# Actuarial Memorandum and Certification

## General Information

***Company Identifying Information:***

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|---|---|
| **Company Legal Name:** | **Innovation Health Insurance Company** |
| **State:** | **Virginia** |
| **HIOS Issuer ID:** | **12028** |
| **Market:** | **Individual** |
| **Effective Date:** | **01/01/2017** |
| **Rate Filing Tracking Number:** | **AETN-130508789** |
| **Policy Form(s):** | **IH IVL HPOL-CB-2017-PPO 01-HIX**<br>**IH IVL HPOL-CB-2017-PPO 01**<br>**IH IVL Insert A 01, IH IVL Insert A 01-HIX** |
| **Form Filing Tracking Number:** | **AETN-130449986** |

***Company Contact Information:***



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|---|---|
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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 Virginia 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 Virginia.

2. Proposed Rate Increase

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

A. Reason for Rate Increase(s):

Revised rates for these products reflect the following:

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Elimination of the reinsurance program;
- Revisions to administrative expense projections;

- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs; and
- Changes in provider networks and contracts.

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

- 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.

The weighted average increase across plans based on current ACA-compliant membership, inclusive of the impact of benefit and cost sharing changes, is 16.6%. The minimum increase is 2.5% and the maximum increase is 18.0%. Exhibit 1 shows the average threshold increases for products covered by this filing.

This filing also includes two new silver benefit plans.

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. This data reflects Individual ACA experience for Innovation Health Insurance Company. There is no Pre-ACA Non-Grandfathered experience for Innovation Health Insurance Company.

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 Virginia. The premiums have been decreased for expected risk adjustment payables for our estimated accruals of risk adjustment, 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 Virginia. As such, no adjustment was made to premiums to account for expected rebates.

C. Allowed and Incurred Claims Incurred During the Experience Period:
Allowed claims come directly from the claim records for hospital and physician services.

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 2015 CMS Advanced Payments for member cost-sharing. These are considered best estimates of actual cost sharing reduction recoveries at the plan level.

As noted above, the experience period reflects two months of paid claim run-off. The IBNP reserves account for approximately 3.6% of the experience period incurred claims.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in February, 2016. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, including day-based mental health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

5. Projection Factors

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 other sources. We then modeled renewals and new market entrants for 2016 and 2017 from information sources, such as 2016 Marketplace enrollment data, 2014 CMS Risk Adjustment Reports, 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 that cover essentially all EHBs. The projection factors reflect the impact of any changes in 2017 State Benchmark EHBs and any new state mandated benefits.

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

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.

Adjustments (Medical) from Experience Period to Projection Period from Worksheet 1, Section II of URRT

| | Base Experience |
|---|---|
| Population Morbidity (Worksheet 1) | |
| Experience Period Risk Score | 1.289 |
| Projection Period Risk Score | 1.276 |
| **Change in Population Morbidity** | 0.990 |
| | |
| Other Adjustments (Worksheet 1) | |
| Changes in Benefits | 0.981 |
| Changes in Demographics | 1.018 |
| Other Adjustments (Network Adj, Area Shift, etc.) | 1.023 |
| **Change in Total Other** | 1.022 |

E. Trend Factors (Cost/Utilization):
Medical trend factors are based on our Medical Economics Unit's national guidance adjusted for local market trend pressures and network experience, 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 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.

Anticipated annual trend from the experience period to the rating period for the product line is as follows

Exhibit 4: Anticipated Annual Trend: Experience to Projection Period

| Component | Unit Cost | Utilization | Total Trend |
|---|---|---|---|
| Facility Inpatient | 2.3% | -0.7% | **1.6%** |
| Facility Outpatient | 2.0% | 1.4% | **3.4%** |
| Physician | 1.7% | 0.3% | **2.0%** |
| Other Medical | 2.0% | 1.4% | **3.4%** |

| | | | |
|---|---|---|---|
| Capitation | 0.0% | 0.0% | **0.0%** |
| **Medical** | **1.9%** | **0.5%** | **2.5%** |
| Pharmacy | 10.2% | 0.1% | **10.3%** |
| **Total (Med+Rx)** | **3.9%** | **1.3%** | **4.3%** |

6. Credibility Manual Rate Development

The experience data is considered fully credible; therefore, we populated the credibility manual with the issuer's projected individual single risk pool values.

7. Credibility of Experience

Full credibility is assigned to the experience data.

8. Paid-to-Allowed Ratio

We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 65%:

| Tier | Projected Membership Distribution | Paid to Allowed Ratio |
|---|---|---|
| Catastrophic | 3% | 60% |
| Bronze | 30% | 60% |
| Silver | 65% | 67% |
| Gold | 2% | 76% |
| Total | 100.0% | 65% |

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. The difference between our projected relative risk and the market's is multiplied by the projected

market average premium, which we trended at 5% for 2016 and 12% for 2017. As a result, we project a risk adjustment payable of $32.83, net of the 2017 user fee of $0.13 PMPM.

10. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is 23.8%. This was developed from the following items and approximated as shown:

1. Taxes and Fees of 7.7% comprised of:
   a. Premium Taxes of 2.4%
   b. Patient Centered Outcomes Research Fund, Reinsurance Contribution, Risk Adjustment Fees of $0.31 per member per month, converted to 0.1%
   c. Health Insurer Fee of 0.0%
   d. Exchange User Fee of 3.2%. This assumes a business mix of 90% on exchange at 3.5% and 10% off exchange.
   e. Federal Income Tax of 2.1%, assuming 35% tax rate
2. General Administrative and Selling Expenses of 12.1% of premium based upon an expected average premium level
3. After-tax Target Profit of 3.9%

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

11. Projected Loss Ratio

The projected MBR for this filing calculated in the traditional way is 76.3%. The expected 2016 MLR for this filing, as defined by PPACA and before any credibility adjustment, is 83.1%.

Exhibit 2 illustrates the MLR projection.

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 Virginia through Innovation Health Insurance Company. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

13. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits (non-EHBs) listed in Section 15, below.

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

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 displayed as a multiplicative factor 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 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 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 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. These expense and profit assumptions do not vary by plan.

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. Specifically, day and visit limitations were removed for PT/OT/ST, rehab, SNF, and home health services. Consequently, we have Benefits in Excess of EHB of 0.41% on an allowed claims basis (0.3% on a paid claims basis).

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 January 2016 membership and projected changes in the market. 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.

As an example of this calculation, consider a family living in Fairfax County that enrolls in the CB VA IH PPO Silver Everyday ON. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6, and no family member uses tobacco. The rate for this family is calculated as:

| Member Age | 42 | 40 | 13 | 11 | 8 | 6 |
|---|---|---|---|---|---|---|
| Calibrated Plan Adjusted Index Rate | $247.04 | $247.04 | $247.04 | $247.04 | $247.04 | $247.04 |
| Age Factor | 1.3250 | 1.2780 | 0.6350 | 0.6350 | 0.6350 | 0.6350 |
| Area Factor | 1.0000 | 1.0000 | 1.0000 | 1.0000 | 1.0000 | 1.0000 |
| Tobacco Factor | 1.0000 | 1.0000 | N/A | N/A | N/A | N/A |
| Final Rate | $327.33 | $315.72 | $156.87 | $156.87 | $156.87 | N/A |

The family's final monthly rate is the sum of the member rates, or $1,113.66. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example.

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 and Cost Sharing Reduction Subsidy Estimates

Exhibit A 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. (We assume that total enrollment will be similar to our current enrollment.)

Terminated Plans and Products

Exhibit 16 provides a plan and product crosswalk from 2015 to 2017. The crosswalk includes the list of single risk pool plans and products that have terminated prior to January 1, 2017, products that have experience in the single risk pool experience period, and products that were made available in 2016 and 2017.

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

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 actual risk adjustment transfers applied to premiums on Worksheet 1 were not equal to the risk adjustment transfer assumed in the development of the Plan Adjusted Index Rate.
For the same reason, Total Premium (TP) differs between Worksheets 1 and 2.

The Projected Plan Adjusted Index Rate on Worksheet 2 differs from the Gross Premium Average Rate on Worksheet 1. This difference results from the tobacco calibration values being applied to the plan adjusted index rates on Worksheet 2. For the same reason, 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 Virginia 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 Innovation Health Insurance Company was approximately $63 million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2015.

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 and Outpatient Pre-Cert Adj
- Experience Period Data – Individual
- 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, Matthew Moor, 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 Virginia, 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.

April 8, 2016

Matthew G. Moor, ASA, MAAA
Innovation Health Insurance Company

Date