Aetna Health of Iowa Inc.
Iowa Small Group
HMO/POS Products

Summary

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

The new rates will apply to coverage effective in 2018. The current membership and range of rate changes by product are:

Product ID	Rate Increase	Current Members
18973IA044	45.6%	0

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 11.4% 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 14.9% 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 12.2%.

Will Premiums for All Individuals Increase 45.6%?

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 v4.2

Company Legal Name: **Aetna Health of Iowa Inc.** State: **IA**
HIOS Issuer ID: **18973** Market: **Small Group**
Effective Date of Rate Change(s): **01/01/2018**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 01/01/2016 to 12/31/2016

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$2,457,547	$344.97	100.00%
Incurred Claims in Experience Period	$1,834,843	257.56	74.66%
Allowed Claims:	$2,187,008	306.99	88.99%
Index Rate of Experience Period		$306.96	
Experience Period Member Months	7,124		

Section II: Allowed Claims, PMPM basis

Projection Period: 01/01/2018 to 12/31/2018 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	145.23	$5,492.03	$66.47	1.153	0.989	1.061	0.964		155.70	$6,119.01	$79.40	131.98	$5,219.87	$57.41
Outpatient Hospital	Visits	687.40	1,393.94	79.85	1.153	0.989	1.051	1.002		795.63	1,522.62	100.95	727.03	1,697.11	102.82
Professional	Visits	8,628.92	116.34	83.66	1.153	0.989	1.027	0.997		9,893.89	121.33	100.03	9606.00	118.81	95.11
Other Medical	Visits	603.01	221.68	11.14	1.153	0.989	1.051	1.002		697.95	242.14	14.08	641.30	413.22	22.08
Capitation	Benefit Period	12,000.00	0.00	0.00	1.153	0.989	1.027	0.941		12,255.43	0.00	0.00	12020.01	0.00	0.00
Prescription Drug	Prescriptions	7,824.26	101.04	65.88	1.153	1.024	1.077	0.979		8,654.96	119.97	86.53	7834.06	72.25	47.17
Total				$306.99								$380.99			$324.59

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$324.59	$309,659
Paid to Allowed Average Factor in Projection Period			0.767	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$248.96	$237,507
Projected Risk Adjustments PMPM			-142.75	(136,188)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$391.71	$373,695
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$391.71	$373,695
Administrative Expense Load		13.41%	68.96	65,790
Profit & Risk Load		3.90%	20.05	19,127
Taxes & Fees		6.49%	33.35	31,812
Single Risk Pool Gross Premium Avg. Rate, PMPM			$514.07	$490,424
Index Rate for Projection Period			$330.45	
% increase over Experience Period			49.02%	
% Increase, annualized			22.07%	
Projected Member Months				954

P odu t-Plan Da a Col ection

Company egal Name **Aetna Heal h o Iowa Inc** State **A**
HIOS ssue ID **18973** Ma ket **Sma l G oup**
E ec ive Da e o Ra e Change(s) **01/01/2018**

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AV P c ng Va ue		0 0 0	0 010	0 010	0 0 0	0 010	0 010	0 10	0 010	0 010	0 10	0 010	0 010
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Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	Aetna Health of Iowa Inc.
State:	IA
HIOS Issuer ID:	18973
Market:	Small Group
Effective Date:	01/01/2018
Rate Filing Tracking Number:	AETN-131049805
Policy Form(s):	See Form Exhibit I
Form Filing Tracking Number:	AETN-130954182

Company Contact Information:

Name:
Telephone Number:
Email Address:

[redacted]

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

1) Provide support for the development of the Part I Unified Rate Review Template;
2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
3) Request approval of the proposed monthly premium rates; and
4) Provide benefit plan designs summaries for the products included in this filing.

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

These rates are for plans issued in Iowa beginning January 1, 2018. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public SHOP Exchange in Iowa.

2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in Iowa are being revised for effective dates January 1, 2018 through December 31, 2018.

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;
- 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, 2016 through December 31, 2016 and paid through February 28, 2017.

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 Small Group business in Iowa. Our internal projections, as of February 22, 2017, indicate that the expected rebate for the Small Group Iowa Minimum Loss Ratio pool in 2016 is approximately 6.5% of premium, after taking into consideration risk adjustment payables/receivables. Experience period premium shown in Worksheet 1, Section I reflect an adjustment of this magnitude. The premiums before and after adjustment for MLR rebates are:

Earned Premium Prior to MLR Rebates:	$2,628,553
Est. CY2016 MLR Rebates:	-$171,006
Earned Premium Net of MLR Rebates & RA:	$2,457,547

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.

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 experience for:

- Community-rated policies issued to small employers in 2016
- Medically underwritten policies renewed under the Transitional Policy

We considered the expected relationships between the morbidity of each of these populations and the likely population that will be covered by Small Group Single Risk Pool policies in 2018. Exhibit 3 discusses the assumptions used to project the change in population morbidity, and illustrates the resulting projection factor.

B. Changes in Benefits:
The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for both Single Risk Pool products that have essentially identical benefits and coverage issued outside the Single Risk Pool which does not cover all EHBs. The projection factor reflects the pro-rated impact of these additional benefits, as well as any changes in 2018 State Benchmark EHBs, and newly 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.

6. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rates is from Coventry Healthcare of Iowa and Coventry Health and Life Insurance Company, commercial group sizes with 2-50 eligible subscribers, ACA qualified and non-ACA qualified, Iowa situsedgroups, experience incurred from January 1, 2016 to December 31, 2016 and paid through February 28, 2017.

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 3-8.

C. Inclusion of Capitation Payments:

No services provided in 2018 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

Given the lack of credible ACA experience, the manual was developed as described in 6.A. above and we assigned 100% credibility to the manual.

8. Paid-to-Allowed Ratio

The projected paid to allowed ratio is 77%. Paid to allowed ratios are based on 2016 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

Transitional Reinsurance recoveries do not apply to Small Group business. The experience period data reflects the Reinsurance Contribution of $2.25 PMPM assessed during 2016.

B. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2016 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 2016 Risk Adjustment fees of $0.15 PMPM in Worksheet 2.

C. Risk Adjustment – Projection Period

We started with 2016 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 and only off-exchange, 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 12.2% for 2017, and 12.2% for 2018.

In addition, the projected risk adjustment transfer includes changes that were outlined in the 2018 Notice of Benefit and Payment Parameters. The 2018 projected market average premium used in the payment transfer formula is also reduced by 14% to remove administrative cost. To that transfer, we subtracted to that Risk Adjustment transfer .5% of premiums for National High Risk pool funding, and added our anticipated High Risk Pool recoveries. High Risk Pool recoveries were estimated based on the average of member-level recoveries that we would have received under this program for 2014-2016 claims as a percent of premium, for Silver Off-Exchange plans.

As a result, we project a risk adjustment payable, net of the 2018 user fee of $0.14 PMPM.

10. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 10.

The prospective general and administrative expenses are set to achieve the 80% MLR threshold requirement. Actual general and administrative expenses are based on historical corporate small group market expense levels, 2017 projections, and projected changes in expenses, inflation, and membership for 2018 for our National book of small group business.

A flat commission per policy per month will be paid to all brokers in Iowa during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2018, 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 2017 plans.

11. Projected Loss Ratio

The expected 2018 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 Small Group market in Iowa through Aetna Health of Iowa Inc. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d). Rates for plans that may be renewed outside the Single Risk Pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing.

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, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

Small Group Market Trend Adjustments: Exhibit 12 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend, leveraging, and also account for changes in the Health Insurers Fee. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2018.

14. Market-Adjusted Index Rate

Exhibit E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustments (Risk Adjustment) were discussed, previously. The risk adjustment on Worksheet 1 of the URRT is displayed on a paid-basis. 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 7. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value, Cost Sharing, and Tobacco:

The factors in Column 2 are the product of two 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 2018 membership.

B. Distribution and Administrative Costs:

Exhibit E-2, Column 3, 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.

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

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

D. Benefits in addition to EHBs:

The factors in Column 5 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 5 are 1.00.

E. Experience Period Plan Adjusted Index Rates

This filing does not include catastrophic plans.

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2016 for the experience period.

16. Calibration

Exhibit C-1 shows an example of how calibration is applied to all plan adjusted index rates.

A. Age Curve Calibration:
The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit C-2. Exhibit C-2 demonstrates the determination of the Plan-Level Average Age Factor. Plan membership is based on issuer's similar January 2017 plan membership and projected changes in the market.

To Age-Calibrate the Plan-Adjusted Index Rates, We project a premium-weighted average age factor for the 2018 membership using the prescribed age curve and the projected age for each plan, as illustrated on exhibit C-2, The overall Age Calibration factor is developed in Column B of Exhibit C-1. This factor is based on the weighting of plan-adjusted Index rate and membership weighted by each plan's average age factor membership. The Age-Calibrated Plan Adjusted Index Rate is determined multiplying each Plan Adjusted Index Rate by the Plan-Level Average Age Factor and then dividing by the weighted over-all average age factor.

The age that most closely corresponds to the premium weighted overall average age factor is the average age for the single risk pool.

B. Geographic Factor Calibration:
Exhibit C-2 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, and this applied in column F of exhibit C-1.

Projected area factors are shown in Exhibits 6 and C-2. Unit cost trend studies were used to evaluate whether there were significant changes to network costs that would require changes from previously filed rating area factors.

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 * Trend 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. Composite Premiums
Small employers will be able to elect to have rates set using a composite approach as permitted by Iowa.

19. AV Metal Values
The AV Metal Values on Worksheet 2 were based on the AV 2018 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

20. AV Pricing Values

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

21. Membership Projections

Exhibit 15 summarizes the membership projections by plan. 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.

Terminated Plans and Products:

Exhibit 16 provides a plan and product crosswalk from 2016 to 2018. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2017 and 2018.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

22. Plan Type

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

23. Warning Alerts

The experience period Total Premium (TP) differs between Worksheets 1 and 2 because premiums reported on Worksheet 1 are net of MLR rebates while premiums on Worksheet 2 do not consider the impact of MLR rebates.

The Experience Period Incurred claims and Incurred Claims PMPM on Worksheet 2 adjust for the impacts of Reinsurance and Risk Adjustment. The Incurred Claims on Worksheet 1 are not adjusted for the impact of Reinsurance and Risk Adjustment. The warning alerts on rows 68 and 73 of Worksheet 2 result from the different treatment of Reinsurance and Risk Adjustment on the two worksheets.

24. Benefit Design

This filing includes the standard plans that are Silver metal tiers. These standard plans are repeated for our different provider network plans.

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.

25. Marketing

Plans will be available outside of the SHOP Exchange. These plans may be marketed in a variety of means, including directly to consumers through direct mail, telemarketing, and the internet and indirectly through brokers and general agents. Marketing and distribution approaches may change from time to time at management's discretion.

26. Underwriting

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

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

28. Company Financial Condition
As of December 31, 2016, the capital and surplus held by Aetna Health of Iowa was approximately $29 Million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2016. 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:

- Experience Period MLR Rebates
- Risk Adjustment Transfer
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Components of Retention/Administrative Fees
- Value of Network Arrangements
- MH Net Trend
- Experience Period Data – Small Group

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] 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.
h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

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

Small Group Off Exchange HMO/POS – AHI-IA

HI SG HCOC 2018-02	Certificate of Coverage
GR-69204-46 (5-17)	Employee App
GR-69205-IA (5-17)	Employer App
HI SG-SOB-HMO-14038735 02	IA Silver HNOnly 5000 80%