Aetna Health of Iowa Inc.
Iowa Individual
HMO/POS Products

Summary

Aetna Health Inc. is filing premium rates for Individual plans in Iowa.

The new rates will apply to coverage effective in 2017. The current membership and range of rate changes by product are:

Product Name	Current Membership	Range of Increases
HNOnly – HMO and POS - CB	37,083	7.1%% - 52.6%

The average increase will be 22.58% for POS - CB and 37.42% for HNOnly – HMO.

Why We Need to Increase Premiums

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 7.5% excluding the effect of benefit or cost sharing changes. Medical costs go up for two reasons – providers raise their prices and members get more medical care. We expect Pharmacy costs to go up 10.9% excluding the effect of benefit or cost sharing changes. Pharmacy costs go up at an even higher rate as more members use more prescriptions and pharmaceutical companies increase their prices and develop new high-cost specialty drug treatments. In total, we expect combined costs to go up 8.0%.

What Else Affects Our Request to Increase Premiums

The federal ACA Reinsurance Program has ended. The discontinuation of this program will increase premiums 4.6%.

Will Premiums for All Individuals Increase The Same Amount?

No, increases differ by plan. The exact rate change depends on what benefit plan the subscriber chooses, where the subscriber lives, and the ages and tobacco usage of family members. Individuals who purchase insurance through the Iowa Marketplace and qualify for advanced premium tax credits may see a different rate change, as the rate they pay depends upon the determination of the applicable government subsidy.

How does this request align to Minimum Loss Ratio Requirements (MLR)?

These rates are expected to produce an MLR equal to or above the 80% requirement for Individual business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to members in accordance with the law.

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

What is Aetna doing to keep premiums affordable?

Aetna strives to keep our products as affordable as possible and to address the underlying cost of health care. We are:

- Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
- Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

We are dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. The Aetna Navigator streamlined mobile app is also available to allow members to take their care on the go.

Additionally, Aetna's Plan for Your Health website aims to educate all consumers on how to take advantage of their health care benefits.

Unified Rate Review v3.3

Company Legal Name: **Aetna Health of Iowa Inc.** State: **IA**
HIOS Issuer ID: **18973** Market: **Individual**
Effective Date of Rate Change(s): **01/01/2017**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 01/01/2015 to 12/31/2015

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$190,238,047	$321.84	100.00%
Incurred Claims in Experience Period	$190,957,728	323.06	100.38%
Allowed Claims:	$270,742,443	458.04	142.32%
Index Rate of Experience Period		$458.00	
Experience Period Member Months	591,094		

Section II: Allowed Claims, PMPM basis

Projection Period: 01/01/2017 to 12/31/2017 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period				Annualized Trend Factors	Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**		**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Days	287.59	$3,881.83	$93.03	0.985	1.019	1.059	1.001		283.86	$4,433.97	$104.89	283.40	$4,314.59	$101.90
Outpatient Hospital	Visits	1,917.88	978.67	156.41	0.985	1.019	1.055	1.036		2,026.48	1,109.93	187.44	1687.75	1,146.61	161.27
Professional	Visits	12,758.67	102.20	108.66	0.985	1.019	1.029	1.033		13,408.12	110.19	123.12	13420.78	109.67	122.65
Other Medical	Visits	1,149.99	360.62	34.56	0.985	1.019	1.055	1.036		1,215.10	408.99	41.41	1122.32	381.44	35.67
Capitation	Benefit Period	12,000.00	7.45	7.45	0.985	1.019	1.000	0.986		11,495.72	7.60	7.28	11484.33	7.80	7.46
Prescription Drug	Prescriptions	13,434.61	51.73	57.91	0.985	1.161	1.102	1.006		13,390.00	72.97	81.43	13060.74	72.14	78.52
Total				$458.04								$545.56			$507.47

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$507.47	$219,477,330
Paid to Allowed Average Factor in Projection Period			0.691	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$350.66	$151,658,835
Projected Risk Adjustments PMPM			-34.15	(14,770,913)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$384.82	$166,429,748
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$384.82	$166,429,748
Administrative Expense Load		9.58%	45.88	19,843,149
Profit & Risk Load		3.90%	18.68	8,078,109
Taxes & Fees		6.17%	29.55	12,779,982
Single Risk Pool Gross Premium Avg. Rate, PMPM			$478.92	$207,130,987
Index Rate for Projection Period			$507.47	
% increase over Experience Period			48.81%	
% Increase, annualized:			21.99%	
Projected Member Months				432,492

Product-Plan Data Collection

Company Legal Name: **Aetna Health of Iowa Inc.** State: **IA**
HIOS Issuer ID: **18973** Market: **Individual**
Effective Date of Rate Change(s): **01/01/2017**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Terminated Produ	
Product ID:		18973IA009	
Metal:		Not Applicable	Bronze
AV Metal Value		0.000	0.619
AV Pricing Value		0.010	0.623
Plan Category		Terminated	Renewing
Plan Type:		POS	POS
Plan Name		Terminated Products	CB IA Mercy Bronze ON
Plan ID (Standard Component ID):		18973IA0090000	18973IA0400001
Exchange Plan?		No	Yes
Historical Rate Increase - Calendar Year - 2		0.00%	
Historical Rate Increase - Calendar Year - 1		0.00%	
Historical Rate Increase - Calendar Year 0		0.00%	
Effective Date of Proposed Rates		01/01/2017	01/01/2017
Rate Change % (over prior filing)		0.00%	22.12%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	22.12%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	75.49%
Product Rate Increase %		0.00%	

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	18973IA0090000	18973IA0400001
Inpatient	$12.10	$0.00	$7.48
Outpatient	$14.03	$0.00	$8.67
Professional	$8.47	$0.00	$5.23
Prescription Drug	$15.30	$0.00	$9.45
Other	$2.95	$0.00	$1.82
Capitation	$0.21	$0.00	$0.13
Administration	$5.92	$0.00	$3.66
Taxes & Fees	$27.01	$0.00	$16.69
Risk & Profit Charge	$5.24	$0.00	$3.24
Total Rate Increase	$91.22	$0.00	$56.37
Member Cost Share Increase	$17.35	$0.00	$17.35
Average Current Rate PMPM	$338.60	$0.00	$254.70
Projected Member Months	432,492	0	11,501

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	18973IA0090000	18973IA0400001
OK	$ 321.84	Premium Information	Plan Adjusted Index Rate	$283.35	$0.00	$204.52
OK	591,094		Member Months	591,024	72	18,202
WARNING	##########		Total Premium (TP)	$167,467,694	$0	$3,722,673
			EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.00%	0.00%	0.00%
OK	##########	Claims Information	Total Allowed Claims (TAC)	$268,429,200	$11,071	$2,383,982
			EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.00%	0.00%	0.00%
			Allowed Claims which are not the issuer's obligation:	$61,263,905	$7,567	-$880,394
			Portion of above payable by HHS's funds	$28,556,026		$4,670
			Portion of above payable by HHS on	46.61%		-0.53%
OK	##########		Total Incurred claims, payable with issuer funds	$207,165,295	$3,504	$3,264,376
			Net Amt of Rein	$22,146,219.80	-$264.24	-$7,219.50
			Net Amt of Risk Adj	$9,283,474.83	$0.00	$2,076,883.55
OK	$ 323.06		Incurred Claims, PMPM	$350.52	$48.66	$179.34
OK	$ 458.04		Allowed Claims, PMPM	$454.18	$153.76	$130.97
			EHB portion of Allowed Claims, PMPM	$454.18	$153.76	$130.97

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	18973IA0090000	18973IA0400001
OK	$ 478.92	Premium Information	Plan Adjusted Index Rate	$474.70	$0.00	$358.93
OK	432,492		Member Months	432,492	-	11,501
OK	##########		Total Premium (TP)	$205,305,633	$0	$4,127,939
			EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.00%	0.00%	0.00%
OK	219,477,330	Claims Information	Total Allowed Claims (TAC)	$219,476,982	$0	$4,824,026
			EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.00%	0.00%	0.00%
			Allowed Claims which are not the issuer's obligation	$53,103,698	$0	$1,383,432
			Portion of above payable by HHS's funds	$17,257,554		$0
			Portion of above payable by HHS on	32.50%		0.00%
OK	166,429,748		Total Incurred claims, payable with issuer funds	$166,373,284	$0	$3,440,594
#DIV/0!	-		Net Amt of Rein	$0	$0	$0
			Net Amt of Risk Adj	-$14,770,912	$0	-$393,794
OK	$ 384.82		Incurred Claims, PMPM	$384.69	#DIV/0!	$299.16
OK	$ 507.47		Allowed Claims, PMPM	$507.47	#DIV/0!	$419.44
			EHB portion of Allowed Claims, PMPM	$507.47	#DIV/0!	$419.44

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	Aetna Health of Iowa, Inc.
State:	IA
HIOS Issuer ID:	18973
Market:	Individual
Effective Date:	01/01/2017
Rate Filing Tracking Number:	AETN-130506410
Policy Form(s):	See Form Exhibit I
Form Filing Tracking Number:	AETN-130537585, AETN-130537499

Company Contact Information:

Name: [redacted]
Telephone Number:
Email Address:

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

1) Provide support for the development of the Part I Unified Rate Review Template;
2) Provide support for the assumptions and 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 Iowa 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 Iowa.

2. Proposed Rate Increase

This filing includes benefit plans that will be marketed to individuals in Iowa for coverage beginning January 1, 2017. The average increase for these plans is 22.58% for the POS-CB product and 37.42% for the HNOnly-HMO product.

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
- Changes in provider networks and contracts.

B. Variation in Rate Changes by Plan/Product:
Rate changes differ by plan for the following reasons:

- Provider cost estimates have been updated, and the change differs 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 threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:
The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2015 through December 31, 2015 and paid through February 29, 2016. These claims are from SG employers with eligible 1-50 eligible employees, both ACA and transitional policies, from Coventry Health Care of Iowa (now renamed to Aetna Health of Iowa Inc.)

B. Premiums (Net of MLR Rebate and Risk Adjustment) in Experience Period:
Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Individual business in Iowa. The premiums have been decreased for expected risk adjustment payables for our estimated accruals of risk adjustment based as discussed in section 9.B., below. Our internal projections indicate that no MLR rebate is expected to be paid in 2016 (for 2015 experience) for the Individual MLR Pool in Iowa. As such, no adjustment was made to premiums to account for expected rebates.

Earned Premium Prior to MLR Rebates:	$199,454,767
Est. CY2015 Risk Adjustment Transfers	-$9,216,720
Est. CY2015 MLR Rebates:	$0
Earned Premium Net of MLR Rebates & RA:	$190,238,047

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

Allowed claims come directly from the claim records for hospital and physician services. Capitated benefits, including pharmacy, use the capitation rate for incurred claims and the allowed claims are calculated as the incurred claims plus estimated cost sharing.

Incurred Claims are captured in our reporting systems as the total amount of claims paid including the enhanced benefits for reduced cost-sharing variant plans sold on the Exchange. We reduce the amount reported on Worksheet 1 of the URRT, by the recovery amounts determined by re-adjudicating claims, paid through February 2016. National completion factors were applied to the aggregated medical portion of the difference between the full payment and the base plan cost-sharing as the amount for the 2015 recoveries, so that the reduction is estimated on an incurred claims basis. This re-adjudication method yields best estimates of actual cost sharing reduction recoveries at the plan level.

Exhibit 2 summarizes the experience data and documents the impact of the IBNP reserves, by date-of-service for each month within the experience period.

In addition to the fee-for-service and capitation payments discussed above, some of our provider contracts include provisions under which we share claim cost differences with the provider relative to a pre-determined target amount. These adjustments serve to increase our claims cost when results are favorable to the target and decrease our claims costs when results are unfavorable. We adjust both allowed and incurred claims by our current estimate of the impact of provider risk sharing provisions.

4. Benefit Categories

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

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:
The experience period data includes claims for single risk pool policies inforce in 2015. The projected change in the morbidity of the population is based on an internal analysis of the 2015 members' standard silver plan liability risk score, normalized for age and gender. This analysis divided our market into cohorts of new members, members renewing from a 2015 ACA plan, and members enrolling from both grandfathered and grandmothered transitional plans. We then modeled renewals and new market entrants for 2016 and 2017 from information sources, such as 2016 Marketplace enrollment data and Wakely 2015 Risk Adjustment reports, as well as internal analysis of special enrollment period members. The projected normalized average risk was developed from the market model, and compared to the average 2015 normalized scores.

B. Changes in Benefits:
The experience data includes experience for Single Risk Pool products. 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.

C. Changes in Demographics:
Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 5 and 6 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts. Exhibit 7 contains detail on these calculations.

E. Trend Factors (Cost/Utilization):
Medical trend factors are based on our Medical Economics Unit's prospective view of national utilization combined with projected local market unit costs, based on 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 a blend of local market and national 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 8 shows the anticipated annual trend from the experience period to the rating period.

A. Inclusion of Capitation Payments:
No services provided in 2017 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches. On Worksheet 1, capitation in the "Projections, before credibility Adjustment" section is intended to cover the capitated claims from our manual experience period data.

6. Credibility Manual Rate Development
A. Source and Appropriateness of Experience Data Used:
The source data for our manual rates is the Individual ACA On and Off Exchange experience incurred from January 1, 2015 to December 31, 2015 and paid through February 29, 2016 for Coventry Healthcare of Iowa in the Iowa (HMO / POS) market. We've excluded experience associated with the IHAWP Marketplace Choice Plans as well as experience from 23 counties we are exiting from.

B. Adjustments Made to the Data:
The experience used as the basis for the manual rate was adjusted for expected changes in population risk morbidity, benefits, and demographic and area normalizations. The data is further adjusted for projected changes in network, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend, as discussed in Exhibits 5-8.

C. Inclusion of Capitation Payments:
No services provided in 2017 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

7. Credibility of Experience
100% Manual rate
Since we're excluding experience from the IHAWP program as well as experience from counties we're exiting, no credibility is assigned to the experience data.

8. Paid-to-Allowed Ratio
The projected paid to allowed ratio is 69%. Exhibit 9 illustrates the development of this number along with the projected membership distribution by metal tier. Paid to allowed ratios are based on 2015

experience that is adjusted for the impact of any plan benefit changes based on our internal pricing models and trend deductible-leveraging.

9. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

Reinsurance recoveries in the experience period incurred claims were calculated by assuming 50% recovery of paid claim amounts less HHS cost-sharing payments between $45,000 and $250,000. Plan information is known on paid claims and thus, recoveries are listed in the appropriate HIOS ID on Worksheet II. Reinsurance recoveries are reduced by the $3.67 reinsurance contribution assessed in 2015.

B. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2015 Wakely data. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2015 Risk Adjustment fees of $0.08 PMPM in Worksheet 2.

C. Risk Adjustment – Projection Period

We started with 2015 Risk Adjustment accruals to determine our current risk transfer relative to the market. We applied estimated changes in our risk relative to the market for 2017 that may be triggered by a shift in metal plan distribution/rating area or geographic cost/demographic distribution to determine our 2017 relativity to market. The difference between our projected relative risk and the market's is multiplied by the projected market average premium, which we trended at 18% annually. As a result, we project a risk adjustment payable, net of the 2017 user fee of $0.13 PMPM.

10. Non-Benefit Expenses and Profit & Risk

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.

The profit and risk load is consistent with the target used in pricing our 2016 plans.

11. Projected Loss Ratio

The expected 2017 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 11.

12. 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 Iowa through Aetna of Iowa, Inc. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

13. Index Rate

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 of 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).

14. 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.

15. 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 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 aggregate factor of 1.0 when applied to the projected 2017 membership.
3. The non-tobacco adjustment is the reciprocal of the average tobacco factor, as illustrated in Exhibit 18.

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:
After reviewing the morbidity of enrollees younger than age 30 across our book of business, and after considering the impact of those eligible to enroll in the plan due to hardship, we have priced our catastrophic premiums to be approximately 15% below an equivalent metallic plan.

F. Experience Period Plan Adjusted Index Rates
Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2015 for the experience period.

16. Calibration
A. Age Curve Calibration:
The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit 13.

We project a premium-weighted average age factor for the 2017 membership using the prescribed age curve and the projected age distribution based on issuer January & February 2016 membership and projected changes in the market. 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 13.

B. Geographic Factor Calibration:
Exhibit 6 summarizes the rating area definitions and factors, and 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.

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

The premium for each billable member is calculated as:
Calibrated Plan Adjusted Index Rate * Age Factor * Area Factor * Tobacco Factor

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

An example of a contract's premium determined by the member build-up calculation is shown in Exhibit 14.

18. 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.

19. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

20. Membership Projections

Exhibit 15 summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through January 2016, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans.

Projected enrollment in cost sharing reduction subsidy plans are based on current % of members enrolled in these variants as of January 2016.

21. Plan Type

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

22. Warning Alerts

The Experience Period Plan Adjusted Index Rate on Worksheet 2 differs from the Experience Period Premium PMPM on Worksheet 1 since 1) the Experience Period Premium reflects the actual enrollment mix for all non-grandfathered business in the market in 2015 while the average Plan Adjusted Index Rate reflects the projected (vs. actual) ACA mix for single risk pool experience and a zero rate for non-single risk pool experience , and 2) premiums reported on Worksheet 1 are net of estimated risk adjustment transfers and MLR rebates while the Plan Adjusted Index Rates on Worksheet 2 do not consider the impact of risk adjustment transfers or MLR rebates.

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

23. Benefit Design

This filing includes the following standard plans: one Catastrophic, one Bronze, four 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 Exhibits A-1 and A-2. All benefit and cost sharing parameters comply with Iowa benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

24. Marketing

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

25. 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.

26. Renewability

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

27. Company Financial Condition

As of December 31, 2015, the capital and surplus held by Aetna of Iowa, Inc. was approximately $39 Million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2015. The Company issues commercial and Medicare Advantage coverage in various states for multiple business segments, including to large employer, small employer, and individual purchasers.

Reliance

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

- URRT Methodology and Data Definitions
- Experience Period MLR Rebates
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Pediatric Dental Claim Cost
- Components of Retention/Administrative Fees
- Value of Network Arrangements
- MH Net Trend
- Experience Period Data – Individual

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, [redacted] am an Associate 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 Iowa, 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.

Form Exhibit I

Health Network Option Open Access/Health Network Only Open Access (ON-Exchange)

HC IVL-SOB-CB-722480 01-HIX	CB IA MIPPA Silver Everyday ON
HC IVL-SOB-CB-722481 01-HIX	CB IA MIPPA Silver Everyday ON CSR 73%
HC IVL-SOB-CB-722482 01-HIX	CB IA MIPPA Silver Everyday ON CSR 87%
HC IVL-SOB-CB-722483 01-HIX	CB IA MIPPA Silver Everyday ON CSR 94%
HC IVL-SOB-CB-722484 01-HIX	CB IA MIPPA Silver Everyday ON AI/AN $0 CS
HC IVL-SOB-CB-722485 01-HIX	CB IA MIPPA Silver Everyday ON AI/AN Limited CS
HC IVL-SOB-CB-722487 01-HIX	CB IA MIPPA Silver Everyday Plus ON
HC IVL-SOB-CB-722488 01-HIX	CB IA MIPPA Silver Everyday Plus ON CSR 73%
HC IVL-SOB-CB-722489 01-HIX	CB IA MIPPA Silver Everyday Plus ON CSR 87%
HC IVL-SOB-CB-722490 01-HIX	CB IA MIPPA Silver Everyday Plus ON CSR 94%
HC IVL-SOB-CB-722491 01-HIX	CB IA MIPPA Silver Everyday Plus ON AI/AN $0 CS
HC IVL-SOB-CB-722492 01-HIX	CB IA MIPPA Silver Everyday Plus ON AI/AN
HC IVL-SOB-CB-722494 01-HIX	CB IA MIPPA Silver Healthy Minds ON
HC IVL-SOB-CB-722495 01-HIX	CB IA MIPPA Silver Healthy Minds ON CSR 73%
HC IVL-SOB-CB-722496 01-HIX	CB IA MIPPA Silver Healthy Minds ON CSR 87%
HC IVL-SOB-CB-722497 01-HIX	CB IA MIPPA Silver Healthy Minds ON CSR 94%
HC IVL-SOB-CB-722498 01-HIX	CB IA MIPPA Silver Healthy Minds ON AI/AN $0 CS
HC IVL-SOB-CB-722499 01-HIX	CB IA MIPPA Silver Healthy Minds ON AI/AN
HC IVL-SOB-CB-722501 01-HIX	CB IA MIPPA Silver Diabetes ON
HC IVL-SOB-CB-722502 01-HIX	CB IA MIPPA Silver Diabetes ON CSR 73%
HC IVL-SOB-CB-722503 01-HIX	CB IA MIPPA Silver Diabetes ON CSR 87%
HC IVL-SOB-CB-722504 01-HIX	CB IA MIPPA Silver Diabetes ON CSR 94%
HC IVL-SOB-CB-722505 01-HIX	CB IA MIPPA Silver Diabetes ON AI/AN $0 CS
HC IVL-SOB-CB-722506 01-HIX	CB IA MIPPA Silver Diabetes ON AI/AN Limited CS
HC IVL-SOB-CB-722508 01-HIX	CB IA MIPPA Gold Diabetes ON
HC IVL-SOB-CB-722509 01-HIX	CB IA MIPPA Gold Diabetes ON AI/AN $0 CS
HC IVL-SOB-CB-722510 01-HIX	CB IA MIPPA Gold Diabetes ON AI/AN Limited CS
HC IVL-SOB-CB-722512 01-HIX	CB IA MIPPA Bronze ON
HC IVL-SOB-CB-722513 01-HIX	CB IA MIPPA Bronze ON AI/AN $0 CS
HC IVL-SOB-CB-722514 01-HIX	CB IA MIPPA Bronze ON AI/AN Limited CS
HC IVL-SOB-CB-722516 01-HIX	CB IA MIPPA Catastrophic ON
HI IVL-SOB-CB-723522 01-HIX	CB IA Chi Silver Everyday ON
HI IVL-SOB-CB-723523 01-HIX	CB IA Chi Silver Everyday ON CSR 73%
HI IVL-SOB-CB-723524 01-HIX	CB IA Chi Silver Everyday ON CSR 87%
HI IVL-SOB-CB-723525 01-HIX	CB IA Chi Silver Everyday ON CSR 94%
HI IVL-SOB-CB-723526 01-HIX	CB IA Chi Silver Everyday ON AI/AN $0 CS
HI IVL-SOB-CB-723527 01-HIX	CB IA Chi Silver Everyday ON AI/AN Limited CS
HI IVL-SOB-CB-723529 01-HIX	CB IA Chi Silver Everyday Plus ON
HI IVL-SOB-CB-723530 01-HIX	CB IA Chi Silver Everyday Plus ON CSR 73%
HI IVL-SOB-CB-723531 01-HIX	CB IA Chi Silver Everyday Plus ON CSR 87%
HI IVL-SOB-CB-723532 01-HIX	CB IA Chi Silver Everyday Plus ON CSR 94%

HI IVL-SOB-CB-723533 01-HIX	CB IA Chi Silver Everyday Plus ON AI/AN $0 CS
HI IVL-SOB-CB-723534 01-HIX	CB IA Chi Silver Everyday Plus ON AI/AN Limited CS
HI IVL-SOB-CB-723536 01-HIX	CB IA Chi Silver Healthy Minds ON
HI IVL-SOB-CB-723537 01-HIX	CB IA Chi Silver Healthy Minds ON CSR 73%
HI IVL-SOB-CB-723538 01-HIX	CB IA Chi Silver Healthy Minds ON CSR 87%
HI IVL-SOB-CB-723539 01-HIX	CB IA Chi Silver Healthy Minds ON CSR 94%
HI IVL-SOB-CB-723540 01-HIX	CB IA Chi Silver Healthy Minds ON AI/AN $0 CS
HI IVL-SOB-CB-723541 01-HIX	CB IA Chi Silver Healthy Minds ON AI/AN Limited
HI IVL-SOB-CB-723543 01-HIX	CB IA Chi Silver Diabetes ON
HI IVL-SOB-CB-723544 01-HIX	CB IA Chi Silver Diabetes ON CSR 73%
HI IVL-SOB-CB-723545 01-HIX	CB IA Chi Silver Diabetes ON CSR 87%
HI IVL-SOB-CB-723546 01-HIX	CB IA Chi Silver Diabetes ON CSR 94%
HI IVL-SOB-CB-723547 01-HIX	CB IA Chi Silver Diabetes ON AI/AN $0 CS
HI IVL-SOB-CB-723548 01-HIX	CB IA Chi Silver Diabetes ON AI/AN Limited CS
HI IVL-SOB-CB-723550 01-HIX	CB IA Chi Gold Diabetes ON
HI IVL-SOB-CB-723551 01-HIX	CB IA Chi Gold Diabetes ON AI/AN $0 CS
HI IVL-SOB-CB-723552 01-HIX	CB IA Chi Gold Diabetes ON AI/AN Limited CS
HI IVL-SOB-CB-723554 01-HIX	CB IA Chi Bronze ON
HI IVL-SOB-CB-723555 01-HIX	CB IA Chi Bronze ON AI/AN $0 CS
HI IVL-SOB-CB-723556 01-HIX	CB IA Chi Bronze ON AI/AN Limited CS
HI IVL-SOB-CB-723558 01-HIX	CB IA Chi Catastrophic ON
HC IVL HPOL-CB-2017 01-HIX	Policy (ON-Exchange) – Health Network Option
HI IVL HPOL-CB-2017 01-HIX	Policy (ON-Exchange) – Health Network Only Open
CB-1-8 (05-16)(WEB)	Online Application

Health Network Option Open Access/Health Network Only Open Access (OFF-Exchange)

HC IVL-SOB-CB-722486 01	CB IA MIPPA Silver Everyday OFF
HC IVL-SOB-CB-722493 01	CB IA MIPPA Silver Everyday Plus OFF
HC IVL-SOB-CB-722500 01	CB IA MIPPA Silver Healthy Minds OFF
HC IVL-SOB-CB-722507 01	CB IA MIPPA Silver Diabetes OFF
HC IVL-SOB-CB-722511 01	CB IA MIPPA Gold Diabetes OFF
HC IVL-SOB-CB-722515 01	CB IA MIPPA Bronze OFF
HC IVL-SOB-CB-722517 01	CB IA MIPPA Catastrophic OFF
HI IVL-SOB-CB-723528 01	CB IA Chi Silver Everyday OFF
HI IVL-SOB-CB-723535 01	CB IA Chi Silver Everyday Plus OFF
HI IVL-SOB-CB-723542 01	CB IA Chi Silver Healthy Minds OFF
HI IVL-SOB-CB-723549 01	CB IA Chi Silver Diabetes OFF
HI IVL-SOB-CB-723553 01	CB IA Chi Gold Diabetes OFF
HI IVL-SOB-CB-723557 01	CB IA Chi Bronze OFF
HI IVL-SOB-CB-723559 01	CB IA Chi Catastrophic OFF
HC IVL HPOL-CB-2017 01	Policy (OFF-Exchange) – Health Network Option

HI IVL HPOL-CB-2017 01	Policy (OFF-Exchange) – Health Network Only
CB-1-8 (05-16)(WEB)	Online Application