Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
United Healthcare Insurance Company

State of California Rate Review

Purpose

The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT) and to comply with California and Federal requirements. It may not be appropriate for other purposes.

General Information

Company Identifying Information

Company Legal Name:	UnitedHealthcare Insurance Company
State:	California
HIOS Issuer ID:	95677
Market:	Small Group
Effective Date:	01/01/2018

Company Primary Contact Information

Name:	[redacted]
Telephone Number:	[redacted]
Email Address:	[redacted]

Proposed Rate Increase(s)

UnitedHealthcare Insurance Company (UHIC) issues group major medical products in California.

Reason for Rate Increase(s)

UHIC is filing for a January 2018 rate change for benefit plans under policy forms COC.INS.2018.SG.CA.SLP (Select Plus), COC.INS.2018.SG.CA.Nav (Navigate), COC.INS.2018.SG.CA.NDF (Non Differential), and COC.INS.2018.SG.CA.COR (Core). The proposed rates included in this filing will be effective for new and existing members enrolling or renewing on or after January 1st 2018. The rates were developed assuming they will be in effect for six months. The proposed rates represent an increase of 2.5% on average (including a 2.8% reduction due to portfolio changes) over July 1, 2017 rates.

Experience Period Premium and Claims

Paid Through Date: The experience period used to support this filing is 01/1/2016 through 12/31/2016. Claims data includes claims incurred from 01/1/2016 through 12/31/2016 and paid through 02/28/2017.

Premiums (net of MLR Rebate) in Experience Period: Earned premium data is for the same experience period. The earned premium for the experience period, net of rebate was $404,753,194. No MLR rebate is assumed during the experience period.

Allowed and Incurred Claims Incurred During the Experience Period: The incurred claims presented in Worksheet 1, Section I represents UHIC's best estimates of claims incurred during the experience period. Incurred claims were developed by first starting with actual claims paid through 02/28/2017. Estimates of incurred but not paid claims were added to these paid claims. The following is a description of the reserve methodology.

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

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

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

Allowed claims by benefit category were obtained from UHIC's claim paying system reports.

Benefit Categories

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

Inpatient: Includes non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient setting and billed by the facility.

Outpatient: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation, ambulance, home health, durable medical equipment (DME), and other services provided in an outpatient facility setting and billed by the facility.

Professional: Includes non-capitated primary care, specialist, therapy, professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.

Pharmacy: Includes drugs dispensed by a pharmacy, and does not include drugs dispensed by the facility or administered by a physician. This amount is net of rebates received from drug manufacturers.

Capitation: Includes mental health / chemical disorder services and wellness programs provided under a capitated arrangement.

Other: Includes non-capitated, fee-for-service costs for physician procedures, inpatient stays, and outpatient procedures related to MHCD. The measurement unit of this category is Days for inpatient and Services for outpatient and physician procedures.

Projection Factors

Insured Population Morbidity Changes

No population morbidity adjustment was assumed for this filing. For this rate filing, the underlying experience includes 1-100 group size segments.

Benefit and Other Changes

Compared to the experience period, claims in the projection period are expected to increase due to factors such as the addition of added Essential Health Benefits (EHBs). The cost impact of these changes was developed using proprietary United Healthcare actuarial methodologies that utilize nationwide experience. The adjustments for EHBs are applied to the portion of claim experience attributable to non-ACA compliant plans (transitional relief plans and 51-99 plans).

Benefit changes for Essential Health Benefits (EHBs) include pediatric dental ([redacted]), pediatric vision ([redacted]), and obesity surgery ([redacted]).

While the experience period underlying our projection is calendar year 2016, recent experience has deteriorated. An adjustment to our projected claims of 1.9% has been applied based on a two month shift of our experience period. We believe this is reasonable even though our adjustment for risk adjustment is based on calendar year 2016.

To establish a rate for new members effective January 2018 – June 2018, 2.5 additional months of trend has been incorporated into the "Other" column in order to bring up the total months of trend to 26.5.

Claim Pooling

Claims in the experience period exceeding $200,000 are considered a catastrophic claim. To prevent random catastrophic claims from distorting results, the catastrophic claims are removed and replaced with an expected claim based on prior experience. The impact of pooling for this experience period is a decrease to claims of [redacted].

Demographics Changes

No change was assumed in the demographics of the covered population. The HHS proposed age factors for 2018 are utilized in this filing.

Trend Factors

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

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

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

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

Business mix changes that influence medical cost trends are also reviewed and projected, with appropriate input from sales and underwriting staff. These factors include changing mix of

employer groups, mix of benefits, and demographic changes. For the purposes of developing premium pricing trend projections, the component of trend attributable to business mix is excluded.

The average medical and pharmacy pricing trend is [redacted]. This reflects a core trend of [redacted] with a leveraging provision of [redacted]. The components of core trend are detailed below.

Benefit Category	Unit Cost Trend	Utilization Trend
Inpatient Hospital	[redacted]	[redacted]
Outpatient Hospital	[redacted]	[redacted]
Professional	[redacted]	[redacted]
Other Medical	[redacted]	[redacted]
Capitation	[redacted]	[redacted]
Prescription Drug	[redacted]	[redacted]

Credibility of Experience

The experience used for rate development contains 852,271 member months. We consider UHIC California PPO small group experience to be fully credible for developing rates, and no credibility adjustment was used.

Paid to Allowed Ratio

The average paid to allowed ratio for the projection period is based on the paid to allowed ratio in the experience period, adjusted for expected leveraging, and plan benefit changes to 2018.

Risk Adjustment and Reinsurance

Projected Risk Adjustments (PMPM)

A major actuarial consulting company simulated the impact of risk adjustment in California for 2016 membership among the various carriers who participated in this study. Most of the carriers, including UHIC California PPO, participated in the study.

According to the study, UHIC California's small group membership in 2016 had an average risk score that was [redacted] than the average across all small group members in the state. But, starting in 2018, HHS will reduce the statewide average premium in the risk adjustment transfer formula by 14% to account for the proportion of administrative costs that do not vary with claims. Due to the risk adjustment mechanism, we need to develop premium rates that are appropriate for the average statewide risk. Therefore, we normalized our claims experience to a 1.0 market risk by applying an adjustment of [redacted].

We are also adding a Risk Adjustment Administration Fee of $0.14 pmpm in Worksheet 1.

Non-Benefit Expenses and Profit & Risk

Administrative Expenses

Administrative expense assumption is estimated at [redacted] of premium and commission expense at [redacted].

Profit & Risk Margin

The after-tax profit and risk load is 2.4%.

Taxes and Fees

The taxes and fees assumption includes premium taxes and PPACA fees.

The components are as follows:

Premium Tax / assessment of 0.0%

Health Insurer Fee of 3.15%

Reinsurance Fee of $0.00

Income Tax of 1.3%

PCORI Fee of $0.20 or 0.04%

Risk Adjustment Administration Fee of $0.14 or 0.03%

Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology is 81.4%.

Index Rate

The index rate for the experience period is equal to the allowed claims PMPM reported in URRT Part I.

The index rate for the projection period was developed using the experience period of allowed claims which was adjusted by the mandated benefits and network savings and trended forward to the projection period. The trend assumption includes the same cost and utilization trend factors used in Section II of Worksheet 1.

The calculation is shown below.

Index Rate	2018 Q1
Allowed Claims	$439.93
[redacted]	[redacted]
Trend month	26.5
Index rate	$502.19

Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for the Federal reinsurance program adjustment, risk adjustment and exchange user fee adjustment. The calculation is shown below.

Market Adjusted Index Rate	2018 Q1
Index Rate	$502.19
[redacted]	[redacted]
Exchange Fee	NA
Market Adjusted Index Rate	$499.82

Plan Adjusted Index Rate

Plan Adjusted Index Rates (PAIR) for the projection period are provided in URRT worksheet 2, Section IV. The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

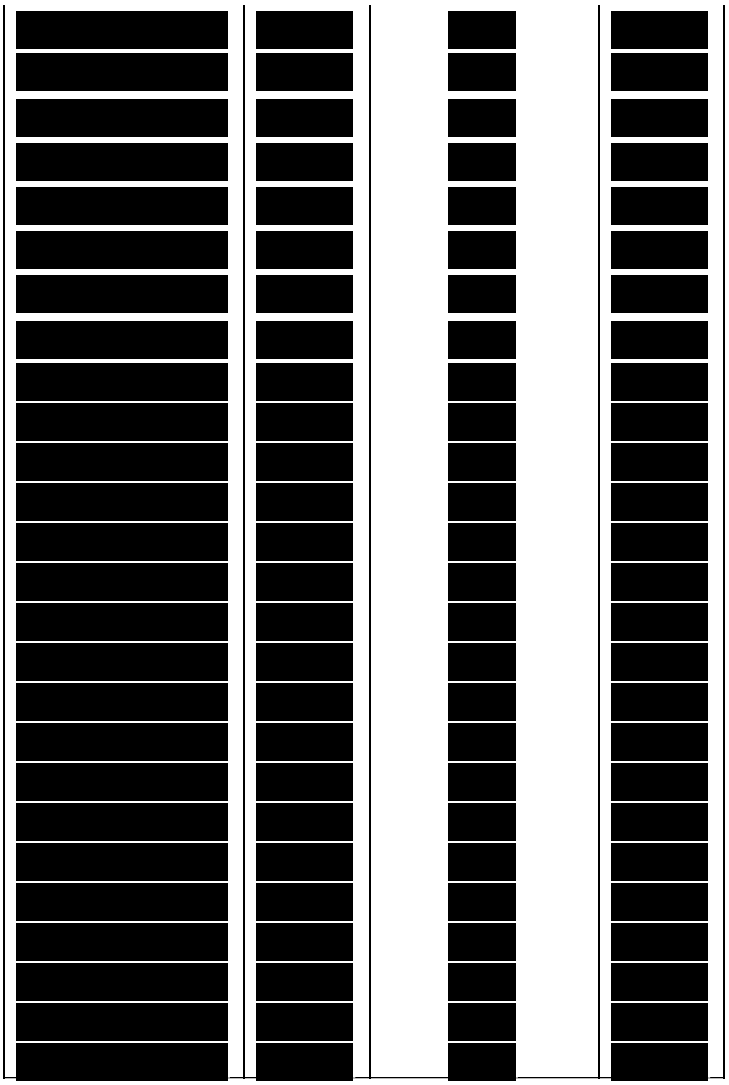
- Actuarial Value and Cost Sharing
- Provider Network, Delivery System and Utilization Management

- Benefits in addition to EHB
- Catastrophic plan eligibility
- Distribution and Administrative costs

The determination of the actuarial value and cost sharing adjustment as well as the adjustment for benefits in addition to the EHBs is developed using our proprietary pricing methodology. This methodology is based on UnitedHealthcare nationwide experience data, containing utilization frequencies and unit costs by service category, and claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected net-to-allowed relativity for each plan is then used to develop the plan relativities for each benefit plan. All benefit plans are priced consistently with each other. The rates differ only by the estimated value of the benefit differences. The prescription drug plan relativities were similarly developed, based on nationwide United Healthcare prescription drug experience. Values reflect the cost differences of Rx copays by tier and other plan cost sharing features such as Rx deductibles and coinsurance. No impact was factored in for the catastrophic plan adjustment.

The calculation of the Plan Adjusted Index Rate is shown below, which incorporates the actuarial value and cost sharing adjustment, as well as adjustment for distribution and administrative costs.

Plan (SCID)	MAIR	AV Pricing Value	PAIR
[redacted]	[redacted]	[redacted]	[redacted]



Calibration

A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

Age Curve Calibration

Age Curve Calibration is calculated as member weighted average rating factors (based on ACR compliant national standard age curve) in the experience period. The factor is calculated to be [redacted]. The calculation reflects the limitation that only three children under age 21 may be rated for.

Geographic Factor Calibration

UnitedHealthcare determined its average geographic area factor based on the state of California defined geographic rating areas and UnitedHealthcare of California distribution of members by geographic rating region for each area factor.

The average geographic area factor of [redacted] was used to calibrate the Plan Adjusted Index Rate to the Consumer Adjusted Premium Rate for the geographic factor component.

The single geographic area factors are as follows:

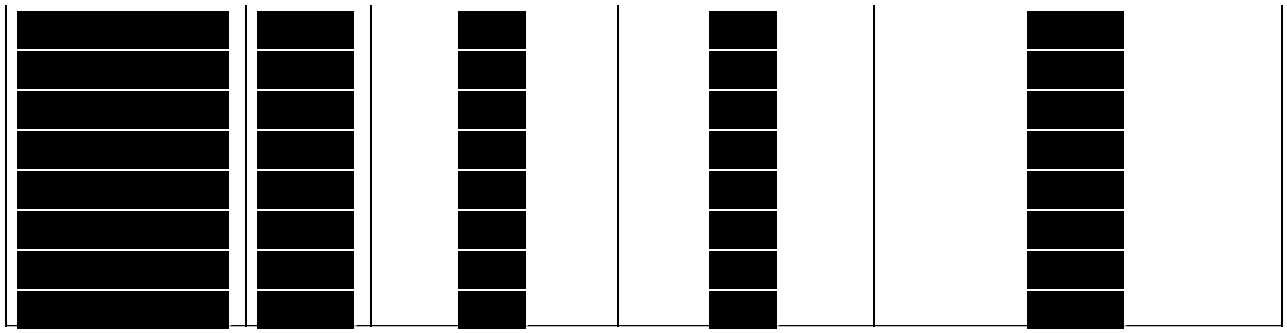
Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if necessary, and applying rating factors as specified by 45 CFR Part 147, Section 147.102.

United Healthcare does not utilize tobacco status as a rating factor. Geographic rating area and age are used. UnitedHealthcare uses member level rating based on the ages of the members covered, taking into account that at most three child dependents under age 21 are considered for rating purposes.

The Consumer Adjusted Premium Rate Development is shown below:

Plan (SCID)	PAIR	Average Age Factor	Average Area Factor	Consumer Adjusted Premium Rate
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]



AV Metal Value

All AV Metal Values were based on the Federal AV Calculator (AVC) for 2018 plans. Some adjustments were made to unique plan designs in order to appropriately model the designs in the AVC, as allowed by CFR 156.135(b)(2). When possible, data from the AVC continuance tables was used to make the adjustments. If the necessary data from the AVC was not available, adjustments were developed based on UnitedHealthcare's historical experience and proprietary pricing methodologies. Examples of these adjustments include:

- **Per-Occurrence Copays:** In order to account for per-occurrence copays that regularly cannot be accounted for in the AV calculator, it was necessary to use the continuance tables, and in cases where that was not viable, our national data, in order to attain an effective coinsurance rate. It was also necessary to blend multiple runs of the AV calculator with tiers.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

Also, note that we derived the metal values for the Covered California plans based on their guidance, which is not consistent with how the rest of the metal values were calculated for the rest of our portfolio.

AV Pricing Values

Plans are priced through the proprietary United Healthcare pricing model. The model, which was updated for January 1, 2018 pricing, uses UHIC fully-insured national small group claim experience for groups that were in force for all of calendar year 2013 and is fully credible. Current claim data is then projected to the pricing period based on national projections of utilization, unit cost, and sloping. These projections are done at the service category (inpatient, outpatient, etc.) level.

At this point, benefit design parameters such as deductibles, copays, coinsurance, etc. are applied to the claim distributions of the matching service category. This cost-sharing is applied

and the values of each service category are summed to come up with the overall benefit value. This overall benefit value is then compared to a base benefit design to calculate the plan relativity.

The base benefit plan used for the AV Pricing Values is a plan that covers 100% of allowed claims. This is not a plan design that will be offered, but making this the assumed reference plan keeps the AV Pricing Values consistent with the AVs Metal Values. The plan-specific adjustments to the market-wide index rate (plan relativities) do not reflect differences in health status or risk selection.

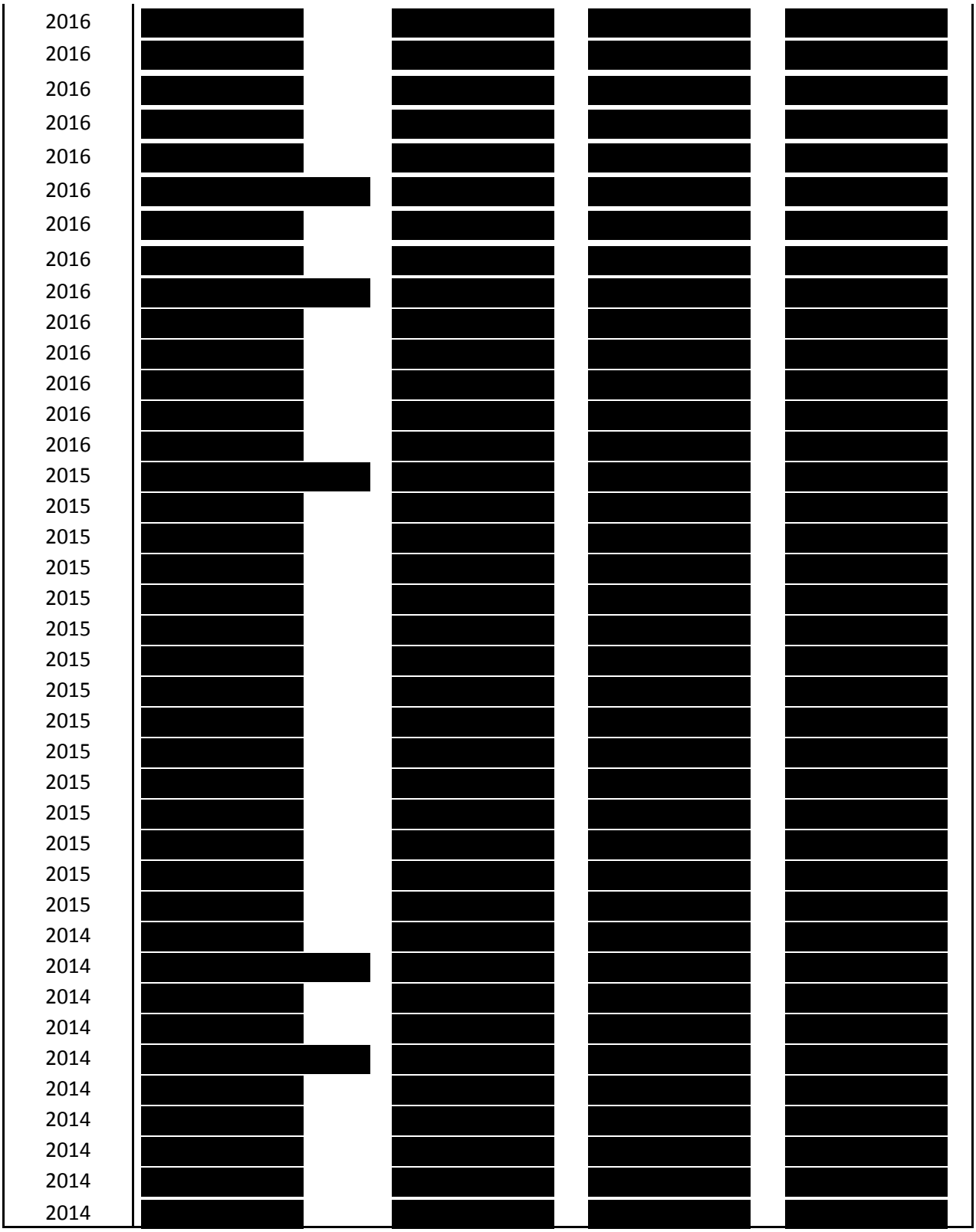
Membership Projections

Membership in the experience period now considers employee group sizes of 1 -100. If there are no members currently on a given plan, one member has been assumed to take the plan.

Terminated Plans and Products

The table below lists the plan mappings from the experience period (2016) to the projection period (2018), and plans introduced after the experience period (2016) to the projection period (2018). Please note that renewing plans often received new SCID assignments each calendar year.

SCID Effective Year	2015 to 2018 Mapping			
	Experience SCID	Mapped 2016 SCID	Mapped 2017 SCID	Mapped 2018 SCID
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]
2016	[redacted]	[redacted]	[redacted]	[redacted]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Warning Alerts

No warnings were indicated in the URRT.

Reliance

Due to responsibility allocation, I relied on United Healthcare's Finance Department to provide the non-benefit expenses and risk margin information, including administrative expenses, profit and risk margin, taxes and fees, and the projected loss ratio under the Federally-prescribed MLR methodology.

I relied on United Healthcare's Product Design Department for reasonable and compliant plan designs. I am not able to completely judge the reasonableness of the plan designs without performing substantial additional work beyond what is required to produce this rate filing.

I also relied on United Healthcare's Economics Department for data and estimates of historical and projected claims trend and for pricing trend going forward.

Actuarial Certification

I, [redacted] am a member of the American Academy of Actuaries and an employee of UnitedHealthcare. I satisfy the necessary education and experience requirements to make this certification.

I certify that the projected index rate to the best of my knowledge is:

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

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that 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.

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

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template. For plan designs that did not fit into the AV Calculator inputs, the AV Metal Value was determined using generally accepted actuarial principles and followed an accepted alternate method described in 45 CFR Part 156 §156.135.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges, and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

[redacted]