Actuarial Memorandum

Health Net Life Insurance Company
Individual PPO Policy Filing
Covered California and Traditional Distribution Structures

Qualifications

I, David G. Hayes, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared on behalf of Health Net Life Insurance Company (the "Company") to comply with California Insurance Code section 10181.6 (b) (2). It may not be appropriate to use for other purposes.

I am affiliated with Milliman, Inc. ("Milliman") an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer or a trade association of health plans or insurers.

Scope

As a consulting actuary with Milliman, I have written this actuarial memorandum at the request of the Company to discuss the rate filing for its individual PPO policies sold through both Covered California and traditional distribution structures. The proposed rates included in this filing will be effective for new and existing policyholders enrolling or renewing from January 1, 2017 through December 31, 2017. Rates are guaranteed through calendar year 2017.

This statement of opinion complies with the Actuarial Standards of Practice No. 8 and No. 41, promulgated by the Actuarial Standards Board.

Reliance

I have relied upon information provided by Mr. Bryan J. Curley, FSA, MAAA, Vice President, Actuarial Consulting at the Company. While I reviewed the information for reasonableness, I did not audit the underlying data for correctness. Appendix A contains a Statement Regarding Accuracy and Completeness of the Underlying Data Sources provided to me as part of my review, and forms a part of this opinion.

Testing Procedures

Under my direction, we reviewed the renewal rating process and analysis performed by Health Net Actuarial staff. This included reviewing the conceptual and arithmetic reasonableness of spreadsheets developed by Health Net staff, which includes claims costs trend rates, development of anticipated unit health care cost and utilization increases, rating variables such as area, age/gender, and plan factors, and calibration of the experience data to reflect anticipated demographic and benefit plan composition during the rating period.

Due to the magnitude of the rate increase and associated implied losses, we took additional steps to determine the reasonability of the requested rate increase. We requested additional data from Health Net, including claims data for the experience period at the member level stratified by the underlying metal tier of the member's benefit plan during the experience period and the 2015 risk score level of each member. We simulated scenarios of the impact of differing levels of assumed metal level membership, differentiation of risk score levels, and altering the portion of members that are behavioral health members. This helped us determine a minimum range of corresponding rate increases given the assumed level of loss.

Opinion – Not Actuarially Sound in the Aggregate

In my opinion, the proposed premium rates are **not** actuarially sound in the aggregate. I based my opinion on what the company modeled and what data was available to the company at the time of filing, along with emerging experience that indicates that Health Net's costs are assumed to considerably exceed their premium and the resulting losses could be greater than expected. While I determined a minimum range of rate increases based on the assumed loss as of the filing, I would need to perform further testing and analysis to determine the appropriate magnitude of the rate increase to reach actuarially sound rates in the aggregate.

Opinion – Insufficient Premium Rate Levels

In my opinion, the proposed premium rate levels are **not** sufficient. I based my opinion of insufficient rate levels on the claims trends and claims experience adjustment factors below.

1. The expected statutory loss ratio for all ACA compliant individual products for calendar year (CY) 2017 is 121.9%. The loss ratio is determined as the ratio of projected incurred claims divided by projected revenue, consistent with the statutory reporting definition for premium revenue.

   While the definitive loss ratio according to the PPACA MLR requirements can only be determined after the experience has emerged, I did calculate a projected federal loss ratio of 109.9%.

   I used the following calculation:

Projected Federal Loss Ratio for CY 2017
PPO Policies Combined

(a) Statutory loss ratio	121.9%
(b) Corporate tax rate	36.2%
(c) After–Tax Profit	-18.6%
(d) Exchange Fee	0.6%
(e) Insurer's Fee	0.0%
(f) Income Tax =[After–Tax Profit + Insurer's Fee)/(1 - Corp Tax Rate) x Corp Tax Rate]	-10.5%
(g) PCORI / Risk Adjustment Fees	0.03%
(h) Premium Tax	0.0%
(i) Allowed Deductible Expenses[(d) + (e) + (f) + (g) + (h)]	-9.9%
(j) Quality Improvement	0.03%
(k) Federal MLR [(a) x ((1+(i) / (1-(j))]	109.9%

   The calculation of the loss ratio is determined using the guidance supplied in the ACA Notice of Benefit and Payment Parameters for 2016 regulations issued by the Federal Department of Health and Human Services.

2. The proposed rate increase is supported by substantial evidence of anticipated claims costs trends.

    a. I reviewed the data and metrics contained in numerous spreadsheets provided by the Company. The summarized results of these spreadsheets, such as morbidity and demographic adjustments and trend rate development are presented in the Company's actuarial opinion or the Rate Filing Form.

3. The choice of assumptions relating to unit health care cost increases, per capita utilization increases, projected relative morbidity levels and other assumptions, is not reasonable in light of the recent experience and expected losses.

    a. I reviewed the premium rate development and have summarized the annual trend and claims adjustment information in the chart below.

Trend Components by
Medical Service Category and Type of Component

Service Category	Total	Utilization Per Capita	Price Inflation	Fees and Risk
Hospital Inpatient	7.9%	1.7%	6.1%	0.0%
Hospital Outpatient	7.8%	1.7%	6.0%	0.0%
Physician/other prof services	7.3%	1.7%	5.5%	0.0%
Prescription Drug	11.0%	0.0%	11.0%	0.0%
Laboratory (other than inpatient)	5.9%	1.7%	4.1%	0.0%
Radiology (other than inpatient)	5.9%	1.7%	4.1%	0.0%
Capitation	0.0%	0.0%	0.0%	0.0%
Other	5.9%	1.7%	4.1%	0.0%
Total	7.85%			

A discussion of the source and development of the morbidity adjustment, impact of benefit changes, changes in demographics and annual trend factors is found in the Company's actuarial opinion.

4. The data, assumptions, rating factors, and methods used to determine the premium rates and documentation provided to the CDI in connection with the proposed rates are complete and adequate, and provide sufficient clarity and detail so that a qualified health actuary can make an objective appraisal of the reasonableness of the proposed rates, subject to the uncertainties noted earlier.

   a. The Company's actuarial opinion presents the projected loss ratio, administrative expenses, profit and risk margins, taxes and fees.

5. The proposed rates result in rates between insureds within similar risk categories that are permissible under applicable California law, and the premium differences correspond to differences in expected claims costs between allowable risk classes.

6. The proposed rates are based on credible experience data on policy forms being replaced and anticipated changes in unit health care costs; however, as noted previously, my opinion is that the proposed rates are insufficient and not actuarially sound.

7. The company's after-tax rate of return, including all segments and regions in which the Company operates over the past three years, has been as follows:

   - 2013 7.4%
   - 2014 -3.0%
   - 2015 -26.8%

   The calculation of the rate of return is based on net income (after tax) divided by the average capital and surplus.

   I reviewed these metrics, but I did not rely upon the return on equity, since it was not considered explicitly in the rate development process.

8. The executive compensation is part of the overall administrative expense assumed in the premium development. I received a listing of the top ten most highly compensated officers at the Company. I

reviewed the listing, but I did not rely upon the compensation levels since it was not considered explicitly in the rate development process.

9. The proposed average overall claims adjustment and trend of 7.85% is greater than the medical care services component of the Consumer Price Index for All Urban Consumers, U.S. City average of 3.8%, for the period June 2015 through June 2016.

While the proposed rate level is based on trend rates and adjustment larger than the medical costs index, material differences between the two measures provide an explanation as to the reasonability of the premium rate levels. The medical component of the CPI measures price inflation at the retail level. That is, it measures the prices paid for a fixed market basket of medical goods and services. The medical CPI is a retrospective measure and does not account for expected future spending, which is the basis for premium rate setting.

The following factors are included in the medical insurance claims trends that are not included in the CPI measure:

- Increased per capita utilization of services
- Cost for new technologies
- Changes in provider practice patterns or the intensity of the service being provided
- Changes in enrollment mix
- New mandated benefits
- Adverse selection
- Deductible leveraging effect
- Changes in provider mix and negotiated provider payment arrangements
- Adverse selection due to the new requirements of guaranteed issue, no pre-existing condition limitations, and modified community rating that prohibits rate variation by other than age, family composition, geographic area, and tobacco use status

- Change in overall risk level due to the migration of new enrollees in an environment that is more likely to attract less healthy individuals than healthier ones

I reviewed the medical trends as part of the premium development. The medical trends are built from a "first principles" approach using the expected unit cost increase by hospital and medical group, and then weighted using the historic volume associated with each provider entity. Expected per capita utilization is also assumed to increase, and incorporated into the expected medical claims trend.

I found the medical claims cost trends insufficient based upon my review.

10. The Company's proposed renewal rating action represents a 23.0% increase over 1Q CY2016 PPO rates and assumes an 18.6% after tax loss

11. The capital and surplus level for the Company at December 31, 2015 is $331,311,000. The dividend history for the past three years is as follows:

2013	$125,000,000
2014	$0
2015	$0

I reviewed the dividend history, but I did not rely upon it since it was not considered explicitly in the rate development process.

12. The unisex age rating factors are those mandated by the ACA as presented in the HHS "Market Rules; Rate Review" regulation.

13. The Company has regular management agreements and service contracts between itself and its affiliated companies, as well as reinsurance agreements. There have also been dividend and capital infusion transactions. This business is impacted by certain management and service contracts with affiliates as indicated in Schedule Y of the Company's annual statements. The amounts of these transactions over the past three years are shown in the following table.

Transactions with Affiliates ($000 omitted)			
Transaction Type	2013	2014	2015
Dividends	(45,000)	0	0
Capital Contributions	(80,000)	120,000	183,000
Mgmt. Agreements / Service Contracts	(115,336)	(108,686)	(109,339)
Reinsurance Income /(Disbursements)	(5,335)	4,386	71,233
Reinsurance Recoverable (Payable)	20,662	106,946	0

14. Since there is no medical underwriting of the products, there will be no morbidity impact as a newly covered insured cohort "ages" each year. Premium rates are also required, and have been priced on an "annual renewable term" basis within a reasonable range around the federal MLR minimum requirements for the entire block of individual business in California. Therefore the projected lifetime loss ratio will effectively equal the projected annual loss ratio.

Respectfully Submitted,

David G. Hayes
Member of the American Academy of Actuaries
September 12, 2016

Appendix A
Statement Regarding Accuracy and Completeness
Of the Underlying Data Sources

Items Relied upon During Testing by Milliman:

- Spreadsheet presenting claims, membership, revenue, and administrative expenses by benefit plan,
- Spreadsheet presenting utilization per capita, unit cost, and risk margin trends included in aggregate pricing trends,
- Actuarial Memorandum submitted by Health Net,
- Spreadsheets presenting claims, membership, and risk scores for all members in 2015 noting their behavioral health status, and
- Conversations with Health Net staff discussing the development of the renewal rating process

The sources identified above were relied upon by Milliman in preparing this statement of actuarial opinion.

I, Bryan J. Curley, Vice President, Actuarial Consulting, hereby affirm that the data sources identified above, and attached to this statement, were prepared under my direction, and to the best of my knowledge are accurate and complete unless otherwise noted below.

September 12, 2016

Date Signature