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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 UnitedHealthcare's January 2015 Small Group Rate Filings (UHLC-129586288, UHLC-129589647, and UHLC-129589692)

Dear Executive Director Kofman:

At your request, we have undertaken a review of the three above captioned filings submitted by UnitedHealthcare Insurance Company (UHIC), Optimum Choice, Inc. (Optimum), and UnitedHealthcare of the Mid-Atlantic, Inc. (UHCMA) for products that are proposed to be offered in the small group market in the District of Columbia (the District) effective January 1, 2015. These entities are part of UnitedHealthcare (United). Our work was intended to be independent, but to also 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 United's initial proposed and final proposed rates are considered to represent publicly available information, and that all correspondence between DISB and United 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 United 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 at 45 CFR 154.301, to the extent the necessary information was available to us. The list of items required in an effective rate review program 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 have developed in working with our various state clients.

Summary of Analysis Performed

Using the information in the filing, and notwithstanding the limitations that follow, it is our opinion that the final proposed first quarter 2015 (2015Q1) rates for UHIC, Optimum, and UHCMA could be reduced by 1.4%, 1.5%, and 0.9%, respectively, primarily due to trends being overstated. Additionally, subsequent rates for 2015Q2, 2015Q3, and 2015Q4 are overstated by an additional 0.3%, 0.6%, and 0.9%, respectively, beyond the reductions noted above from the 2015Q1 rates. These rate reductions are in addition to the rate reductions United has already made throughout the rate review process.

Relative to the initial submissions of the filings, United has reduced rates for the UHIC and Optimum filings by a total of 5.2% as a result of removing a 0.3% load applied to the ACA insurer fee, reducing federal income taxes and reducing profit margins.

Our findings should be used with caution, as we were unable to obtain all of the desired information from United. A table summarizing the key areas where errors were made or assumptions were not supported, along with alternate assumptions, can be found in Appendix B.

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 three filings from SERFF. We completed a high-level initial review on June 20, 2014 at which time we forwarded a set of four questions to DISB for consideration. These questions were related to benefit plan information, historical claims and membership information, and inconsistencies between the URRT and support associated with the rate development. We received responses to these questions on August 12, 2014.

On June 30, 2014, a second, more detailed round of questions was sent to DISB for consideration. These questions employed our standard effective rate review checklist and reflected a more in-depth review of each of the filings. These questions ranged from requests for clarification of information provided in the filings to requests for information to support or test key assumptions made in the filings. We received responses to these questions on August 4, 2014. However, many of the responses required additional information, resulting in another round of questions being sent to DISB for consideration on August 12, 2014. On August 27, 2014, we received responses to these questions along with a revised set of filings.

It should be noted that the revised rate filings submitted on August 27, 2014 included unexpected changes to the rate development. While these changes did not have a material impact on rates, United did not provide sufficient information for us to be able to understand the rationale for the changes, nor was there sufficient time for us to send additional questions to DISB for consideration. As a result, we were not able to complete an in-depth review of some of the 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 United. United submitted their final rate filings on September 8, 2014.

Our analysis was limited to the information included in the initial and revised filings and United's responses. If additional information or clarification were to be provided, the results of our analysis 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 United'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 United's UHIC, Optimum, and UHCMA legal entities.

Index Rate Development

According to 45 CFR 156.80(d), the index rate is to reflect the average expected allowed cost for essential health benefits (EHBs) during the projection period. In developing the index rate, several adjustments must be made to the base period experience to reflect differences between the population, provider costs and benefits underlying the current single risk pool and those expected in the projection period. These adjustments 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.

Rating Methodology

The 2015 small group rates for the three United entities were developed using the combined experience of UHIC and Optimum for claims incurred in 2013. This experience data represents allowed claims for small group members in the District. United is filing rates in the small group market for the first time under UHCMA. United does not market products in the individual market.

According to 45 CFR 156.80(d), the index rate is to reflect the average expected allowed cost for EHBs during the projection period for each legal entity. The experience of UHIC and Optimum was combined in the rate development because the experience data underlying the two entities utilizes the same provider networks and the same covered services.

The claims experience was adjusted for several items to arrive at an estimate of the index rate for 2015. These adjustments are summarized below:

Adjustments Applied to Claims Experience

Adjustment	Component
17.2%	Trend
1.6%	Essential Health Benefits
0.5%	Market Adjustment
19.3%	**Total**

The index rate was then adjusted for market-level items (i.e., transitional reinsurance, risk adjustment, and exchange user fees). These adjustments, summarized below, were applied evenly to each plan as a percent of the index rate.

Market-Level Adjustments Applied to the Index Rate

Adjustment	Component
0.7%	Transitional Reinsurance
1.2%	Risk Adjustment
1.0%	Exchange User Fees
2.9%	**Total**

After adjusting for market-level items, plan level adjustments were applied to account for the cost-sharing provisions of each plan, differences in provider networks, care management and utilization, and non-benefit expenses.

HMO plans will be offered under Optimum and UHCMA. EPO and POS plans will be offered under UHIC. It is difficult to assess the appropriateness of using the combined experience of UHIC and Optimum since care management varies by HMO. It is possible that each entity may attract a different risk profile as POS plans offer broader access to providers than HMO plans.

Based on the URRTs from the final version of the filings, the level of capitated services in the projected manual rate was reduced for all three entities to $0.41 PMPM. However, sufficient information was not provided to determine the reasonableness of the change. .

Opinion: For the most part, United has followed the general format of the required rating methodology of 45 CFR 156.80. There are some slight inconsistencies; however, we believe the overall rates would be very similar to the current proposed rates had the appropriate methodology been used. Additionally, we do not believe United has provided enough information to determine the reasonableness of the capitation amounts used in the index rate. It is unclear how rates would be impacted by updating the index rates for the items noted above.

It is difficult to assess the appropriateness of using the combined experience of UHIC and Optimum to develop the 2015 rates as each entity may attract a different risk profile based on the type of plans marketed (i.e., HMO, POS, and EPO).

Essential Health Benefits

United has adjusted the experience data underlying the manual rate by 1.6% to reflect the addition of benefits required to be provided to comply with the EHB package. United indicated the following benefits were added:

- Pediatric dental and vision
- Mental health parity
- Habilitative services and applied behavior analysis
- Temporomandibular joint (TMJ) disorder
- DME and prosthetics: from $2,500 limit to unlimited
- Physical therapy: from 20 visits to unlimited
- Occupational therapy: from 20 visits to unlimited
- Speech therapy: from 20 visits to unlimited
- Pulmonary rehabilitation: from 20 visits to unlimited
- Office spinal manipulation: from 20 visits to unlimited
- Home health service: from 60 visits to 90 visits

While the direction of the adjustments is appropriate, United has not provided sufficient detail to determine whether some benefits are included in the experience period. For example, at a high level, the estimated impact of adding pediatric dental and vision services does not appear to be sufficient. However, it is possible that some pediatric dental and vision services were covered in 2013, and the adjustment provided by United could represent the impact of the additional benefits that will be covered in 2015.

Opinion: United has adjusted the experience data underlying the manual rate by 1.6% to reflect the addition of benefits required to be provided to comply with the EHB package. Given the lack of detail provided by United, it is difficult to assess the appropriateness of the adjustments. For example, the adjustment for pediatric dental and vision does not appear to be sufficient to cover the additional cost for offering these services. However, we do not know whether the experience data includes any pediatric dental and vision benefits.

Trend

An annual trend rate of 7.9% was assumed in the development of the proposed rates. The table below provides a breakdown of the various trend components:

Components of Trend Assumptions

Component	Medical	Pharmacy	Total
Utilization/Service Mix	1.6%	5.8%	2.2%
Unit Cost	4.7%	4.8%	4.7%
Benefit Leveraging	0.6%	1.8%	0.8%
Total	**7.0%**	**12.8%**	**7.9%**

The trend estimates developed by United are based on recent and emerging experience and reflect anticipated changes in provider contracts and mix of services. Historical trends are

normalized to remove the impact of certain items, such as changes in demographic mix and changes in benefits levels. We believe the assumed increased in pharmacy utilization is overstated. The utilization estimate for 2015 appears to double-count the increase in utilization that is forecasted to occur in 2014. We believe it may be more appropriate to use an annualized utilization/service mix trend of 3.2% instead of 5.8%.

The trend assumption also includes a component for benefit leveraging, which is not appropriate since allowed claims are being trended forward to the projection period.

It should be noted that the membership associated with the paid claims data provided by United does not appear to be consistent with the information reported in Exhibit A of the filings. However, we believe the data shown in Exhibit A of the filings is incorrect.

Opinion: United has stated that an annualized trend rate of 7.9% was assumed in trending the experience from the base period to the projection period.

In our opinion, an annualized trend assumption of 6.7% may be more appropriate given the level of information provided by United. We believe United has overstated the utilization/service mix component of the pharmacy trend. We also believe it is inappropriate to include a component for benefit leveraging since the trend factor applies to allowed claims. When reducing the utilization component of the pharmacy trend from 5.8% to 3.2% and removing the benefit leveraging component from pharmacy and medical trends, the overall trend reduces from 7.9% to 6.7%. The table below summarizes the recommended trend assumption.

Recommended Trend Assumptions

Component	Medical	Pharmacy	Total
Utilization/Service Mix	1.6%	3.2%	1.9%
Unit Cost	4.7%	4.8%	4.7%
Benefit Leveraging	0.0%	0.0%	0.0%
Total	**6.4%**	**8.2%**	**6.7%**

Prospective Quarterly Trend

United is proposing to increase rates quarterly at an annual rate of 7.9%. The following quarterly trend increases are noted in the Actuarial Memorandum:

United's Proposed Quarterly Trend Increases

Quarter	Increase from Prior Quarter
Q2 2015	1.9%
Q3 2015	2.0%
Q4 2015	1.9%

The trend assumptions noted in the Actuarial Memorandum would not appear to produce a consistent annualized trend rate for each quarter. However, despite the language in the

Actuarial Memorandum, the index rate development by quarter demonstrates that the trend factors are based on a consistent annualized trend assumption (e.g., 7.9%).

We believe the quarterly trend factors should be consistent with the trend factor noted in the Trend section above. As a result, we believe the quarterly trend factors should also be developed using an annualized trend rate of 6.7%, which is consistent with our independent trend estimate.

Opinion: United is proposing to increase rates quarterly using an annualized trend rate of 7.9%. However, we believe the quarterly trend factors should be developed using an annualized trend rate of 6.7% in order to be consistent with the trend rate recommended in the Trend section.

Market Risk Adjustments

United applied an adjustment of 0.5% to account for an expected increase in the average morbidity of the small group market.

In 2014, the rating structure in the District became more restrictive, as several provisions of the ACA were implemented (e.g., rates prohibited from varying except for differences in benefit design/care delivery and age). As groups move to the revised rating structure, some groups will experience rate increases while others will realize decreases. The “rate shock” associated with the new rating structure may result in an overall increase in claim costs as groups adversely impacted by the new rating structure may choose to drop coverage. Based on a review of additional information provided, we believe the assumption used by United is reasonable.

Opinion: United increased the paid-to-allowed ratios by 0.5% to reflect an anticipated increase in the morbidity of the small group market for 2015 relative to 2013. We believe the 0.5% adjustment is appropriate.

Induced Utilization Adjustment

Induced utilization can occur when cost-sharing elements of a plan affect utilization behavior. For example, it generally is assumed that individuals in plans with lower cost-sharing requirements will use more services, even after controlling for differences in health status. The index rate has not been adjusted to reflect an induced utilization component. The paid-to-allowed ratios for the projection period as shown in the URRTs suggest that United expects the average paid-to-allowed ratio in the projection period to be significantly lower than the paid-to-allowed ratio underlying the base experience. We would have expected United to adjust the index rate to reflect the average allowed claims associated with the projected paid-to-allowed ratio, with each plan subsequently being adjusted for induced utilization relative to the average projected benefit level. However, while an adjustment has not been made to the index rate for induced utilization, additional information provided by United shows that the rates reflect an adjustment for induced utilization.

Opinion: United did not apply an adjustment in developing the index rate to account for anticipated changes utilization as a result of changes in average benefit levels relative to the

base period. However, based on additional information provided by United, the final rates reflect an adjustment for induced utilization, so the net impact should be negligible.

Projected Membership

The following table compares 2013 member months to projected 2015 member months as reported in the Unified Rate Review Template (URRT).

Comparison of Reported 2013 to 2015 Projected Member Months

	UHIC	Optimum	UHCMA
2013 Actual	106,112	21,183	-
2015 Projected	106,140	21,200	2,800

The tables above show that United is projecting a slight increase in membership across all three entities relative to 2013 enrollment. UHCMA is offering products in the District's small group market for the first time in 2015.

Given that a rate decrease of approximately 7.7% was approved effective July 1, 2014 for UHIC and Optimum, and that United's final rate filings for these entities reflect another rate decrease of approximately 10.4% relative to December 2014 rates, it is not unreasonable to expect an increase in enrollment for 2015.

It should be noted that plans marketed under UHCMA will utilize a narrow network. We believe it is reasonable to expect low enrollment in a narrow network product for the small group market relative to a broad network product despite any differences in rates.

Opinion: United has projected an overall increase in enrollment relative to 2013 membership. DISB previously approved a rate decrease of 7.7% effective July 1, 2014, and United is filing for a further decrease of 10.4% effective January 1, 2015, relative to December 2014 rates. Given this information, we believe it is reasonable to expect an increase in membership relative to 2013 levels. We also find it reasonable that United does not expect to enroll a significant number of members under UHCMA since the products sold under UHCMA will feature a narrow network.

Risk Adjustment

The ACA establishes a risk adjustment program intended to transfer funds from carriers that attract lower than average risk to carriers that attract higher than average risk within the same state and market. 45 CFR 156.80(d) states that the index rate must be adjusted on a marketwide basis based on the total expected market-wide payments and charges under the risk adjustment program." The intent of this requirement is that carriers who anticipate receiving money from other carriers under the risk transfer program reflect these payments in their rate development, leading to lower premiums due to the fact that the payments from other carriers will cover a portion of the anticipated claims cost. The same is true for carriers anticipated to make payments to other carriers in that they must collect additional premium to cover the cost of

the anticipated payments, and these additional costs are to be recognized in the premium development. This allows the premiums charged by all carriers to reflect a risk closer to the market average and does not disadvantage carriers that attract a higher than average risk profile.

United has assumed it will be a net payer into the risk adjustment program and has reflected this by increasing the projected index rate by 1.2%. United indicated that the 1.2% risk adjustment assumption was based on an analysis completed in conjunction with Wakely Consulting Group (Wakely), based on the small employer market in the District using diagnostic and demographic information from calendar year 2013. Additional information provided by the Company revealed that the risk adjustment assumption used by the carrier was not the direct result from the study. However, support for the risk adjustment assumption used in pricing was not provided.

It should be noted that United has developed premium estimates using the combined experience of UHIC and Optimum. The assumed risk adjustment liability applied to this experience is based on the aggregate risk transfer liability across both entities, which is appropriate for the given rate development. It should be noted that actual risk adjustment payments for 2015 will be determined separately for each legal entity. Given this, it would appear as though United does not expect a significant difference in the risk profiles of each legal entity, which may not be appropriate.

Opinion: United has assumed it will be a net payer into the risk adjustment program of approximately 1.2% of premium. An analysis of diagnostic and demographic information for all carriers in the District's small group market was performed by Wakely. United adjusted the results from the analysis performed by Wakely in determining that the Company would be a net payer into the risk adjustment program. However, we do not believe United provided sufficient information to justify an adjustment to the estimate produced by the Wakely analysis. As a result, we believe it may be more appropriate to assume a risk transfer liability equal to the results of the Wakely study. Additionally, United expects each entity to have similar risk profiles, which may not be appropriate.

Transitional Reinsurance

A transitional reinsurance program will be in effect in the individual market for the years 2014-2016. Since all three filings are for the small group market, an anticipated recovery under the transitional reinsurance program was not included, which is appropriate. United did include a $3.67 PMPM charge for the assessment that will be made against membership in the small group market. United has stated that the transitional reinsurance assessment represents approximately 0.7% of premium. However, the Part III Actuarial Memorandum and Certification Instructions require carriers to reflect anticipated recoveries from the transitional reinsurance programs, net of any assessments, as a market-wide adjustment to the index rate. This adjustment should be grossed up for the projected paid-to-allowed ratio so that after the application of the paid-to-allowed ratios in a later step of the calculation, the average anticipated recoveries, net of any assessments, are realized. Based on the information provided by United, the index rate was increased 0.7% to account for the transitional reinsurance fee. However, we estimate that the index rate should have been increased between 1.3% and 1.9%, depending

on the entity, in order to realize the $3.67 necessary to cover the fee. This translates to increases in premium ranging from 0.6% to 1.2%.

Opinion: Consistent with the provisions of the transitional reinsurance program, an adjustment for anticipated reinsurance recoveries was not included as the recoveries are not applicable to the small group market. We do not believe United has applied the transitional reinsurance fee as a market wide adjustment in accordance with the 45 CFR 156.80(d). The correct application of the transitional reinsurance fee to the market adjusted index rate would have resulted in an increase in premium of between 0.6% and 1.2% to the index rate, depending on the entity, all else equal.

Benefit Plan Relativities – Plan Level Adjustments

Using Oliver Wyman's (OW's) proprietary pricing model, we independently calculated paid-to-allowed ratios (AVs) (consisting of both the paid-to-allowed factor and an induced utilization factor) for each of United's 116 benefit plan designs, Optimum's 50 benefit plan designs, and UHCMA's 28 benefit plans. We calibrated the model to reflect the overall projected allowed cost for all entities prior to calculating the factors. However, the results in this section should be used with caution. While we utilized the benefit summaries in the filing, we did not receive detailed benefit plan information, so there is the potential that not all aspects of the benefit plans were fully considered. As an example, if a benefit plan had both a prescription drug deductible and prescription drug copays, we have assumed that the deductible was applicable prior to the application of the copay, regardless of drug tier. It is possible the prescription drug deductible is only applicable to specific tiers. Additionally, the prescription drug tiers were not classified based on generic or brand status.

Notwithstanding these limitations, an analysis was conducted to perform a reasonableness check on the relative difference in the factors among plans. We ran each of the plans through OW's pricing model to develop our estimate of the paid-to-allowed ratios for each plan. The paid-to-allowed ratios developed by United include an adjustment for induced utilization. As such, we have included an adjustment for induced utilization that follows the HHS induced utilization assumptions underlying the risk adjustment transfer formula. The HHS induced utilization factors can be characterized using the following formula:

$$\text{Induced Utilization} = (\text{Paid to Allowed Ratio})^2 - \text{Paid to Allowed Ratio} + 1.24$$

Given the volume of plans that will be offered, we have not included a chart as it would be cumbersome to read. We compared these results to United's "Actuarial Value and Cost Share" values for each plan by calibrating both sets of factors to be relative to a selected reference plan. The proposed paid-to-allowed ratios for the non-HSA plans were relatively close to the OW factors, with differences ranging from -2% to +7%. However, the UHIC benefit factors appear to be based on a slightly flatter benefit slope than the OW factors. The average difference by metal tier for the non-HSA plans is shown in the following table.

Non-HSA Paid-to-Allowed Ratio Comparison

Plan	United AV	OW AV	Difference
Platinum	94.9%	94.3%	0.7%
Gold	80.0%	77.3%	2.7%
Silver	69.4%	63.2%	6.1%

Based on the results of this comparison, we find United's proposed paid-to-allowed ratios for the non-HSA plans to be within a reasonable range of the OW factors.

For the HSA plans which include non-embedded deductibles (i.e., family deductible without separate individual deductibles, or a family "umbrella" deductible as defined by the IRS) additional pricing work is required to adjust the paid-to-allowed ratios to reflect this plan feature. Given the volume of plans proposed to be offered by United, this additional analysis was outside the scope of our work. We compared United's proposed HSA paid-to-allowed ratios (which include a family umbrella deductible when there is more than one enrollee) to the OW factors for the same benefit plan, but with individual deductibles. The results are shown in the following table.

HSA Paid-to-Allowed Ratio Comparison

Plan	United AV	OW AV	Difference
Gold	74.8%	77.9%	-3.2%
Silver	62.3%	66.7%	-4.4%
Bronze	54.0%	56.0%	-2.1%

United's paid-to-allowed ratios for the HSA plans range from 1% higher to 6% lower than the OW paid-to-allowed ratios. On average, the paid-to-allowed ratios for HSA plans are 2% to 4% lower than the OW paid-to-allowed ratios. However, we would expect that United's factors would be lower, since the OW paid-to-allowed ratios are calculated assuming individual deductibles, equal to one half the family deductible, apply to each family member. Based on the results of this comparison, we find United's proposed paid-to-allowed ratios for the non-HSA plans to be within a reasonable range of the OW factors.

Additionally, the paid-to-allowed ratios have been adjusted to reflect differences in provider networks and care management. Plans marketed under UHCMA will reflect a narrow network of providers. As such, United expects the average discount for plans sold under the CORE network to be 4.5% lower than current contract rates and 7.4% lower than current contract rates for the Navigate network. While the Navigate network utilizes the same network as the CORE network, the Navigate network will include a gatekeeper primary care physician. United has based its estimate of the impact of the gatekeeper on a review of United's national experience and various independent industry studies. While we did not have the detail available to review the quantification of the discount differential, we believe the network and care management adjustments for UHCMA appropriately reflect the differentials calculated by United.

Opinion: We find the proposed paid-to-allowed ratios for the benefit plans to be reasonable. We also believe the network adjustments applied to the paid-to-allowed ratios are appropriately reflected in the UHCMA filings.

Age Factors

United provided their proposed age factors. These factors are consistent with the standard District age factors prescribed in the DC Carrier Reference Manual.

Opinion: The age factors proposed by United are consistent with the standard District age factors.

Non-Benefit Expenses

United has assumed the following non-benefit expenses, broken down into various components:

Component	UHIC	Optimum	UHCMA
General administrative	4.2%	4.2%	4.2%
Sales and marketing	0.5%	0.5%	0.5%
Commissions and broker fees	3.4%	3.4%	3.4%
Taxes, licenses and fees	5.9%	5.9%	5.9%
Quality improvement	1.1%	1.1%	1.1%
Federal income taxes	2.1%	2.1%	1.1%
Profit	4.0%	4.0%	2.0%
Total	**21.2%**	**21.2%**	**18.2%**

United indicated that these non-benefit expense amounts, with the exception of the addition of the ACA fees and Exchange User Fees, are equal to the actual 2013 average expenses for UHIC and Optimum. United expects these non-benefit expense levels to continue in the future. While no quantitative support was provided, in the table below we provide a comparison of the proposed non-benefit expense assumptions to the actual 2013 small group amounts from the Supplemental Health Care Exhibits (SHCEs) for UHIC and Optimum for several of the non-benefit expense categories.

Comparison of Non-Benefit Assumptions to 2013 Supplemental Health Care Exhibits

Component	Filing Assumption	2013 UHIC SHCE	2013 Optimum SHCE
General Administrative	4.2%	3.0%	4.4%
Sales and Marketing	0.5%	0.5%	0.5%
Commissions and Broker Fees	3.4%	3.5%	2.8%
Premium Taxes and Other Taxes, Licenses and Fees	5.9%	2.2%	1.9%
Quality Improvement and Fraud Detection	1.1%	1.1%	1.0%

Most of the non-benefit assumptions shown in the preceding table are consistent with the actual 2013 non-benefit expenses, as shown in the SHCEs. The only exception is the premium taxes, etc. The assumption for premium tax, etc. is almost 4% higher than the actual 2013 observed

amounts for UHIC and Optimum. United has indicated that they have added 3.7% to this category to account for the ACA insurer fee and the transitional reinsurance payment.

Additionally, we note that the complement of the total non-benefit expense assumption (i.e., the loss ratio), is projected to result in a MLR above the 80.0% minimum requirement for all three companies.

Opinion: We have verified that the other non-benefit assumptions are consistent with the actual amounts from the 2013 SHCEs, with adjustment for the new insurer fee and assessments for the transitional reinsurance program that will impact 2015. Additionally, we note that the complement of the total non-benefit expense assumption (i.e., the loss ratio) is projected to result in a MLR above the 80.0% minimum requirement. We are unable to determine the reasonableness of the federal income tax and profit assumptions.

ACA Fees (Insurer Fee + Transitional Reinsurance Assessment)

United has assumed a 3.7% increase for ACA fees – 3.0% for insurer fees and 0.7% for the transitional reinsurance assessment. In the initial submission of the filings, United had included a 3.3% increase for insurer fees. However, 0.3% of the 3.3% increase was to account for the impact of lower-than-expected premium market share in 2014. We did not believe such an adjustment was appropriate since United was proposing to overcharge small employer groups in 2015 in order to cover an expected shortfall in the funds that were to be collected for the 2014 insurer fee payment. In its final filing, United revised the rates to reflect a 3.0% adjustment to account for the ACA insurer fee. This adjustment was extracted from the Oliver Wyman report titled “Simulation of the Impact of the Annual Fees on Insurers Using 2011 Data,” dated September 3, 2013.

As noted earlier, United did not appropriately apply the transitional reinsurance assessment as a market-level adjustment. Based on the information provided by United, the index rate was increased 0.7% to account for the transitional reinsurance fee. However, we estimate that the index rate should have been increased between 1.3% and 1.9%, depending on the entity, in order to realize $3.67 on average to cover the fee.

Opinion: We find the revised 3.0% increase for insurer fees to be appropriate. The index rate was increased 0.7% to account for the transitional reinsurance assessment. However, a 0.7% adjustment to the index rate is not a sufficient adjustment to realize $3.67 after the application of the average paid-to-allowed ratio. We estimate that the index rate should have been increased between 1.3% and 1.9%, depending on the entity, in order to realize an average increase of $3.67 to paid claims to account for the transitional reinsurance assessment.

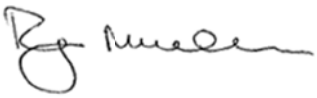
Conclusion

As previously noted, our review was limited to the information included in the initial and revised filings. While we developed a list of questions and requests for additional information, responses were not provided to some of these questions. Had this additional information been provided, our opinions noted herein may differ. 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,



Ryan Mueller, FSA, MAAA
Senior Consultant

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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.

OLIVER WYMAN

Appendix B
Questions Requested of Carrier

	Small Group								
	UHIC			Optimum Choice, Inc			UHC of the Mid-Atlantic		
	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									
Trend	7.9%	6.7%	-2.3%	7.9%	6.7%	-2.3%	7.9%	6.7%	-2.3%
Risk Adjustment	1.2%	1.4%	0.2%	1.2%	1.4%	0.2%	1.2%	1.4%	0.2%
Population Change (Demographics)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Population Change (Morbidity/Early Renewals)	0.5%	0.5%	0.0%	0.5%	0.5%	0.0%	0.5%	0.5%	0.0%
Transitional Reinsurance Recoveries (% Claims, Net of Fee)	0.7%	1.3%	0.6%	0.7%	1.5%	0.8%	0.7%	1.9%	1.2%
Induced Utilization - Base Period vs. Projection Period	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Induced Utilization - Index Rate vs. Market Level	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Exchange Fee	1.0%	1.0%	0.0%	1.0%	1.0%	0.0%	1.0%	1.0%	0.0%
Contribution to Surplus/Profit	4.0%	N/A	N/A	4.0%	N/A	N/A	2.0%	N/A	N/A
Admimistrative Expenses	9.2%	N/A	N/A	9.2%	N/A	N/A	9.2%	N/A	N/A
Network Differentials	EPO: -0.8% POS: 1.7% to 2.0%	N/A	N/A	-6.0% to -7.4%	N/A	N/A	CORE: -4.5% Navigate: -7.4%	CORE: -4.5% Navigate: -7.4%	N/A
ACA Insurer Fee	3.3%	3.0%	-0.3%	3.3%	3.0%	-0.3%	3.3%	3.0%	-0.3%
Pediatric Dental	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Catastrophic Plan Level Adjustment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A