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October 3, 2014

Ms. Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority
1100 15th Street, NW, 8th floor
Washington, DC 20005

Subject:
Actuarial Review of Aetna's January 2015 Rate Filings (Aetna Health Small Group AETN-129582439, Aetna Life Individual AETN-129582430, and Aetna Life Small Group AETN-129582423

Dear Executive Director Kofman:

At your request, we have undertaken a review of the three above captioned filings submitted by Aetna Life Insurance Company (ALIC) and Aetna Health Inc. (AHI) legal entities for products that are proposed to be offered in the individual and small group markets in the District of Columbia (the District) effective January 1, 2015. Our work was intended to supplement the reviews conducted by the Department of Insurance, Securities and Banking (DISB), the District regulator tasked with rate approval authority, and assist them in conducting the volume of reviews that needed to be completed in short order. This letter summarizes the analysis we performed.

It is our understanding that only the information submitted in association with Aetna's initial proposed rates are considered to represent publicly available information, and that all correspondence between DISB and Aetna throughout the review process is considered confidential. Given this version of our report will be made public, some detailed information that appear in the more thorough confidential version of this report have been redacted in order to comply with confidentiality requirements in the District. Therefore, in some cases we are unable to include a discussion of additional information provided by Aetna that ultimately led us to agree or disagree with an assumption that was made.

Oliver Wyman is not engaged in the practice of law and this letter, which may include commentary on regulations, does not constitute, nor is it a substitute for, legal advice. There are no third party beneficiaries with respect to this letter, and Oliver Wyman does not accept any liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect to the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

At your request, our review focused on the prescribed 15 items which are required in an effective rate review program as highlighted in HHS regulation 45 CFR 154.301, to the extent the necessary information was available to us. The list is contained in Appendix A for reference, along with other District-specific items that were considered in our review. To ensure internal consistency in our reviews, we used a comprehensive effective rate review check list which we developed in working with our various state clients.

## Summary of Analysis Performed

Using the information in the filings, and notwithstanding the limitations that follow, it is our opinion that the rates for both ALIC and AHI could potentially be reduced from the originally proposed levels. We estimate that the rates for ALIC could, on average, be reduced by up to 13.0% in the Individual market and 12.3% in the Small Group market from originally proposed 2015 levels. We estimate that the rates, on average, for AHI could be reduced by up to 10.2% from originally proposed 2015 levels. The estimated reductions come primarily from potentially conservative trend assumptions, with a portion of the estimate coming from inconsistent premium tax assumptions. Lastly, we note that additional adjustments, potentially both positive and negative, could be made if Aetna's plan factors related to utilization were found to be unreasonable. A table summarizing the key areas where we have found that assumptions could vary from those assumed by Aetna, can be found in Appendix B.

We understand that DISB approved final rates that are lower than those originally proposed.[1] However, the filing documentation in SERFF was not revised as of this writing to reflect the final approved rates; therefore we are unable to attribute the changes in the rates to any specific assumption(s) within the filing. Throughout this report, differences in assumptions and rate changes refer to differences from the filing documentation which reflect the originally proposed rate levels.

## Information Received and Data Limitations

While we were able to review and comment on the rate filings in most of the 15 key areas listed in Appendix A, there were some areas where we were not able to conduct an in-depth analysis due to data limitations.

On June 16, 2014, we downloaded the three filings from SERFF. We employed our standard effective rate review checklist and completed an initial rapid review on June 20, 2014 at which time we forwarded a set of four questions to DISB for consideration. These questions focused on information that was missing from the filing that would be needed for a thorough review. We received responses to these questions on August 1, 2014.

We provided DISB with a full set of 19 questions based on a more thorough review of the filing on June 30, 2014. Responses were received on July 22, 2014.

Follow up questions were drafted and sent to DISB on August 13, 2014, with responses received on August 22, 2014.

Finally, additional follow up questions were drafted and sent to DISB on August 25, 2014. Response to this final set of questions was not received.

Because in many instances quantitative support was not provided when requested, we were not able to perform an in-depth review of all of 15 items required under an effective rate review program at the level typically required to form an opinion as to the reasonableness of the assumptions being made by the carrier.

[1] http://disb.dc.gov/node/897742

Our analysis was limited to the information included in the filings and responses to questions sent to Aetna through SERFF. If additional information or clarification were to be provided, our analysis results may change. A detailed discussion of our analysis follows.

## Analysis Performed

In this section we discuss each of the assumptions reviewed. Where sufficient information was provided to perform analysis and arrive at an independent estimate, we present the results of our analysis and a comparison with the carrier's assumption(s), in those cases where the carrier's assumptions are included in the publicly available information. In other areas, we indicate whether or not the carrier's assumption appears reasonable or whether it appears over or understated. Unless specifically noted, the following review applies to both the ALIC and AHI legal entities.

### Rating Methodology

A reasonable methodology was utilized by Aetna in developing the proposed 2015 rates, consistent with our understanding of the rating rules of the Affordable Care Act (ACA). An allowed claim cost per member per month (PMPM) was first developed for each specific legal entity based on claims experience for the period of calendar year 2013. The rating methodology uses a manual rate due to the lack of credibility of the District of Columbia (the District) experience alone. The manual rate is based on experience in the District and Virginia. In the case of ALIC, experience was pooled between the individual and small group markets, consistent with requirements of the District.

The following adjustments were then applied to develop the projected Index Rate, or an allowed claim cost consistent with levels anticipated in 2015:

- Allowed Claims Trend
- Future Population Morbidity Changes
    - Impact of Guaranteed Issue/Community Rating
    - Pent Up Demand
- Essential Health Benefit (EHB) Adjustment
- Change in Demographics

Next, a Market Adjusted Index Rate was calculated as required by the ACA. In developing the Market Adjusted Index Rate, the following adjustments were applied:

- Market Level Reinsurance (Individual Market Only)
- Market Level Risk Adjustment
- DC Health Link User Fees

We note that both the reinsurance and risk adjustment factors were applied on a market wide basis consistent with ACA rules. Exchange user fees are also to be applied on a market wide basis; however, Aetna did not incorporate the cost of exchange user fees into its small group rates. Only the individual rates include a provision for DC Health Link user fees.

Next, a Plan Adjusted Index Rate was calculated for each plan design as required by the ACA. The allowable plan level adjustments are:

- Cost Sharing Design of the Plan
- Provider Network and Delivery System Characteristics of the Plan
- Benefits in Addition to EHB
- Administrative Costs, excluding exchange user fees
- For Catastrophic Plans, the Expected Impact of the Eligibility Categories for the Plan

The adjustment for cost sharing design of the plan has the effect of converting the rate to expected incurred claims PMPM rather than allowed claims PMPM. It reflects both the member liability and expected differences in utilization by plan based on the cost sharing design. Federal guidance in the instructions to the Unified Rate Review Template indicates issuers are to also convert the projected claims to those of a non-tobacco user when tobacco loads are used in setting premiums. Aetna does not use tobacco loads, consistent with District requirements, so this adjustment was not necessary.

Aetna included a network adjustment in the individual filing, and reflects the expected cost differences between the different networks for Individual and Small Group.

Aetna is not providing benefits in addition to EHB, so no adjustment for non-EHB benefits was included in the rate development.

Administrative costs were applied at the plan level, but are based on a constant percent of premium adjustment.

Aetna filed one catastrophic plan in the individual market filing.

We discuss the reasonability of the adjustments and assumptions which were utilized in developing the proposed rates in the sections that follow.

## Index Rate Development

According to 45 CFR 156.80(d), the index rate is to reflect the average expected allowed cost for EHBs during the projection period. In developing the index rate, there are several adjustments that must be made to the base period experience to reflect differences between the population, provider costs and benefits underlying the single risk pool and those expected in the projection period. These include but are not limited to changes in covered services, morbidity, demographics, trend, and induced demand based on the actuarial value (AV) of the average plan in force during both periods.

### Base Period Allowed Cost PMPM

As previously described, an allowed claim cost PMPM was first developed for each legal entity (ALIC and AHI) based on claims experience for the period of January 2013 through December 2013 and, in the case of ALIC, experience was pooled between the Individual and Small Group markets, consistent with District requirements.

Virginia and District claims experience was combined for credibility purposes in developing the base period allowed cost PMPM; however, no adjustment was later applied to ensure that the underlying claims experience is reflective of District specific cost levels. Examples of adjustments which could be applied in cases such as this include those which normalize for differences in

expected costs between the two geographic areas due to provider discounts and provider practice patterns.

**Opinion:** We believe it is reasonable to use the combined Virginia and District data as the base experience upon which the rate development is based given the lack of credibility of the District experience. It seems plausible that no area adjustment is needed; however, without additional claims or provider contracting information, we are not able to opine on the reasonability of this assumption.

### Allowed Claims Trend

Aetna assumed an annual allowed claim trend rate of 15.1% for ALIC and 11.4% for AHI in the development of the proposed rates. These assumptions represent a combined trend rate for both medical and pharmacy claims. The following table summarizes the components of the trend rates for each legal entity:

**Components of Trend Assumptions**

| | ALIC | AHI |
|---|---|---|
| Unit Cost | 5.4% | 5.4% |
| Utilization | 3.5% | 3.5% |
| Benefit Changes Utilization | 5.5% | 2.1% |
| **Total** | **15.1%** | **11.4%** |

The filing did not include detailed claims data; therefore, we were unable to independently estimate Aetna's historical unit cost and utilization trends. Based on additional information provided by Aetna, we believe a 7.5% trend assumption is supportable, not the 9.1% used. We note that Aetna's trends are significantly higher than those in all the other carriers' filings.

The Benefit Changes Utilization component of trend is intended to reflect changes in induced demand that occurs when cost sharing levels are changed. All else equal, members utilize more services if there is less out of pocket expense associated with those services. Aetna indicated they needed to add amounts to the trend to reflect higher expected benefit levels (i.e., lower member cost sharing amounts) as measured by paid to allowed ratios in the projection period than was underlying the base period experience. However, data subsequently provided by Aetna did not support this assertion.

We estimated an annualized percent change of -0.5% for ALIC and -3.2% for AHI, which compare to Aetna assumptions of 5.5% and 2.1%, respectively. The impact of this difference in annual assumptions gets compounded over two years from the base period to projection period.

**Opinion:** We requested the Company's actual experience on a monthly basis be provided to perform our own independent calculation of the historical trend as a reasonableness check on the proposed trend assumption; however, this actual experience was not provided to us. Although we were not able to perform an independent analysis of Aetna's historical observed trends, based on the summary data provided by Aetna, it is our belief that ALIC's annual allowed claims trend of 9.1% for cost and utilization could be overstated by about 1.6% annually.

In addition, Aetna's benefit changes utilization assumptions are not supported by the data provided by Aetna in the filings. We estimate the annual benefit changes utilization trends are overstated by 6.0% for ALIC and 5.3% for AHI.

Given that the underlying claims estimates are being projected over a 24 month period, from the midpoint of the base period to the midpoint of the rating period, and taking into consideration that some administrative expenses are fixed amounts that would not be reduced by this amount, this potential overstatement of annual trends could result in an overstatement of rates of about 12.7% for ALIC and 11.9% for AHI.

### Network Re-Contracting Adjustment

The stated intent of this adjustment is to reflect the impact of changes in network contracts between the historical experience and the products/network that will be offered in 2015 in the Individual market. This adjustment was equal to 0.963 and only applies to the ALIC filing for the Individual market. Numeric support for the adjustment was not provided in the filing.

**Opinion:** We are unable to opine on the reasonableness of this assumption.

### Future Population Morbidity Changes

The future population morbidity adjustment applied is made up of two components:

- An adjustment to reflect the impact on projected morbidity due to the removal of underwriting for the individual and small group markets.
- An adjustment to reflect the impact of pent up demand for newly covered individuals in the individual market.

Some support was provided for the assumptions, but contained hard coded values from an internal Aetna model so we were unable to observe the underlying assumptions that led to the values applied in the rating.

**Opinion:** We requested additional justification with respect to Aetna's morbidity adjustments, however, responses were not provided in a detailed manner in which to understand the underlying assumptions. We are unable to opine on the reasonableness of the assumptions.

### Essential Health Benefits

The Company has increased its rates to reflect the addition of benefits required to be provided as part of the EHB package in 2015 that were not covered in the base period. For both ALIC and AHI, this adjustment was equal to 1.012.

**Opinion:** While the direction of this change is appropriate, we are unable to determine whether the magnitude is reasonable.

### Demographic Change

In projecting the 2013 experience to 2015, Aetna included a demographic adjustment. The demographic factor is based on the true estimated cost difference by age and gender. Aetna used

an internally developed age and gender cost curve to determine the impact of projected demographic changes, not the standard District age curve that is used in determining the premium rate differential. Aetna provided the projected distribution and factors used in the calculation.

**Opinion:** We received demographic data provided by you for recent 2014 exchange enrollment; however, Aetna's enrollment is very low and therefore may not fully represent the expected distribution of its population in the future. Analysis of the data for AHI was not possible due to the extremely low volume of enrollees. For ALIC, current enrollment is younger, on average, than Aetna's projection. If enrollment continues to emerge similarly, the demographic factor for ALIC may be overstated. Much of the change in demographics has no impact on rates as a result of calibrating the rates to the standard age curve in a later step in the rate development. However, to the extent Aetna is projecting more 55-64 year olds for example, where the standard age curve does not fully compensate for the expected cost in the calibration step, it could result in conservative rates.

## Risk Adjustment

Aetna assumed the manual rate represents market average risk. The risk adjustment factor applied to the index rate approximates the risk adjustment user fee. No additional support was provided showing that the manual rate reflects market average risk.

**Opinion:** The adjustment is consistent with the assumption that the manual rate represents market average risk. We are unable to opine on whether the manual rate reflects a market average level of risk.

## Transitional Reinsurance Recoveries

A transitional reinsurance program will be in effect in the individual market for the years 2014-2016. Aetna has assumed an adjustment equal to 0.941 for its individual rates to reflect anticipated recoveries in 2015 due to the transitional reinsurance program, net of contributions. In developing this adjustment, Aetna utilized an internal model based on small group claims data, trended to 2015 and adjusted to the average benefits anticipated in the District's individual market. The estimated recoveries were based on as assumed attachment point of $70,000. While this is the attachment point currently in place for 2015, CCIIO has indicated its intent to reduce it to $45,000.

We note that, appropriately, no adjustment was made for recoveries in developing the small group rates as the transitional reinsurance program does not apply to the small group market. The small group filings include a factor of 1.015 for AHI and 1.011 for ALIC for the reinsurance contributions.

**Opinion:** We note that Aetna's projected net recoveries as a PMPM in the individual market are similar to assumptions used by both Kaiser and GHMSI, and significantly exceed the assumption of Blue Choice. While we do not agree with all of Aetna's assumptions in developing the reinsurance estimate, the resulting value is within a range that we would consider reasonable.

If the attachment point is reduced from $70,000 to $45,000, actual recoveries would be expected to be greater than those assumed by Aetna.

The small group factors result in amounts consistent with the 2015 reinsurance contribution amount of $3.67 PMPM and are therefore reasonable.

## DC Health Link User Fee

Aetna included a user fee for the exchange in the individual filing only. The assumed fee is 0.7% of premium. The premium tax amount assumed includes exchange user fees. Therefore, this 0.7% charge is double counted.

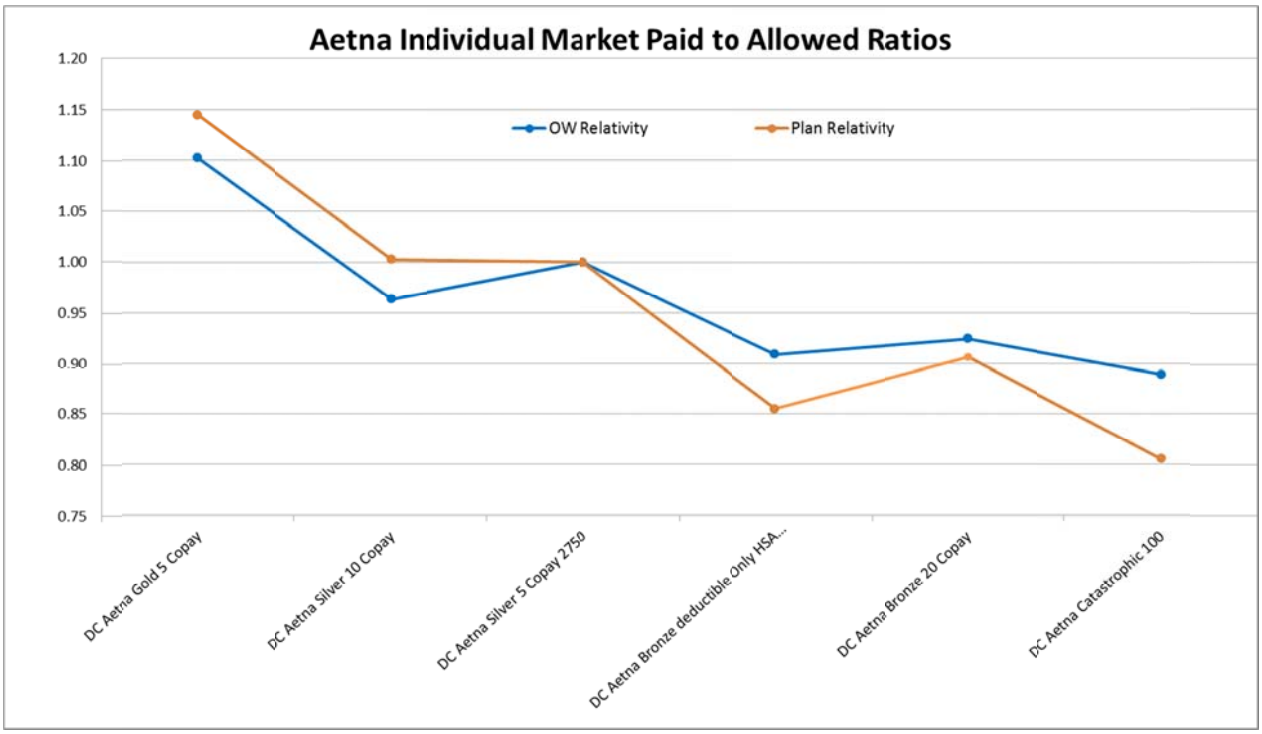
**Opinion:** The small group filings do not include an exchange user fee. The assumed individual market user fee of 0.7% of premium should not have been charged, since the correct exchange fee amount is already included in the plan level non-benefit expenses. Since the District's exchange fee is applied as a broad based tax rather than as a user fee, we believe the plan level administrative adjustment is the more appropriate placement of this tax.

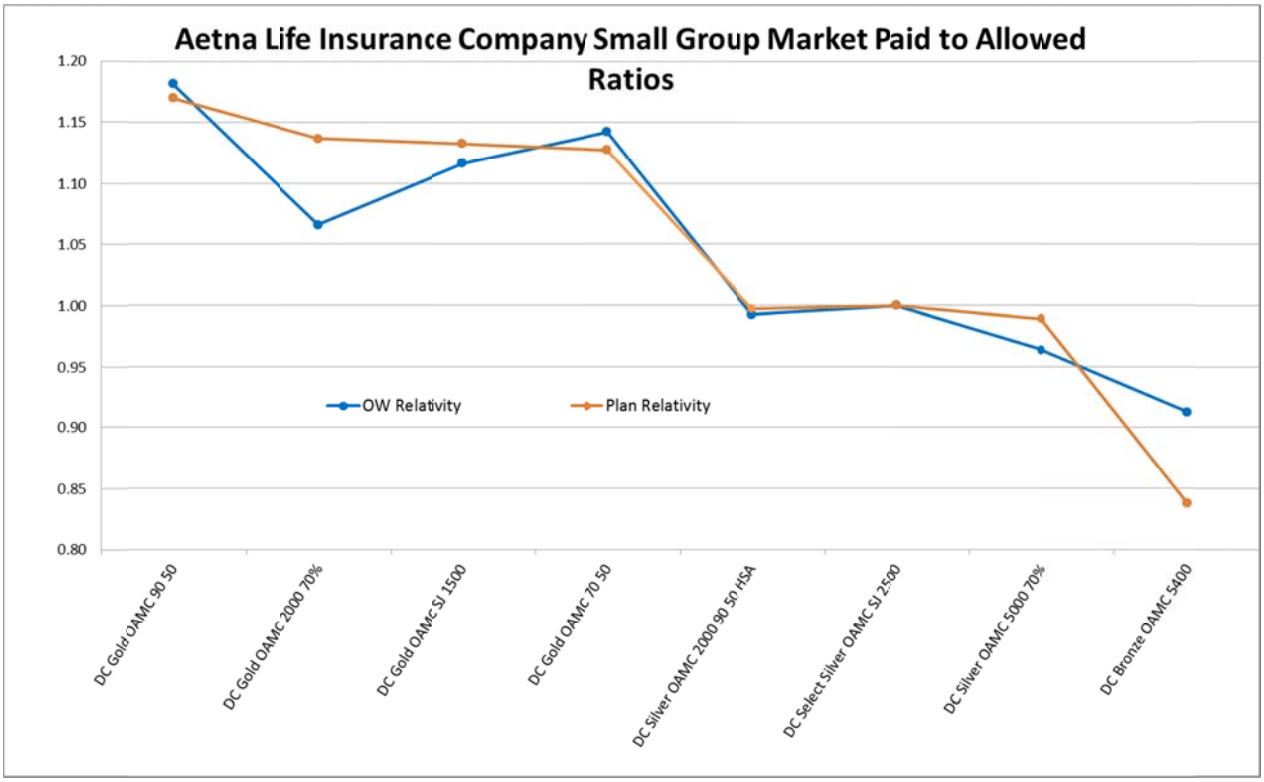
## Pricing Actuarial Values

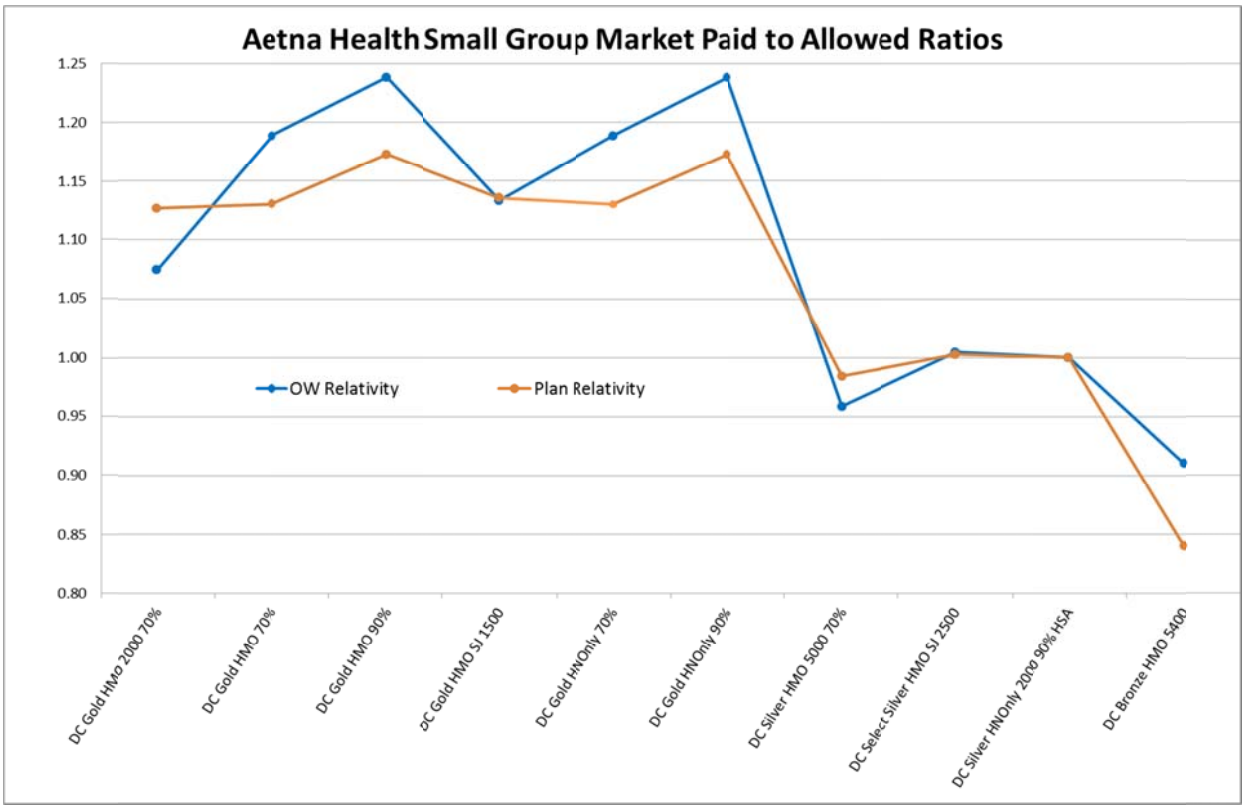
Aetna has presented their calculated cost sharing factors in the rate filing, for each proposed plan design. These come from Aetna's internal pricing model. A second factor, a "Utilization Adjustment" is also applied to reflect induced demand related to differences in cost sharing.

Using Oliver Wyman's (OW's) proprietary pricing model, we independently calculated paid-to-allowed ratios for each of the ALIC and AHI plans. We calibrated the model to reflect an overall projected allowed cost consistent with Aetna's projected allowed cost levels prior to calculating the factors. However, the results in this section should be used with caution. While we utilized the benefit summaries in the filings, given the data limitations and the fact that we did not receive detailed benefit plans, there is the potential that not all aspects of the benefit plans were fully considered.

We compared these results to Aetna's plan factors for each plan by calibrating both sets of factors to be relative to a single reference plan. A summary of our results is provided in the charts which follow:


Aetna Individual Market Paid to Allowed Ratios
1.20
1.15
1.10
1.05
1.00
0.95
0.90
0.85
0.80
0.75
OW Relativity
Plan Relativity
DC Aetna Gold 5 Copay
DC Aetna Silver 10 Copay
DC Aetna Silver 5 Copay 2750
DC Aetna Bronze deductible Only HSA...
DC Aetna Bronze 20 Copay
DC Aetna Catastrophic 100


Aetna Life Insurance Company Small Group Market Paid to Allowed Ratios
1.20
1.15
1.10
1.05
1.00
0.95
0.90
0.85
0.80
OW Relativity
Plan Relativity
DC Gold OAMC 90 50
DC Gold OAMC 2000 70%
DC Gold OAMC SJ 1500
DC Gold OAMC 70 50
DC Silver OAMC 2000 90 50 HSA
DC Select Silver OAMC SJ 2500
DC Silver OAMC 5000 70%
DC Bronze OAMC 5400




As can be seen from the charts above, the Aetna relativities track relatively closely to the relativities that we calculated.

In reviewing the utilization adjustments, there were some relativities between plans that we believe may not be reasonable. As an example, there are two Gold plans in the AHI filing with Cost Sharing factors of 0.813 and 0.790. These plans were assigned Utilization Adjustments of 1.098 and 0.953, respectively. We do not understand why there would be a roughly 15% difference in utilization on plans that have paid to allowed ratios that vary by only 3%. Any anomalies in the utilization factors do not affect the rates in aggregate, but would affect how the rates of the various plans relate to each other.

**Opinion:** We find Aetna's paid to allowed ratios to be within a reasonable range. However, some utilization adjustments do not appear reasonable.

## Age Factors

The Company provided the age factors being used in developing the proposed rates. We compared the proposed factors with the standard District age factor curve. The curves were identical for all ages.

**Opinion:** The proposed age factor slope is consistent with the standard District age factor slope at all ages.

## Non-Benefit Expenses

The Company has assumed a non-benefit expense portion of premium equal to 21.36% for ALIC Individual, 22.51% for ALIC Small Group, and 24.82% for AHI, consisting of the following components:

**Non-Benefit Expenses**

| | ALIC Individual | ALIC Small Group | AHI |
|---|---|---|---|
| Taxes and Fees | 8.62% | 7.89% | 6.70% |
| Commissions | 0.96% | 4.02% | 5.34% |
| General Administrative Expenses | 8.78% | 6.70% | 8.88% |
| Risk Charge | 3.00% | 3.90% | 3.90% |
| **Total** | **21.36%** | **22.51%** | **24.82%** |

The premium tax amounts varied in each of the filings. Aetna included 3.25% in the Individual ALIC filing, 2.75% in the Small Group ALIC filing, and 1.55% in the AHI filing. Based on known tax amounts and information provided by Aetna, we believe the correct value is 3.25% for all three filings. The Individual ALIC filing would appear to be correct, except that ALIC included a separate exchange user fee of 0.7%, therefore this additional 0.7% is double counted. There were no separate exchange user fees in either of the small group filings; therefore, the ALIC small group filing reflected taxes and fees 0.5% too low, and the AHI filing included taxes and fees 1.7% too low.

We have compared the non-benefit expense amounts to the similar amounts shown in the prior year filing. Those amounts were:

**Non-Benefit Expenses – 2014 Filing**

| | ALIC (Individual & Small Group) | AHI |
|---|---|---|
| Taxes and Fees | 4.90% | 5.00% |
| Commissions | 4.13% | 5.92% |
| General Administrative Expenses | 11.08% | 6.28% |
| Risk Charge | 4.00% | 4.00% |
| **Total** | **24.11%** | **21.20%** |

The AHI general administrative expense increased significantly. We compared the proposed amount to the 2013 Supplemental Health Care Exhibit. It showed general administrative expenses of 10.0% of premium, which is greater than the proposed charge. All three filings demonstrated projected federal MLRs in excess of 80%.

**Opinion:** Aetna overstated taxes and fees by 0.7% in the Individual ALIC filing. Aetna understated taxes and fees by 0.5% in the Small Group ALIC filing and by 1.7% in the AHI filing. While AHI significantly increased its charge for general administrative expenses, it is now more in line with their actual experience, and given the understatement in taxes and fees we find the expenses charge in aggregate to be reasonable.

## Calibration to 1.0 on District Age Curve

In adjusting the calculated 2015 plan adjusted index rates to consumer level premiums, one of the adjustments applied was to normalize the projected claim cost to reflect that of an individual at a 1.00 factor on the District age curve. For ALIC, this adjustment was equal to 0.808, and for AHI, this adjustment was equal to 0.961. These amounts are equal to the reciprocal of the weighted average District age factor, with the weighting based on projected enrollment by age.

**Opinion:** For ALIC, the adjustment to normalize the index rate to reflect that of an individual at a 1.00 factor on the District age curve was equal to 0.808, and for AHI, the adjustment was equal to 0.961. Aetna's 2014 enrollment is too premature to rely on it for projecting enrollment. Therefore, we cannot opine on the projected distribution of enrollment, but we can opine that the process of calculating the age calibration was reasonable.

## Conclusion

As previously noted, our review was limited to the information included in the filing provided by Aetna, and responses which in some cases did not provide the level of support requested. Had additional information been provided our opinions noted herein may have differed. Also, please note that since the proposed rates are an estimate of future contingent events, the actual results may vary.

I am a member of the American Academy of Actuaries and meet all of its requirements to render the opinions provided in the letter. I have utilized generally accepted actuarial methodology in reaching these opinions.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Dianna K. Welch, FSA, MAAA
Principal and Consulting Actuary

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# Appendix A
# Effective Rate Review

Effective Rate Review Requirements of 45 CFR 154.301

1. Medical trend changes by major service category;
2. Utilization changes by major service category;
3. The impact of cost sharing changes by major service categories, including actuarial values;
4. The impact of benefit changes, including essential health benefits and non-essential health benefits;
5. The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under Section 2701 of the PHSA;
6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative expenses;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical loss ratio;
12. Capital and surplus;
13. The impact of geographic factors and variations;
14. The impact of changes within a single risk pool to all products or plans within the risk pool; and
15. The impact of reinsurance and risk adjustment payments and charges under Sections 1341 and 1343 of the Affordable Care Act.

Additional District Specific Considerations:

1. Carriers operating in both the individual and small group markets must utilize the pooled experience from both markets in calculating their index rate;
2. Carriers must use the District specific standardized age curve;
3. Carriers may not rate by geography; and
4. Carriers may not rate by tobacco use status.

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# Appendix B
# Summary of Proposed and Alternate Assumptions

| | Aetna Life Insurance Company - Individual | | | Aetna Life Insurance Company - Small Group | | | Aetna Health Inc. - Small Group | | |
|---|---|---|---|---|---|---|---|---|---|
| | Filing | Oliver Wyman Review | Potential Rate Impact | Filing | Oliver Wyman Review | Potential Rate Impact | Filing | Oliver Wyman Review | Potential Rate Impact |
| **IMPACT ON ALL PLANS** | | | | | | | | | |
| Allowed Cost PMPM | | N/A | N/A | | N/A | N/A | | N/A | N/A |
| Allowed Claims Trend (Cost and Utilization) | 9.1% | 7% to 8% | -2.7% | 9.1% | 7% to 8% | -2.7% | 9.1% | 7% to 8% | -2.7% |
| Benefit Change Utilization Trend | 5.5% | -0.5% | -10.0% | 5.5% | -0.5% | -10.3% | 2.1% | -3.2% | -9.3% |
| Network Recontracting Adjustment | -3.7% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Population Morbidity Changes | confidential | N/A | N/A | confidential | N/A | N/A | confidential | N/A | N/A |
| EHB Adjustment | 1.2% | N/A | N/A | 1.2% | N/A | N/A | 1.2% | N/A | N/A |
| Demographic Change | confidential | possibly high | likely down | confidential | possibly high | likely down | confidential | N/A | N/A |
| Risk Adjustment | 0.0% | N/A | N/A | 0.0% | N/A | N/A | 0.0% | N/A | N/A |
| Transitional Reinsurance | -5.9% | N/A | N/A | 1.1% | N/A | N/A | 1.5% | N/A | N/A |
| DC HealthLink User Fee | 0.7% | 0.0% | -0.7% | N/A | N/A | N/A | N/A | N/A | N/A |
| Pricing Actuarial Values | varies | N/A | N/A | varies | N/A | N/A | varies | N/A | N/A |
| Premium Taxes | 3.25% | 3.25% | N/A | 2.75% | 3.25% | 0.5% | 1.55% | 3.25% | 1.7% |
| Other Non-Benefit Expenses | 18.11% | N/A | N/A | 19.76% | N/A | N/A | 23.27% | N/A | N/A |
| Age Normalization to 1.0 on District Age Curve | -19.2% | N/A | N/A | -19.2% | N/A | N/A | -3.9% | N/A | N/A |
| **IMPACT ON SPECIFIC PLANS** | | | | | | | | | |
| Plan Factors | ALIC plan utilization factors do not always appear consistent with the estimated paid to allowed ratios of the plans. | | N/A | ALIC plan utilization factors do not always appear consistent with the estimated paid to allowed ratios of the plans. | | N/A | AHI plan utilization factors do not always appear consistent with the estimated paid to allowed ratios of the plans. | | N/A |

MARSH & McLENNAN COMPANIES