
	Tier 1		Tier 2		Tier 1		Tier 2		Tier 1		Tier 2	
Narrow Network Util	74%		26%		74%		26%		74%		26%	
	Copay	**Coins**	**Copay**	**Coins**	**Copay**	**Coins**	**Copay**	**Coins**	**Copay**	**Coins**	**Copay**	**Coins**
IP Services	$500	77.4%		79.1%	$500	75.9%		77.5%	$500	75.9%		77.5%
ER	$250	72.1%	$250	72.1%	$250	72.1%	$250	72.1%	$250	72.1%	$250	72.1%
Imaging	$250	56.5%	$250	56.5%	$250	56.5%	$250	56.5%	$250	56.5%	$250	56.5%
OP Facility		74.1%				74.1%				74.1%		
OP Surgery		67.4%		67.4%		60.0%		60.0%		60.0%		60.0%
PCP Cost Share	$45		$45		$45		$45		$90		$90	
Specialist Cost Share	$100		$100			60.0%		60.0%		60.0%		60.0%
Prelim AV	**71.52%**				**71.23%**				**70.07%**			
PD Utilization (High steerage)	45%				26%				29%			
Final AV	**71.0%**											

- Run 1: All PD cost sharing assuming all Specialist Physicians are eligible for PD
- Run 2: All PD cost sharing and assume Specialist Physicians are not eligible for PD
- Run 3: All services at non-PD cost sharing
- Each run is given a certain weight representing the expected utilization that members use preferred providers as indicated in the descriptions of each run

Plan AL-F4 (HSA) has two runs associated because it does not share the tiered copay/coinsurance for specialist visits like Plan AL-F3 above. The differential between PD and Non-PD specialists is a difference in coinsurance only. The first run represents inputs with only PD Provider cost sharing and the same category split for Facility versus Professional for IP and OP Facility. The second run represents only non-PD cost sharing with the same IP/OP Facility versus Professional split. These two runs are blended by the expected utilization of all PD providers versus non-PD providers. The utilization blending assumes steerage from non-PD providers to PD providers.

- **Specialty Drugs Copay Input**

The Actuarial Value Calculator allows the user to reflect a different level of cost sharing to apply to Specialty Pharmacy expenses than other Pharmacy costs. This may be reflected by entering a copay that applies only to Specialty Pharmacy. UnitedHealthcare's benefit designs include plans with different Specialty Pharmacy cost sharing levels depending on the tier designation of the specific script.

In order to reflect the Specialty benefit in the AV calculator, the Rx Tier cost share with the highest specialty drug utilization is entered into the Specialty Drug tier in the AV calculator. For plans with no specialty copays, this would be the same as the Tier 2 copay. For plans with specialty copays at different tiers, the Tier 2 specialty copay is input into the calculator. Below are two examples for a $15/$45/$85 plan, which have specialty copays of $15/$100/$300 and a plan with copays of $10/$35/$60 with no specialty copays.

	Example 1		Example 2	
	Non-Specialty Copay	Specialty Copay	Non-Specialty Copay	Specialty Copay
Tier 1	$15.00	$15.00	$10.00	N/A
Tier 2	$45.00	$100.00	$35.00	N/A
Tier 3	$85.00	$300.00	$60.00	N/A
Tier 4	**$100.00**		**$35.00**	

- **Narrow Formulary Plans**

Narrow Formulary (NF) drug plans design have a wider range of member cost share and specialty drugs have been up-tiered {specialty tier2→tier3 & tier3→tier4}. Consequently, a different approach is applied to translate UHC's Tiered drug cost share into the AV Calculator's Drug Classes. For these drug plans a weighted cost share approach is used based on individual exchange plan experience. The following example is for a plan with copays of $5/35/135/285 and no specialty copays.

	Weight	Copay	Avg Ingredient Cost	Effective Copay Min(Copay, Avg Ing Cost)
Tier 1				
Generic	92.4%	$5	$0	$5
Preferred Brand	55.3%	$5	$0	$5
Non-preferred Brand	0.0%	$5	$0	$5
Specialty	20.7%	$5	$0	$5
Tier 2				
Generic	4.8%	$35	$48	$35
Preferred Brand	44.7%	$35	$253	$35
Non-preferred brand	0.0%	$35	$0	$0
Specialty	0.0%	$35	$0	$0
Tier 3				
Generic	2.1%	$135	$51	$51
Preferred Brand	0.0%	$135	$0	$0
Non-preferred Brand	44.5%	$135	$178	$135
Specialty	62.1%	$135	$3,940	$135
Tier 4				
Generic	0.7%	$285	$140	$140
Preferred Brand	0.0%	$285	$0	$0
Non-preferred Brand	55.5%	$285	$285	$285
Specialty	17.3%	$285	$4,493	$285
Average copays to be entered into AV Calculator:				
Generic				**$ 8.33**
Preferred Brand				**$ 18.40**
Non-Preferred Brand				**$ 218.22**
Specialty				**$ 133.98**

The following chart outlines the adjustments by plan.

Plan Name	Plan ID	HSA Employer Funding Amount	Metallic Level	AV Score Min	AV Score Max	Non Standard IP and OP Cost Sharing	POC's and Cost Sharing Converted to Effective Coinsurance	Copay limits on PCP/SPC (combined)	Navigate Plus (Gate keeper)	Navigate Premier	Specialty Rx Copays	Narrow Formulary Plans
6L-T	45920KY0020026		Gold	80.6%		N	Y	N	N	N	Y	N
AL-FI	45920KY0020029		Silver	72.0%		N	Y	N	N	N	Y	N
AL-FJ	45920KY0020025		Gold	81.9%		N	Y	N	N	N	Y	N
6M-V	45920KY0020033		Silver	70.6%		N	Y	N	N	N	Y	N
AC-ST	45920KY0020045		Silver	71.4%		N	Y	N	N	N	Y	N
AL-FK	45920KY0020046		Silver	71.7%		Y	Y	N	N	N	Y	N
AL-FL	45920KY0020047		Silver	71.2%		N	Y	N	N	N	Y	N
AC-SW	45920KY0020048		Silver	71.2%		N	Y	N	N	N	Y	N
AL-FM	45920KY0020028		Silver	71.8%		N	Y	N	N	N	Y	N
AL-FO	45920KY0020052		Gold	79.4%		N	Y	N	N	N	Y	N
AL-FP	45920KY0020053		Gold	79.3%		N	Y	N	N	N	Y	N
AL-FQ	45920KY0020055		Gold	79.5%		N	N	N	N	N	Y	N
AL-FR	45920KY0020056		Silver	71.2%		N	N	N	N	N	Y	N
AL-F5	45920KY0020030		Silver	72.0%		Y	Y	N	N	N	Y	N
AL-F6	45920KY0020031		Silver	71.7%		Y	Y	N	N	N	Y	N
AC-S9	45920KY0020037		Silver	71.7%		Y	Y	Y	N	N	Y	N
AC-TA	45920KY0020035		Silver	71.4%		N	Y	Y	N	N	Y	N
AC-TB	45920KY0020057		Gold	81.7%		N	Y	N	N	N	Y	N
AL-F9	45920KY0020013		Bronze	62.0%		N	Y	N	N	N	Y	N
AC-TI	45920KY0020034		Silver	71.4%		Y	Y	Y	N	N	Y	N
AL-GA	45920KY0020036		Silver	72.0%		Y	Y	Y	N	N	Y	N
AL-GB	45920KY0020027		Silver	71.5%		N	Y	N	N	N	Y	N
6M-2	45920KY0020039		Gold	80.5%		N	Y	N	Y	N	Y	N
AC-TL	45920KY0010001		Gold	81.7%		N	Y	N	N	N	Y	N
AC-TM	45920KY0010002		Gold	80.6%		N	Y	N	N	N	Y	N
AL-FS	45920KY0010005		Silver	71.9%		N	Y	N	N	N	Y	N
AL-FT	45920KY0010006		Silver	71.8%		N	Y	N	N	N	Y	N
AL-FU	45920KY0020043		Silver	71.8%		N	Y	N	Y	N	Y	N
AL-FV	45920KY0020041		Silver	71.1%		N	Y	N	Y	N	Y	N
AC-TT	45920KY0010009		Silver	70.9%		N	Y	N	N	N	Y	N
AL-FY	45920KY0010003		Silver	71.8%		N	Y	N	N	N	Y	N
AL-FZ	45920KY0010004		Silver	71.8%		N	Y	N	N	N	Y	N
AL-F3	45920KY0010014		Silver	71.0%		Y	Y	N	N	Y	N	Y
AL-GD	45920KY0010012		Silver	72.0%		Y	Y	Y	N	N	Y	N
AL-GE	45920KY0010013		Silver	70.0%		Y	Y	Y	N	N	Y	N
AL-F1	45920KY0020044	$0 - $10	Bronze	61.9%	62.0%	N	Y	N	Y	N	Y	N
AL-F8	45920KY0020011	$0 - $150	Silver	70.0%	71.9%	N	N	N	N	N	Y	N
AL-FW	45920KY0010007	$0 - $150	Silver	70.0%	72.0%	N	N	N	N	N	Y	N
AL-FX	45920KY0010008	$0 - $50	Silver	70.6%	71.2%	N	N	N	N	N	Y	N
AL-GC	45920KY0010011	$0 - $50	Bronze	61.2%	61.9%	N	N	N	N	N	Y	N
AC-TE	45920KY0020010	$100 - $250	Silver	69.7%	71.6%	N	N	N	N	N	Y	N
AL-F2	45920KY0010010	$200 - $300	Silver	69.8%	71.0%	N	N	N	N	N	Y	N
AL-F4	45920KY0010015	$225 - $500	Silver	68.3%	71.4%	Y	Y	N	N	Y	N	Y
AL-F7	45920KY0020009	$225 - $525	Silver	68.2%	71.6%	N	N	N	N	N	Y	N
AL-FN	45920KY0020051	$250 - $400	Silver	69.4%	71.2%	N	N	N	N	N	Y	N

AV Pricing Values

The AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. The AV Pricing Value is attributable to the following allowable modifiers:

- Provider network, delivery system and utilization management adjustment
- Actuarial value and cost-sharing design of the plans
- Distribution and administrative costs

Please refer to the Plan Adjusted Index Rate section for additional details.

Membership Projections

Most recent membership data on current plans was used to estimate the projected membership. The projected membership is based on the projection period of 1/1/2017 – 12/31/2017. It was assumed current non-grandfathered membership and terminated plan membership would migrate to similar fully ACA-compliant plans offered in 2017. No persistency or new business sales assumptions were included in the projected membership.

Terminated Products

There are 3 new terminated plans or products in this filing, which are shown below. Terminated plan mappings are summarized in the Plan Mapping Crosswalk exhibit on the following page. All non-single risk pool plans have the Plan ID "23671KY0020000".

ORIGINAL Effective Date of Plan	SCID	Exchange Plan	Termination Date
1/1/2016	45920KY0020054	No	12/31/2016
1/1/2016	45920KY0020050	No	12/31/2016
1/1/2016	45920KY0020049	No	12/31/2016

Exhibit - Plan Mapping Crosswalk

State: KY | | Market Segment:Small Group | | Company: UnitedHealthcare of Ohio Inc. | | HIOS Issuer ID: 45920 | | Proposed Effective Date: 1/1/2017

SCID	Original Effective Date of Plan	Active Plan Indicator	Terminated Plan Indicator	Terminated Date	Active Plan Mapping (if applicable)	Separate Column In Wksht 2 - URRT Indicator	Wksht 2 - URRT Column Exclusion Reason Code **
45920KY0010011	1/1/2017	X				X	
45920KY0010012	1/1/2017	X				X	
45920KY0010013	1/1/2017	X				X	
45920KY0010001	1/1/2015	X				X	
45920KY0010002	1/1/2015	X				X	
45920KY0010003	1/1/2015	X				X	
45920KY0010004	1/1/2015	X				X	
45920KY0010005	1/1/2015	X				X	
45920KY0010006	1/1/2015	X				X	
45920KY0010007	1/1/2016	X				X	
45920KY0010008	1/1/2016	X				X	
45920KY0010009	1/1/2016	X				X	
45920KY0010010	1/1/2016	X				X	
45920KY0010014	1/1/2017	X				X	
45920KY0010015	1/1/2017	X				X	
45920KY0020039	1/1/2015	X				X	
45920KY0020041	1/1/2015	X				X	
45920KY0020043	1/1/2015	X				X	
45920KY0020044	1/1/2015	X				X	
45920KY0020025	1/1/2015	X				X	
45920KY0020026	1/1/2015	X				X	
45920KY0020052	1/1/2016	X				X	
45920KY0020053	1/1/2016	X				X	
45920KY0020055	1/1/2016	X				X	
45920KY0020057	1/1/2016	X				X	
45920KY0020009	1/1/2014	X				X	
45920KY0020010	1/1/2014	X				X	
45920KY0020011	1/1/2014	X				X	
45920KY0020027	1/1/2015	X				X	
45920KY0020028	1/1/2015	X				X	
45920KY0020029	1/1/2015	X				X	
45920KY0020030	1/1/2015	X				X	
45920KY0020031	1/1/2015	X				X	
45920KY0020033	1/1/2015	X				X	
45920KY0020034	1/1/2015	X				X	
45920KY0020035	1/1/2015	X				X	
45920KY0020036	1/1/2015	X				X	
45920KY0020037	1/1/2015	X				X	
45920KY0020045	1/1/2016	X				X	
45920KY0020046	1/1/2016	X				X	
45920KY0020047	1/1/2016	X				X	
45920KY0020048	1/1/2016	X				X	
45920KY0020051	1/1/2016	X				X	
45920KY0020056	1/1/2016	X				X	
45920KY0020013	1/1/2014	X				X	
45920KY0020001	1/1/2014		X	12/31/2015		X	
45920KY0020002	1/1/2014		X	12/31/2015		X	
45920KY0020003	1/1/2014		X	12/31/2015		X	
45920KY0020004	1/1/2014		X	12/31/2015		X	
45920KY0020005	1/1/2014		X	12/31/2015		X	

****Worksheet 2 - URRT Column Exclusion Reason Code Key**

(1) - Highest membership plan mapped to New Plan, Experience Captured in column of Mapped Plan (see page 74 of 2017 URRT Instructions)

(2) - Terminated Plan not available during Experience Period (see page 78 of 2017 URRT Instructions)

SCID	Original Effective Date of Plan	Active Plan Indicator	Terminated Plan Indicator	Terminated Date	Active Plan Mapping (if applicable)	Separate Column In Wksht 2 - URRT Indicator	Wksht 2 - URRT Column Exclusion Reason Code **
45920KY0020006	1/1/2014		X	12/31/2015		X	
45920KY0020007	1/1/2014		X	12/31/2015		X	
45920KY0020008	1/1/2014		X	12/31/2015		X	
45920KY0020012	1/1/2014		X	12/31/2015		X	
45920KY0020014	1/1/2014		X	12/31/2015		X	
45920KY0020015	1/1/2014		X	12/31/2015		X	
45920KY0020016	1/1/2014		X	12/31/2015		X	
45920KY0020017	1/1/2014		X	12/31/2015		X	
45920KY0020018	1/1/2014		X	12/31/2015		X	
45920KY0020019	1/1/2014		X	12/31/2015		X	
45920KY0020020	1/1/2014		X	12/31/2015		X	
45920KY0020021	1/1/2014		X	12/31/2015		X	
45920KY0020022	1/1/2014		X	12/31/2015		X	
45920KY0020023	1/1/2014		X	12/31/2015		X	
45920KY0020024	1/1/2014		X	12/31/2015		X	
45920KY0020032	1/1/2015		X	12/31/2015		X	
45920KY0020038	1/1/2015		X	12/31/2015		X	
45920KY0020040	1/1/2015		X	12/31/2015		X	
45920KY0020042	1/1/2015		X	12/31/2015		X	
45920KY0020049	1/1/2016		X	12/31/2016	45920KY0020013		(2)
45920KY0020050	1/1/2016		X	12/31/2016	45920KY0020009		(2)
45920KY0020054	1/1/2016		X	12/31/2016	45920KY0020053		(2)

****Worksheet 2 - URRT Column Exclusion Reason Code Key**

(1) - Highest membership plan mapped to New Plan, Experience Captured in column of Mapped Plan (see page 74 of 2017 URRT Instructions)

(2) - Terminated Plan not available during Experience Period (see page 78 of 2017 URRT Instructions)

Plan Type

All plans fall under the POS and HMO plan type.

Warning Alerts

There are no warning alerts on Worksheet 1.

There is one warning alert due to differences between the projection period information on Worksheet 2 section IV and the total projected amounts on Worksheet 1:

- **Total Premium:** The total premium in Worksheet 1 is lower than the total premium in Worksheet 2 because the Single Risk Pool Gross Premium Avg. Rate in Worksheet 1 is lower than the Plan Adjusted Index Rate in Worksheet 2. This is because the average rate PMPM in Worksheet 1 represents the projection period 1/1/17 – 12/31/17, whereas the Plan Adjusted Index Rate in Worksheet 2 reflects quarterly trend adjustments by accounting for rate effective dates throughout 2017.

Reliance

I have relied on data provided by Unitedhealthcare's Finance Department in determining the Non-Benefit Expenses and Risk Margin information, including administrative expenses, profit and risk margin, taxes and fees, and the projected loss ratio under the Federally prescribed MLR methodology.

Actuarial Certification

I, James M. Shallow, am an actuary of Unitedhealthcare and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80 and 147.102),
- Developed in compliance with the applicable Actuarial Standards of Practice,
- Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80 and 147.102 were used to generate plan level rates.

I certify that the percent of total premium that represents EHBs included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice.

I certify that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plans designs that did not fit into the AV Calculator, included in this Part III Actuarial Memorandum is a description of the methodology and numerical values used to develop the AV metal values, and a certification as required by 45 CFR Part 156, §156.135. In accordance with ASOP 50 the AVC- AV metal values are based on prescribed methodology and, therefore, may not reasonably reflect the estimate of the portion of allowed costs covered by the health insurance plan.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare 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 exchanges, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

James M. Shallow

Digitally signed by James M. Shallow
DN: cn=James M. Shallow, o=UnitedHealthcare, ou, email=jamie_shallow@uhc.com, c=US
Date: 2016.05.31 15:44:35 -05'00'

James M. Shallow, ASA, MAAA
UnitedHealthcare

Unique Plan Design Supporting Documentation and Justification

Please fill in the following information.

HIOS Issuer ID: 45920

HIOS Product IDs: 45920KY001, 45920KY002

Applicable HIOS Plan IDs (Standard Component): See the "AV Metal Values" section of the Part III Actuarial Memorandum.

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

See the "AV Metal Values" section of the Part III Actuarial Memorandum.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

See the "AV Metal Values" section of the Part III Actuarial Memorandum.

Confirmation that only in-network cost sharing, including multitier networks, was considered:

Only in-network cost sharing was considered.

Description of the standardized plan population data used:

See the "AV Metal Values" section of the Part III Actuarial Memorandum.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

See the "AV Metal Values" section of the Part III Actuarial Memorandum.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

See the "AV Metal Values" section of the Part III Actuarial Memorandum.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV

The analysis was
(i) conducted by a member of the American Academy of Actuaries;
(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: James M. Shallow Digitally signed by James M. Shallow DN: cn=James M. Shallow, o=UnitedHealthcare, ou, email=jamie_shallow@uhc.com, c=US Date: 2016.05.31 15:45:13 -05'00'

Actuary Printed Name: James M. Shallow

Date: 05/31/2016