State: *Connecticut* ***Filing Company:*** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name: *2014 CT HIX Filing*
Project Name/Number: */*

Filing at a Glance

Company:	Aetna Life Insurance Company
Product Name:	2014 CT HIX Filing
State:	Connecticut
TOI:	H15I Individual Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15I.001 Health - Hospital/Surgical/Medical Expense
Filing Type:	Rate
Date Submitted:	05/29/2013
SERFF Tr Num:	AETN-129004040
SERFF Status:	Submitted to State
State Tr Num:	201396696
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Joseph bochicchio
Reviewer(s):	
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: Connecticut
Filing Company: Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: 2014 CT HIX Filing
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Joseph bochicchio

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 05/29/2013
State Status Changed:
Created By: Joseph bochicchio
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: This filing is for the Connecticut Exchange, Access Health CT.

Filing Description:

We enclose, for your Department's review, a rate filing which will be offered in the State of Connecticut by Aetna Life Insurance Company effective January 1, 2014. This filing provides details of the premium rate development and the resulting proposed monthly premium rates for calendar year 2014. This rate filing supports a Qualified Health Plan (QHP) application offered through the Connecticut Exchange, Access Health CT. The health benefit plans included in this filing comply with all Connecticut benefit requirements and rating regulations, as well as those associated with Federal Health Care Reform H.R. 3590 - the Patient Protection and Affordable Care Act (PPACA).

Company and Contact

Filing Contact Information

Joseph Bochicchio,
151 Farmington Ave
Hartford, CT 06156

BochicchioJ@aetna.com
860-273-0123 [Phone]

Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name:
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

Rate Information

Rate data applies to filing.

Filing Method: Review & Approval
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Aetna Life Insurance Company	New Product	%	%				%	%

Rate Review Detail

COMPANY:

Company Name: Aetna Life Insurance Company
HHS Issuer Id: 39159
Product Names: HHS Product Id 39159CT008. Aetna Preferred Provider Organization benefit plans for Access Health CT.
Trend Factors:

FORMS:

New Policy Forms: HIXGR-96786 01
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 258,611
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 113,794,280.00
Projected Incurred Claims: 83,082,720.00
Annual $: Min: 111.00 Max: 1,175.00 Avg: 363.56

State: *Connecticut* **Filing Company:** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name: *2014 CT HIX Filing*
Project Name/Number: */*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		CT Rates	HIXGR-96786 01	New		CT_IVL_39159_Rates.xml,

Attachment CT_IVL_39159_Rates.xml is not a PDF document and cannot be reproduced here.

Supporting Document Schedules

Bypassed - Item:	Actuarial Memorandum
Bypass Reason:	Attached below.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	Attached below.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	Attached below.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Market Head Cover Letter
Comments:	
Attachment(s):	CT_HIX_CoverLetter_2014-01_MarketHead.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Cover Letter

Comments:	
Attachment(s):	CT_Individual_Cover_Letter_2014_HIX.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	Actuarial Memo.
Attachment(s):	CT_Individual_Memorandum_2014_HIX.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit A - Actuarial Value and Product Summary
Comments:	
Attachment(s):	Exhibit A-1 CT AV and Product Summary.pdf Exhibit A-2 - CT Plans Forms AV Benefit factor.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit B - Age Factors
Comments:	
Attachment(s):	Exhibit B - CT Age Factors.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit C - Rating Area Factor Support
Comments:	
Attachment(s):	Exhibit C-1 - CT Rating Area Support.pdf Exhibit C-2 - CT Area Definitions.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit D - Historic Experience
Comments:	

Attachment(s):	Exhibit D - Historic Connecticut Experience.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit E - Trend Support
Comments:	
Attachment(s):	Exhibit E - CT Trend Details.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit F - Rate Development
Comments:	
Attachment(s):	Exhibit F-1 - Rate Development Summary.pdf Exhibit F-2 - Rate Development.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit G - Morbidity Adjustments
Comments:	
Attachment(s):	Exhibit G - Morbidity Adjustments.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit H - MLR Projection
Comments:	
Attachment(s):	Exhibit H - MLR Projection.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	URRT Part III Memorandum and Certifications.
Attachment(s):	URRT Part III IVL - CT.pdf
Item Status:	

State: Connecticut **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H15I Individual Health - Hospital/Surgical/Medical Expense/H15I.001 Health - Hospital/Surgical/Medical Expense
Product Name: 2014 CT HIX Filing
Project Name/Number: /

Status Date:	

Satisfied - Item:	Unified Rate Review Template Worksheets
Comments:	URRT Part I.
Attachment(s):	Unified_Rate_Review_Template_CT.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Rates
Comments:	Attached are rates in both .xls and .xlm formats. Files are zipped due to SERFF's upload limitations.
Attachment(s):	CT Rates.zip
Item Status:	
Status Date:	

Attachment Unified_Rate_Review_Template_CT.xlsm is not a PDF document and cannot be reproduced here.

Attachment CT Rates.zip is not a PDF document and cannot be reproduced here.

Thomas B. Leonardi
Insurance Commissioner
Connecticut Department of Insurance
153 Market St.
Hartford, CT 06103

Re: Connecticut Individual
Aetna Life Insurance Company (ALIC)

Dear Commissioner Leonardi:

The New Marketplace

Some of the most significant provisions of the Affordable Care Act (ACA) are set to go into effect on January 1, 2014, including guarantee issue and rating rule changes, taxes and fees, and new minimum benefit requirements. These provisions will fundamentally change the way the Individual and Small Group markets operate. In many states, including Connecticut, health plans will be filing products for 2014 that are substantially different from what we have filed in these markets in the past.

This filing contains the rates for new products that comply with the ACA requirements.

The health care environment continues to change and a great deal of uncertainty still remains. We remain committed to meeting the needs of the market, and as more details emerge we will continue to assess our product offerings to ensure we are delivering value to our customers.

Factors Impacting Premium

<u>New ACA Requirements</u>

A number of new ACA-related requirements are included in the rates we are filing today. Under the ACA, health insurers are mandated to follow new rules and cover more of the cost of care. Unfortunately, these federal changes also result in higher premium costs for many to purchase basic health coverage.

- **Guarantee Issue and new rating rules**: The ACA requires health insurers to offer coverage to all people who wish to purchase it regardless of their health status. Health insurers are also limited in their ability to adjust premiums. Going forward, premiums will be based on age, geographic area, family size, and tobacco use. Combined, these provisions are the largest driver of new premium costs over 2013 levels.
- **Minimum Actuarial Value:** The ACA requires that health benefit plans have at least a 60% minimum actuarial value. Enrollee cost sharing for these plans will generally be much lower in comparison to plans that are popular in today's marketplace. In turn, health plans will be required to cover more of the cost of care beginning January 1, 2014.
- **Essential Health Benefits**: The ACA expands the benefits that all health insurance plans must cover, both inside and outside of insurance exchanges, as part of a core package of benefits and services.
- **Taxes and Fees:** The ACA includes several new taxes and fees payable in 2014, including two that specifically apply to insured products – the health insurer fee and the reinsurance contribution.

Our proposed rates for Connecticut are similar to the rates being charged in states that have already adopted reforms similar to those required under the ACA. As a result, the individual rates we submitted in Connecticut will now be on par with states such as Vermont and New Jersey, which chose to enact Guaranteed Issue and Community Rating prior to the passage of the ACA.

<u>Medical Costs</u>

We expect medical costs to increase 11.0 percent in Connecticut in 2014, excluding the effects of the new ACA requirements outlined above. These costs include hospital care, outpatient care and doctor fees. They also include reimbursement for prescription drugs, lab and X-ray fees.

Aetna is committed to meeting the needs of the Marketplace

Aetna is taking a number of steps to mitigate "rate shock" and address the underlying cost of health care, such as:

- Developing new agreements, arrangements or partnerships with health care providers that compensate them for the quality of care they provide, and not the quantity of services.
- Creating medical management programs which address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.

We also are dedicated to increasing transparency within the health care system, as well as helping our members best utilize the plans that they have. Members can access Aetna Navigator, our secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's Plan for Your Health website aims to educate all consumers, not just Aetna members, on how to take advantage of their health care benefits.

Our goal is to deliver competitive pricing that allows our customers and members to get the greatest value out of their health benefits.

Thank you in advance for your review and consideration.

Martha R. Temple
President, New England Market
Aetna

151 Farmington Ave, RWAB
Hartford, CT 06156

Joseph Bochicchio, ASA
Aetna Life Insurance Company
151 Farmington Avenue, RS12
Hartford, CT 06156
Phone: 860-273-1795
Email: BochicchioJ@aetna.com

May 29, 2013

Mr. Paul Lombardo, ASA, MAAA
Department of Life and Health
State of Connecticut Insurance Department
153 Market Street
Hartford, CT 06142-0816

Subject: Aetna Life Insurance Company, NAIC No. 001-60054
Form Number: HIXGR-96786 01
Aetna Filing Number: 2014 CT HIX Filing
HIOS Product ID: 39159CT008

Dear Mr. Lombardo:

We enclose, for your Department's review, a rate filing for the above referenced new Individual Health product form which will be offered in the State of Connecticut by Aetna Life Insurance Company effective January 1, 2014. This filing provides details of the premium rate development and the resulting proposed monthly premium rates for calendar year 2014. This rate filing supports a Qualified Health Plan (QHP) application offered through the Connecticut Exchange, Access Health CT. The health benefit plans included in this filing comply with all Connecticut benefit requirements and rating regulations, as well as those associated with Federal Health Care Reform H.R. 3590 – the Patient Protection and Affordable Care Act (PPACA).

This submission includes the following:

- Actuarial Memorandum and Certification
- Exhibits A though H
- Unified Rate Review Actuarial Memorandum and Certification
- Unified Rate Review Template
- Rate Sheets

Please feel free to contact me at the above listed telephone number and/or e-mail address if you have any additional questions.

Sincerely,

Joseph Bochicchio, ASA
Encl: a/s

Aetna Life Insurance Company
Actuarial Memorandum
HIOS Product ID: 39159CT008
Policy Forms: HIXGR-96786 01
Comprehensive Individual Medical Expense Benefit Plans

1. Purpose, Scope, and Effective Date

The purpose of this filing is to request approval of monthly premium rates for the policy forms referenced above. The development of these rates reflects the impact of the market changes and rating requirements resulting from PPACA and subsequent regulation.

These rates are for plans issued in the individual market in conjunction with our Qualified Health Plan (QHP) application in Connecticut beginning January 1, 2014. The rates comply with all rating guidelines under federal and state regulation. The filing covers plans that will be available on and off the Connecticut Exchange, Access Health CT.

2. Key Assumptions

The rates in this filing were developed using the following assumptions:

- Connecticut will not have a supplemental reinsurance program
- Existing non-grandfathered policies in Connecticut will not enter the single risk pool until the first policy renewal after December 31, 2013
- Medicare eligibility will be expanded
- The financial sustainability plan for the Connecticut Exchange has not been established. An assumption was made that user fees and market assessments would be required that amounted to 1.9% of premium.

The proposed rates are dependent upon these assumptions and may not be appropriate if these assumptions prove to be materially different.

3. Lack of Final Guidance

The descriptions and analysis presented in this rate filing reflect our understanding of regulations and guidance issued through May 24, 2013. As further guidance and information is received, we reserve the right to submit revisions or withdraw our filing entirely.

4. Benefit Design

This filing covers 5 benefit designs. There are three standard benefit plans defined by the Exchange, one each of a Bronze, Silver and Gold, and 2 optional plans, one Catastrophic and one Bronze. The CT Aetna Premier 1000 PD (Gold plan) and CT Aetna AdvantagePlus 5500 PD (Bronze plan) will only be available through the Exchange. All plans offered both on and off the Exchange will be available with pediatric dental benefits.

Please refer to the corresponding policy forms for detailed benefit language. Information on the cost-sharing parameters of the covered benefit plans, including deductibles, copays, and Actuarial Values, is summarized in Exhibits A-1 and A-2. All benefit and cost sharing parameters comply with Connecticut benefit mandates and the requirements of PPACA, including preventive care benefits and deductible limits. The AV Metal Values for the standard On-Exchange plans and their Off-Exchange counterpart plans are based on standard plan design parameters established by Access Health Connecticut. In accordance with a waiver obtained by Access Health Connecticut, the minimum AV differential between

the 70 percent and the 73 percent silver plan variations is less than the two percent required under federal law.

We will be offering additional benefit plans in the off-exchange market. These plans will be filed at a later date.

5. Marketing

These plans will be made available through the Exchange. In addition, plans outside of the Exchange may be marketed through brokers and general agents, and directly to consumers through direct mail, telemarketing, and the internet.

6. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations. Aetna may rely on information provided by the Exchange as verification of eligibility.

7. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

8. Experience

This filing is for new policy forms. While there is no applicable experience for these products, Exhibit D summarizes the individual experience that forms the basis for our rate development.

Incurred claims used in the rate development include a provision for claims incurred but not reported (IBNR). The IBNR reserve is estimated using actuarial principles and assumptions that consider historical and projected claim submission patterns, historical and projected claim processing time, medical cost trends, utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors. For the experience period, we include two months of runoff to reduce the reliance on reserve estimates for the most recent months. The IBNR reserves represent approximately 1.6% of claims for our individual business during the experience period.

9. Medical Trend and Provider Network

We project an average annual medical trend of 10.0% from the experience period to the pricing period. A summary of historical and projected paid cost trend by service category is provided in Exhibit E. Historical trends are based on fully insured small group HMO experience for members living in Connecticut. The experience is normalized for demographic, benefit, and large claims. The historical unit cost trends include changes in provider and service mix. Note we do not explicitly measure changes in medical technology trend, the impact of benefit buy-downs or the impacts of cost sharing leverage on trend.

The resulting trend is calculated as {(1 + unit cost trend) * (1 + utilization trend)} - 1.

10. Risk Adjustment, Reinsurance, and Risk Corridors

As discussed below, we developed a market base rate representative of the average market morbidity expected in 2014. We believe the proposed rates are consistent with a market-average risk profile and anticipate that any risk adjustment will approximate the actual deviation in claims from the projected market-average level.

As noted in Line 22 of Exhibit F-2, we expect the transitional reinsurance program to reduce the average claims for these products by approximately 9.2% in 2014. This estimate is based on the national reinsurance program parameters and uses pricing assumptions for Aetna's stop loss business adjusted to reflect the anticipated demographics of the 2014 individual market in Connecticut.

The risk corridor program is intended to protect carriers from significant deviation between actual results and carriers' projections, and as such, does not impact the required premium on a prospective basis.

11. Claims Development and Morbidity Adjustments

The claims base for a 21-year old in the benchmark silver plan is $224.78. The development of this is discussed in Exhibit G and Exhibit F-1 and shown in Exhibit F-2.

The development of these rates involves a projection of who will be covered and at what cost in 2014. We have used available models and tools to accomplish this and shown, in our judgment, what the various components are worth relative to the final premium. The largest assumptions impacting the final rates are the cost of guaranteed issue and the market dynamics relative to who actually will be covered in 2014 given the relatively small tax penalties to incent the healthy and the delayed entry of existing medically underwritten market. We believe this dynamic will lead to significant adverse selection in 2014. Of course, with each assumption, there is a range of reasonable values. Our final choice of assumptions was made with an expectation of a reasonable relationship between final premiums in the Individual market and Small Group markets. As such, the final premiums presented here should also be evaluated on a reasonable basis against Small Group premiums rather than the contribution of a particular assumption.

The projected claim level was based on our 11/1/2011-10/31/2012 experience of our current individual PPO and small group HMO blocks of business in Connecticut. Small group experience will contain many of the anticipated dynamics of the individual market in year 2014 and thus is a suitable basis upon which to evaluate the appropriate claim level. These dynamics include, but are not limited to

1. Guaranteed issue & renewability provisions apply to all CT small employers and associated membership
2. Rate adjustments due to medical underwriting are not allowed
3. Small group utilizes a modified community rating methodology with similar rating variables

As part of the experience projection, we made adjustments as appropriate to normalize for the rating and benefit changes and to account for the expected market dynamics in 2014. The purpose of this is to bring the experience between the markets to a comparable basis and ultimately to a single base level for Individual premiums. While the experience of Individual and Small Group markets will be comparable after they are normalized, there will be differences in the risk pools between the markets causing the Individual market to have a higher claim expectation.

Relative to the Small Group Market, the Individual Risk pool has at least the following differences

1. Presence of a High Risk Individuals that will transition into the Individual market
2. The addition of previously uninsured lives to the market pool. These newly insureds would come from both those individuals who were not able to access the market previously because of affordability issues as well as those with pre-existing conditions.
3. The additional utilization of the newly insureds without prior coverage
4. The delayed entry of the existing Individual medically-underwritten market to the pool due to staggered anniversary dates throughout 2014.

The basic approach was to normalize our experience for the Individual and Small Group markets in order to put the paid claims on the same basis so that they could be compared. This step serves as a reasonability check to the market participation and morbidity changes as a result of PPACA.

Once a comparable claim level is established, the Individual Comparative Claim level is projected to the 2014 level taking into account allowed claim trend, network contracting and the adjustments for the PPACA rating changes. The result of this step is the Silver Base Claim Rate.

12. Retention

The Retention Portion of the Market Base Rate is 26.99%. This was developed from the following items:

1. Taxes and Fees of 9.69% comprised of:
    a. Premium Taxes of 2.06%
    b. Patient Centered Outcomes Research Fund of $2.00 per member per year, converted to .05%
    c. Reinsurance Contribution of $5.25 PMPM, converted to 1.44%
    d. Health Insurer Fee of 2.6%
        i. 1.7% paid post-tax as the Health Insurer Fee
        ii. 0.9%, charged as a corporate tax of 35% on the 2.6% pre-tax charge
    e. Exchange User Fee of 1.9%. This is assuming a 3.5% Exchange User Fee applicable to 53% of total membership enrolling through Access Health CT.
    f. Federal Income Tax of 1.62%, assuming 35% tax rate
    g. Risk Adjustment Program Fee of .02%
2. Commissions of 3.5% of premium:
3. General Administrative Expenses of $39.26, converted to 10.8% of premium based upon an expected average premium level.

    Of the above total general administration expenses,
    a. 0.6% is classified as Quality Improvement Activities under 45 CFR Part 158.
    b. Salaries and employee benefits and welfare programs are 50% of total
    c. Licensing Fees are 0.2%
4. After-Tax Risk Charge of 3.00%.

These prospective expenses are based on historical expense levels and the changes expected with the requirements of PPACA and Access Health CT.

The Risk Charge of 3% is in line with the amount allowed in the Risk Corridor calculation. Aetna is applying for QHP certification on these plans in Connecticut in order to benefit from this program.

13. Market Base Rate

The base premium for our benchmark Silver plan is $279.54, as indicated on Line 27 of Exhibit F-2. This base premium forms the basis for developing plan premium rates for all other plans discussed in this filing.

14. Membership Projections

The model discussed in Exhibit G contains detail on current and projected membership by age band and benefit level. It is used to form a basis for projecting the membership distribution in these plans. We consolidate model results for several states to produce a common membership distribution that is used on a national basis. We assume the enrollment distribution by metal level will be consistent with the model output except that membership projected for Platinum plans will instead enroll in a Gold plan (since we will not offer a Platinum plan in Connecticut) and that 80% of the projected membership for ages 18-29 in a Bronze plan will instead select a Catastrophic plan.

The distribution by age band reflects a blend of the model's membership distribution for the current small group market and the 2014 individual market. We apply 70% weight to the current small group distribution and 30% weight to the projected individual distribution. The resulting distribution by age is fairly consistent with Aetna's current distribution of small group membership.

The average rate level for these forms is the product of the benchmark plan base rate and the weighted-average adjustment factors for age, rating area and plan design. To estimate this relationship, we combine the projected membership distribution by plan, rating area and age with the age factors, rating area factors and estimated plan factors (based on AV differences and the catastrophic plan adjustment). This calculation indicates that the average rate will be approximately 30% larger than the base rate.

Please see below for a development of our average premium rate (as illustrated in Exhibit H):

	Distribution	Average Premium	Actuarial Value
Catastrophic	11.4%	$177	60%
Bronze	67.2%	$356	60%
Silver	19.3%	$487	70%
Gold	2.1%	$477	80%
Platinum	0.0%	N/A	N/A
Total	100.0%	$364	63%

15. Catastrophic Plan
The average morbidity level for the Catastrophic plan is estimated to be approximately 25% lower than that of a similar Bronze plan. This adjustment is reflected in the plan factors shown in Exhibit A-1.

16. Anticipated Loss Ratio
We expect the loss ratio for these products to be 73.0%. This is consistent with the effective retention target of 27.0% of premium. A projection of the MLR for this product is provided in Exhibit H. This projection includes anticipated experience for this product for the 12 months in 2014 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 81.5%, as illustrated in Exhibit H.

17. Age Factors
The age factors are based on the HHS Default Standard Age curve. The factors are shown in Exhibit B.

18. Area Definitions and Factors
As a result of PPACA, it is anticipated that utilization patterns in the Connecticut Individual market will follow those of the Small Group market going forward. As such, we have used our normalized Small Group experience for the period January 1, 2012 through December 31, 2012 to determine our proposed rating area factors. Support for our proposed area factors is provided in Exhibit C-1; our proposed rating area definitions are provided in Exhibit C-2.

19. Tobacco Rating
Access Health CT does not permit tobacco to be used as a rating factor and as such was not considered in the determination of our rates.

20. Plan Benefit Factors
We calculate a plan factor to adjust the market base rate for differences in plan-specific expected claims. These factors account for differences in benefits, cost sharing, and network design (where applicable). The benchmark Silver plan is assigned a factor of 1.0. The factors were developed using a proprietary pricing model which relies on:

1) State- and product-specific service category weights;

2) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and, copays.

The service category weights are based on experience for our Small Group business. The cost-sharing rating factors are based on experience for our Large Group business which excludes the effects of selection.

Final plan factors reflect the value of the EHB and state mandated benefits (including pediatric dental and vision), the impact of out-of-network benefits, and any additional benefits as indicated in the attached benefit summaries. The final plan factor for the CT Aetna AdvantagePlus 5500 PD plan has been reduced by an additional 4.5% to consider differences in in-network discounts and steerage to preferred providers. This plan is multi-tiered, having In-Network Preferred, In-Network Non-Preferred and Out-of-Network benefits. This plan will have a reduced coverage area and will therefore not be available in New London County. No adjustments were made to differentiate benefit factors based on morbidity differences or benefit selection. Final plan factors are displayed in Exhibit A-1.

21. Rating Methodology

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents under age 21 will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

Based on Aetna's individual experience, we estimate that billing for no more than three dependents under age 21 requires a 0.6% increase to the base rate.

The premium for each billable member is calculated as:
Market Base Rate * Age Factor * Area Factor * Plan Factor

The resulting rate for each member is rounded to the nearest dollar.

As an example of this calculation, consider a family living in Hartford County that enrolls in the Aetna Classic 3250 PD plan. Assume that the parents are ages 40 and 42 and have children ages 6, 8, 11, and 13. The rate for this family is calculated as:

Member Age	42	40	13	11	8	6
Market Base Rate	279.54	279.54	279.54	279.54	279.54	279.54
Age Factor	1.325	1.278	0.635	0.635	0.635	0.635
Area Factor	1.000	1.000	1.000	1.000	1.000	1.000
Plan Factor	.8566	.8566	.8566	.8566	.8566	.8566
Final Rate	317	306	152	152	152	N/A

The family's final monthly rate is the sum of the member rates, or $1,079. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example.

22. History of Rate Revisions

This is a filing for new products which will be effective beginning January 1, 2014.

23. Company Financial Condition

As of December 31, 2012, the capital and surplus held by Aetna Life Insurance Company was approximately $3.3 billion. This amount is disclosed in the Company's statutory financial statement dated December 31, 2012. The Company issues insurance nationwide for multiple lines of business including large group medical, small group medical, individual medical, and various non-medical products.

Certification

I, Bruce T. Campbell, am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I certify that, to the best of my knowledge and judgment, the entire rate filing is in compliance with the applicable laws of the State of Connecticut and with the rules of the Department of Insurance, and complies with Actuarial Standard of Practice No. 8, "Regulatory Filings for Rates and Financial Projections for Health Plans," as adopted by the Actuarial Standards Board, December, 2005, which standard is hereby adopted and incorporated by reference, and that the benefits provided are reasonable in relation to the proposed premiums.

May 29, 2013

________________________________ ____________________

Bruce T. Campbell, FSA, MAAA Date

Aetna Life Insurance Company

Aetna Life Insurance Company
SERFF #: AETN-129004040
HIOS Product ID: 39159CT0080005
Exhibit A-1

Connecticut Individual Portfolio | Summary of Benefits

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Summary of Benefits Covered

CT AETNA BASIC PD

Connecticut

Catastrophic Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$6,350	$12,700
Family	$12,700	$25,400
Coinsurance *(Member Responsibility)*	0%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,350	15,000
Familiy	$12,700	$30,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$20 ded waived/visits 1-3	50% after deductible
Specialist Visit	0% after deductible	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible	50% after deductible
Emergency Room Services	0% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible	50% after deductible
Rehabilitative Speech Therapy	0% after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	0% after deductible	50% after deductible
X-rays and Diagnostic Imaging	0% after deductible	50% after deductible
Skilled Nursing Facility	0% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	Integrated with med	Integrated with med
Family	Integrated with med	Integrated with med
Generics	0% after deductible	50% after deductible
Preferred Brand Drugs	0% after deductible	50% after deductible
Non-Preferred Brand Drugs	0% after deductible	50% after deductible
Specialty Drugs (i.e. high-cost)	0% after deductible	50% after deductible

Summary of Benefits Covered

CT AETNA CLASSIC 3250 PD

Connecticut

Bronze Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$3,250	$6,500
Family	$6,500	$13,000
Coinsurance *(Member Responsibility)*	40%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,250	$12,500
Familiy	$12,500	$25,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$30 per visit after deductible	50% after deductible
Specialist Visit	40% after deductible	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	40% after deductible	50% after deductible
Emergency Room Services	40% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$30 per visit after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	40% after deductible	50% after deductible
Rehabilitative Speech Therapy	40% after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50%
Laboratory Outpatient and Professional Services	40% after deductible	50% after deductible
X-rays and Diagnostic Imaging	40% after deductible	50% after deductible
Skilled Nursing Facility	40% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	40% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	Integrated with med	Integrated with med
Family	Integrated with med	Integrated with med
Generics	$10 copay	50% after deductible
Preferred Brand Drugs	40% after deductible	50% after deductible
Non-Preferred Brand Drugs	40% after deductible	50% after deductible
Specialty Drugs (i.e. high-cost)	40% after deductible	50% after deductible

Summary of Benefits Covered

CT AETNA ADVANTAGEPLUS 5500 PD

Connecticut

Bronze Plan

Summary of Features	In-Network Preferred	In-Network Non-Preferred	Out-of-Network
Deductible			
Individual	$5,500	$6,250	$12,500
Family	$11,000	$12,500	$25,000
Coinsurance *(Member Responsibility)*	10%	10%	50%
	$0 once out-of-pocket max. is satisfied		
Out-of-Pocket Maximum			
Individual	$6,350	$6,350	$19,050
Familiy	$12,700	$12,700	$38,100
	All cost sharing accumulates to the Out of Pocket Maximum above		
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	10% after deductible	10% after deductible	50% after deductible
Specialist Visit	10% after deductible	10% after deductible	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible	10% after deductible	50% after deductible
Emergency Room Services	10% after deductible	Paid as In-Network after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	10% after deductible	Paid as designated after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	10% after deductible	Paid as designated after deductible	50% after deductible
Rehabilitative Speech Therapy	10% after deductible	Paid as designated after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	10% after deductible	Paid as designated after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	0%	50% after deductible
Laboratory Outpatient and Professional Services	10% after deductible	10% after deductible	50% after deductible
X-rays and Diagnostic Imaging	10% after deductible	Paid as designated after deductible	50% after deductible
Skilled Nursing Facility	10% after deductible	Paid as designated after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible	10% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible	10% after deductible	50% after deductible

Pharmacy	In-Network Preferred	In-Network Non-Preferred	Out-of-Network
Pharmacy Deductible			
Individual	Integrated with med	Integrated with med	Integrated with med
Family	Integrated with med	Integrated with med	Integrated with med
Generics	10% after deductible	Paid as in-network	50% after deductible
Preferred Brand Drugs	50% after deductible	Paid as in-network	50% after deductible
Non-Preferred Brand Drugs	50% after deductible	Paid as in-network	50% after deductible
Specialty Drugs (i.e. high-cost)	50% after deductible	Paid as in-network	50% after deductible

Summary of Benefits Covered

CT AETNA PREMIER 1000 PD

Connecticut

Gold Plan

Summary of Features	In Network	Out-of-Network
Deductible		
Individual	$1,000	$3,000
Family	$2,000	$6,000
Coinsurance *(Member Responsibility)*	0%	30%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Familiy	$6,000	$12,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$20 per visit	30% after deductible
Specialist Visit	$45 per visit	30% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$500 day/$1000 per admit after deductible	30% after deductible
Emergency Room Services	$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$20 per visit	30% after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit	30% after deductible
Rehabilitative Speech Therapy	$20 per visit	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$20 per visit	30% after deductible
Preventive Care/Screening/Immunization	0%	30%
Laboratory Outpatient and Professional Services	$20 per visit	30% after deductible
X-rays and Diagnostic Imaging	$45 per visit	30% after deductible
Skilled Nursing Facility	$500 day/$1000 per admit after deductible	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible	30% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	30% after deductible

Pharmacy	In Network	Out-of-Network
Pharmacy Deductible		
Individual	$150 [Waived for Generic]	Integrated with Med
Family	$150 [Waived for Generic]	Integrated with Med
Generics	$10 copay; deductible waived	30% after deductible
Preferred Brand Drugs	$25 copay	30% after deductible
Non-Preferred Brand Drugs	$40 copay	30% after deductible
Specialty Drugs (i.e. high-cost)	30% after deductible	30% after deductible

Summary of Benefits Covered

CT AETNA ADVANTAGE 3000 PD

Connecticut

Silver Plan

Summary of Features	In Network	Out-of-Network
Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance *(Member Responsibility)*	0%	40%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum Individual Familiy	 $6,250 $12,500	 $12,500 $25,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$30 per visit	40% after deductible
Specialist Visit	$45 per visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$500/d, days 1-4 after deductible	40% after deductible
Emergency Room Services	$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$30 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit	40% after deductible
Rehabilitative Speech Therapy	$30 per visit	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$30 per visit	40% after deductible
Preventive Care/Screening/Immunization	0%	40%
Laboratory Outpatient and Professional Services	$30 per visit	40% after deductible
X-rays and Diagnostic Imaging	$45 per visit	40% after deductible
Skilled Nursing Facility	$500/d, days 1-4 after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	40% after deductible

Pharmacy	In Network	Out-of-Network
Pharmacy Deductible Individual Family	 In-network: $400 In-network: $400	 Integrated with Med Integrated with Med
Generics	$10 copay; deductible waived	40% after deductible
Preferred Brand Drugs	$25 copay	40% after deductible
Non-Preferred Brand Drugs	$40 copay	40% after deductible
Specialty Drugs (i.e. high-cost)	40% after deductible	40% after deductible

SILVER TIER CSR PLANS

The next set of plans have Cost Sharing Reductions (CSR) . When ACA provisions go into effect, Individuals who qualify to enroll in CSR plans will receive a cost sharing subsidy from the government that lets them receive a richer benefit plan for the same price that a non-eligible individual pays. To reflect this, different variations of the Silver-tiered product, Aetna Classic PD, were created with varying Actuarial Values. In order to qualify for the CSR plans below, Individuals:

1. *Must be legally present in the US and not incarcerated*
2. *Must not be eligible for “affordable” employer-sponsored coverage*
3. *Must have income that falls within 100%-250% of the Federal Poverty Level*
4. *Must enroll in a silver plan*

Summary of Benefits Covered

CT AETNA ADVANTAGE 3000 PD: CSR 73%

Connecticut

Silver 73% Plan

Summary of Features	In Network	Out-of-Network
Deductible		
Individual	$2,500	$6,000
Family	$5,000	$12,000
Coinsurance *(Member Responsibility)*	varies; see below	varies; see below
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,200	$12,500
Familiy	$10,400	$25,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$30 per visit	40% after deductible
Specialist Visit	$45 per visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$500 day/$1000 per admit after deductible	40% after deductible
Emergency Room Services	$150 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$30 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit	40% after deductible
Rehabilitative Speech Therapy	$30 per visit	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$30 per visit	40% after deductible
Preventive Care/Screening/Immunization	0%	40%
Laboratory Outpatient and Professional Services	$30 per visit	40% after deductible
X-rays and Diagnostic Imaging	$45 per visit	40% after deductible
Skilled Nursing Facility	$500 day/$1000 per admit after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500 per visit after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	40% after deductible

Pharmacy	In Network	Out-of-Network
Pharmacy Deductible		
Individual	$300 [Waived for Generic]	Integrated with Med
Family	$300 [Waived for Generic]	Integrated with Med
Generics	$10 copay; deductible waived	40% after deductible
Preferred Brand Drugs	$25 copay	40% after deductible
Non-Preferred Brand Drugs	$40 copay	40% after deductible
Specialty Drugs (i.e. high-cost)	$40 copay	40% after deductible

Summary of Benefits Covered

CT AETNA ADVANTAGE 3000 PD: CSR 87%

Connecticut

Silver 87% Plan

Summary of Features	In Network	Out-of-Network
Deductible		
Individual	$500	$6,000
Family	$1,000	$12,000
Coinsurance *(Member Responsibility)*	varies; see below	varies; see below
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$2,250	$12,500
Familiy	$4,500	$25,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$10 per visit	40% after deductible
Specialist Visit	$30 per visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$250 day/$500 per admit after deductible	40% after deductible
Emergency Room Services	$100 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$10 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$75 per visit	40% after deductible
Rehabilitative Speech Therapy	$10 per visit	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$10 per visit	40% after deductible
Preventive Care/Screening/Immunization	0%	40%
Laboratory Outpatient and Professional Services	$10 per visit	40% after deductible
X-rays and Diagnostic Imaging	$30 per visit	40% after deductible
Skilled Nursing Facility	$250 day/$500 per admit after deductible	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$250 per visit after deductible	40% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	40% after deductible

Pharmacy	In Network	Out-of-Network
Pharmacy Deductible		
Individual	In-network: None	Integrated with Med
Family	In-network: None	Integrated with Med
Generics	$5 copay	40% after deductible
Preferred Brand Drugs	$15 copay	40% after deductible
Non-Preferred Brand Drugs	$30 copay	40% after deductible
Specialty Drugs (i.e. high-cost)	$40 copay	40% after deductible

Summary of Benefits Covered

CT AETNA ADVANTAGE 3000 PD: CSR 94%

Connecticut

Silver 94% Plan

Summary of Features	In Network	Out-of-Network
Deductible		
Individual	$0	$6,000
Family	$0	$12,000
Coinsurance *(Member Responsibility)*	varies; see below	varies; see below
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$2,000	$12,500
Familiy	$4,000	$25,000
	All cost sharing accumulates to the Out of Pocket Maximum above	
Primary Care Visit to Treat an Injury or Illness (excludes Preventative and X-rays)	$5 per visit	40% after deductible
Specialist Visit	$15 per visit	40% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	$250 day/$500 per admit	40% after deductible
Emergency Room Services	$75 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$5 per visit	40% after deductible
Imaging (CT/PET Scans, MRIs)	$50 per visit	40% after deductible
Rehabilitative Speech Therapy	$5 per visit	40% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$5 per visit	40% after deductible
Preventive Care/Screening/Immunization	0%	40%
Laboratory Outpatient and Professional Services	$5 per visit	40% after deductible
X-rays and Diagnostic Imaging	$15 per visit	40% after deductible
Skilled Nursing Facility	$250 day/$500 per admit	40% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$250 per visit	40% after deductible
Outpatient Surgery Physician/Surgical Services	0%	40% after deductible

Pharmacy	In Network	Out-of-Network
Pharmacy Deductible		
Individual	In-network: None	Integrated with Med
Family	In-network: None	Integrated with Med
Generics	$5 copay	40% after deductible
Preferred Brand Drugs	$15 copay	40% after deductible
Non-Preferred Brand Drugs	$30 copay	40% after deductible
Specialty Drugs (i.e. high-cost)	$40 copay	40% after deductible

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Benefit Plans Form # and Plan-Ids, AV and Pricing Factors
Exhibit A-2

Form #	HIOS Plan-Id	Plan	Exchange ON/OFF	Metallic Tier	Cost - sharing	Deductible	Actuarial Value	Plan Factors
G1aHIXGR-96786-SB 01	39159CT0080001	CT Aetna Premier 1000 PD	ON	Gold	Base	$1,000	81.8%	1.2213
G1bHIXGR-96786-SB 01	39159CT0080001	CT Aetna Premier 1000 PD: NA CSR $0	ON	Gold	Native American	$1,000	100.0%	1.2213
G1cHIXGR-96786-SB 01	39159CT0080001	CT Aetna Premier 1000 PD: NA CSR LTD	ON	Gold	Native American	$1,000	81.8%	1.2213
GR-96812-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD	OFF	Silver	Base	$3,000	72.0%	1.0000
S1cHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD: CSR 73%	ON	Silver	CSRCoins	$3,000	73.8%	1.0000
S1dHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD: CSR 87%	ON	Silver	CSRCoins	$3,000	87.8%	1.0000
S1eHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD: CSR 94%	ON	Silver	CSRCoins	$3,000	93.3%	1.0000
S1fHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD: NA CSR $0	ON	Silver	Native American	$3,000	100.0%	1.0000
S1gHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD: NA CSR LTD	ON	Silver	Native American	$3,000	72.0%	1.0000
S1aHIXGR-96786-SB 01	39159CT0080002	CT Aetna Advantage 3000 PD	ON	Silver	Base	$3,000	72.0%	1.0000
B1aHIXGR-96786-SB 01	39159CT0080003	CT Aetna Classic 3250 PD	ON	Bronze	Base	$3,250	61.6%	0.8566
GR-96812-SB 01	39159CT0080003	CT Aetna Classic 3250 PD	OFF	Bronze	Base	$3,250	61.6%	0.8566
B1bHIXGR-96786-SB 01	39159CT0080003	CT Aetna Classic 3250 PD: NA CSR $0	ON	Bronze	Native American	$3,250	100.0%	0.8566
B1cHIXGR-96786-SB 01	39159CT0080003	CT Aetna Classic 3250 PD: NA CSR LTD	ON	Bronze	Native American	$3,250	61.6%	0.8566
B3cHIXGR-96786-SB 01	39159CT0080005	CT Aetna AdvantagePlus 5500 PD: NA CSR $0	ON	Bronze	Native American	$5,500	100.0%	0.7691
B3dHIXGR-96786-SB 01	39159CT0080005	CT Aetna AdvantagePlus 5500 PD: NA CSR LTD	ON	Bronze	Native American	$5,500	58.0%	0.7691
B3aHIXGR-96786-SB 01	39159CT0080005	CT Aetna AdvantagePlus 5500 PD	ON	Bronze	Base	$5,500	58.0%	0.7691
GR-96812-SB 01	39159CT0080006	CT Aetna Basic PD	OFF	Catastrophic	Base	$6,350	N/A	0.6277
C1aHIXGR-96786-SB 01	39159CT0080006	CT Aetna Basic PD	ON	Catastrophic	Base	$6,350	N/A	0.6277

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Exhibit B
Age Rating Definitions and Factors for Connecticut Individual

HHS Default Standard Age Curve

Age	Factor
0-20	0.635
21	1.000
22	1.000
23	1.000
24	1.000
25	1.004
26	1.024
27	1.048
28	1.087
29	1.119
30	1.135
31	1.159
32	1.183
33	1.198
34	1.214
35	1.222
36	1.230
37	1.238
38	1.246
39	1.262
40	1.278
41	1.302
42	1.325
43	1.357
44	1.397
45	1.444
46	1.500
47	1.563
48	1.635
49	1.706
50	1.786
51	1.865
52	1.952
53	2.040
54	2.135
55	2.230
56	2.333
57	2.437
58	2.548
59	2.603
60	2.714
61	2.810
62	2.873
63	2.952
64 and Older	2.994

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Exhibit C-1
Rating Area Support for Connecticut Individual

County	Rating Area	Normalized CT SG HMO PMPM	Relationship to Hartford County	Current Individual Area Factors	Current Small Group HMO Area Factors	Proposed Individual Area Factors
Fairfield	Rating Area 1	304.46	1.161	1.074	1.150	1.150
Hartford	Rating Area 2	262.29	1.000	1.000	1.000	1.000
Litchfield	Rating Area 3	251.58	0.959	1.000	1.000	1.000
Middlesex	Rating Area 4	232.86	0.888	1.000	1.050	1.000
New Haven	Rating Area 5	289.73	1.105	1.074	1.050	1.075
New London	Rating Area 6	338.07	1.289	1.074	1.050	1.150
Tolland	Rating Area 7	254.2	0.969	1.000	1.000	1.000
Windham	Rating Area 8	250.51	0.955	1.000	1.000	1.000

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Exhibit C-2
Rating Area Defintions and Factors for Connecticut Individual

Rating Area 1 1.150	Rating Area 2 1.000	Rating Area 3 1.000	Rating Area 4 1.000	Rating Area 5 1.075	Rating Area 6 1.150	Rating Area 7 1.000	Rating Area 8 1.000
Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Policy form # HIXGR-96786 01
Exhibit D
Historic Connecticut Experience

DOS	Member Months	Earned Premium	Incurred Claims	Paid Claims	MBR	Target MBR	Actual to Expected
CY 2005	3,230	$ 459,609	$ 104,512	$ 104,512	22.7%	N/A	N/A
CY 2006	20,171	$ 2,777,729	$ 1,122,777	$ 1,122,777	40.4%	N/A	N/A
CY 2007	44,835	$ 6,829,519	$ 4,218,868	$ 4,218,868	61.8%	57.9%	1.066
CY 2008	71,749	$ 12,218,411	$ 6,396,948	$ 6,396,948	52.4%	59.9%	0.874
CY 2009	121,273	$ 22,914,681	$ 12,327,530	$ 11,083,566	53.8%	64.1%	0.839
Jan-10	11,862	$ 2,492,989	$ 900,089	$ 824,272	36.1%	65.1%	0.555
Feb-10	12,176	$ 2,332,070	$ 983,235	$ 863,280	42.2%	65.6%	0.642
Mar-10	12,347	$ 2,439,779	$ 1,155,132	$ 1,003,500	47.3%	65.8%	0.720
Apr-10	12,478	$ 2,461,791	$ 1,374,763	$ 1,277,785	55.8%	66.3%	0.843
May-10	12,591	$ 2,556,045	$ 1,347,038	$ 1,206,384	52.7%	66.6%	0.792
Jun-10	12,678	$ 2,629,936	$ 1,280,745	$ 1,175,289	48.7%	66.7%	0.730
Jul-10	12,841	$ 2,707,224	$ 1,535,899	$ 1,342,333	56.7%	67.2%	0.844
Aug-10	13,091	$ 2,727,816	$ 1,533,947	$ 1,442,719	56.2%	67.4%	0.834
Sep-10	13,364	$ 2,871,063	$ 1,624,598	$ 1,480,518	56.6%	67.6%	0.837
Oct-10	13,717	$ 2,864,696	$ 2,357,402	$ 2,007,685	82.3%	67.4%	1.221
Nov-10	14,193	$ 3,072,423	$ 1,778,664	$ 1,800,853	57.9%	67.4%	0.859
Dec-10	14,596	$ 3,185,495	$ 2,379,107	$ 2,030,724	74.7%	67.6%	1.105
Jan-11	14,457	$ 3,314,921	$ 1,631,462	$ 1,693,986	49.2%	67.7%	0.727
Feb-11	14,650	$ 3,242,306	$ 1,986,335	$ 1,859,118	61.3%	67.7%	0.905
Mar-11	15,002	$ 3,285,115	$ 2,193,112	$ 1,930,538	66.8%	67.7%	0.986
Apr-11	15,179	$ 3,380,418	$ 1,584,999	$ 1,528,358	46.9%	68.2%	0.688
May-11	15,266	$ 3,476,299	$ 1,756,362	$ 1,531,512	50.5%	68.5%	0.737
Jun-11	15,354	$ 3,506,885	$ 2,083,901	$ 1,821,853	59.4%	68.8%	0.864
Jul-11	15,487	$ 3,470,656	$ 1,949,240	$ 1,820,321	56.2%	69.5%	0.808
Aug-11	15,632	$ 3,660,716	$ 2,571,022	$ 2,314,603	70.2%	69.4%	1.012
Sep-11	16,155	$ 3,465,804	$ 2,036,303	$ 1,930,199	58.8%	68.9%	0.852
Oct-11	16,554	$ 3,427,670	$ 2,790,076	$ 2,537,931	81.4%	69.3%	1.174
Nov-11	17,116	$ 3,502,506	$ 3,051,001	$ 2,829,162	87.1%	69.4%	1.255
Dec-11	17,709	$ 3,694,580	$ 2,982,832	$ 2,722,868	80.7%	69.2%	1.167
Jan-12	18,623	$ 3,903,856	$ 2,074,580	$ 1,914,811	53.1%	68.9%	0.772
Feb-12	19,494	$ 4,125,434	$ 2,436,348	$ 2,207,658	59.1%	68.6%	0.861
Mar-12	20,428	$ 4,299,961	$ 2,994,062	$ 2,747,377	69.6%	68.3%	1.019
Apr-12	21,246	$ 4,518,626	$ 2,897,117	$ 2,651,102	64.1%	68.3%	0.938
May-12	21,923	$ 4,678,646	$ 3,513,051	$ 3,132,604	75.1%	68.3%	1.099
Jun-12	22,690	$ 4,724,698	$ 2,863,846	$ 2,629,216	60.6%	68.4%	0.886
Jul-12	23,582	$ 4,978,413	$ 3,111,821	$ 2,776,148	62.5%	68.4%	0.914
Aug-12	24,427	$ 5,137,286	$ 3,466,348	$ 2,936,383	67.5%	68.4%	0.986
Sep-12	25,156	$ 5,316,505	$ 3,342,264	$ 3,011,924	62.9%	68.5%	0.918
Oct-12	25,814	$ 5,481,365	$ 3,428,279	$ 3,037,101	62.5%	68.6%	0.912
Nov-12	26,357	$ 5,670,195	$ 4,148,566	$ 3,784,931	73.2%	68.6%	1.066
Dec-12	27,055	$ 6,112,689	$ 3,783,812	$ 3,422,064	61.9%	68.7%	0.901

Aetna Life Insurance Company
SERFF Filing # AETN-129004040
HIOS Product ID: 39159CT008
Exhibit E
Trend Support for Connecticut Individual (Calculated using Normalized Small Group HMO Claims)

	Paid Claim PMPM			Unit Cost (Admit/Day/Visit/Script)			Utilization/1000 (Admit/Day/Visit/Script)		
Medical Cost Category	**07/2010 through 06/2011**	**7/2011 through 06/2012**	**Trend**	**07/2010 through 06/2011**	**7/2011 through 06/2012**	**Trend**	**07/2010 through 06/2011**	**7/2011 through 06/2012**	**Trend**
Inpatient Services	$93.07	$102.79	10.4%	$13,464.10	$15,187.53	12.8%	366.2	358.5	-2.1%
Outpatient Services	$54.84	$64.02	16.8%	$1,114.52	$1,193.40	7.1%	576.6	628.5	9.0%
Physician Services	$110.34	$120.14	8.9%	$184.56	$191.56	3.8%	6,824.4	7,158.8	4.9%
Other Services	$72.10	$79.91	10.8%	$182.84	$184.12	0.7%	4,269.7	4,700.9	10.1%
Pharmacy	$53.75	$60.48	12.5%	$85.48	$88.05	3.0%	7,411.3	8,093.1	9.2%
Total	$384.10	$427.35	11.3%	$15,031.50	$16,844.68	12.1%	$491.90	$488.50	-0.7%

Aetna Life Insurance Company

Exhibit F-1: Connecticut Individual Market Base Rate Development

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This exhibit summarizes the adjustments made to historical experience in developing the market base rate illustrated in Exhibit F-2. The purpose to this calculation is to develop a market level average claim rate. We include small group experience and adjustments through Line 7 to demonstrate the relationship between normalized claims for our current individual and small group business in Connecticut after accounting for the impact of adopting guaranteed issue and modified community rating. This comparison is intended as a reasonability check on both the historical individual claims experience and the associated adjustments. We note that the small group experience is based on a larger population and is more similar to the anticipated 2014 Individual market.

- Lines 1 and 2
  - 1 - Member months for experience incurred 11/1/2011 through 10/31/2012 and paid through 12/31/2012.
  - 2 - Corresponding paid claims PMPM. The individual experience has been adjusted to reflect the national-average level of large claims for Aetna's individual business.
  - Approximately 1.6% of the individual claims on Line 2 is a provision for claims incurred but not reported (IBNR) as of 12/31/2012.
  - No credibility adjustment is made to experience period claims since the Connecticut experience for each market exceeds Aetna's threshold for full credibility which is set at 24,000 member months.
- Lines 3a through 3e are used to normalize claims to a common basis. Adjustments include:
  - 3a – Average demographic factor (the factor for a 45 year-old male is 1.0).
  - 3b – Adjustment to reflect the difference between the current mix of benefit plans and the benefit level for a common silver plan.
  - 3c – Adjustment to include costs for state-specific Essential Health Benefits (EHBs) not included in Aetna's existing benefit factors.
  - 3d – Area index to reflect the average claims level in the experience vs. Hartford County.
  - 3e – Adjustment to reflect the cost difference between the actual duration mix of individual business and the anticipated lifetime average duration.
- Line 4
  - Product of Lines 2, 3b, 3c, 3e divided by the product of Lines 3a, 3d.
- Line 5
  - Anticipated impact of guarantee issue on individual experience and modified community rating on small group experience in the state of Connecticut. Please see Exhibit G for a description of the development of the guaranteed issue adjustment. The impact of modified community rating reflects the additional selection inherent in the Exchange.
- Line 6
  - Adjustment to reflect differences between the morbidity-profile of Aetna's historical experience and the overall neutral market.
- Line 7
  - Product of Lines 4 – 6.
- Line 8
  - Estimated impact of increased first-year utilization for previously uninsured participants due to pent-up demand as discussed in Exhibit G.
- Lines 9 and 10
  - Medical trend factor used to project historical experience to the pricing period. Please see Exhibit E for support of the trend assumption.

- Line 11
  - Adjustment for changes in network contracts between the historical experience and products/network that will be offered in 2014.
- Line 12
  - Adjustment to remove the impact of tobacco use in the experience data, allowing a separate tobacco-use rating factor to be used in the rating formula. This adjustment is not applicable in Connecticut.
- Line 13
  - Product of Lines 7, 8, 10, 11 and 12.
- Line 14
  - Adjustment bringing the base rate to the 1.0 factor level (age 21) for the new age scale.
- Line 15
  - Adjustment to rate level in Hartford County to offset changes in rating area definitions and mix of business. This adjustment is 1.0 since we are assuming a similar distribution in membership by rating area and believe costs in the future will follow a pattern similar to the current small group market.
- Line 16
  - Product of Lines 13 – 15.
- Line 17
  - Estimated cost of pediatric dental claims adjusted to the basis for the base rate.
- Line 18
  - Sum of Lines 16 and 17.
- Line 19
  - Adjustment for the family billing limit of three dependent children.
- Line 20
  - Adjusts rate level from the common silver plan in Line 3c to that of the Connecticut specific Standard Silver Plan which is the 1.0 for the new plan factor scale.
- Line 21
  - Product of Lines 19 and 20.
- Line 22
  - Anticipated reduction in claims costs due to expected reimbursements from the federal reinsurance program.
- Line 23
  - Product of Lines 21 and 22.
- Line 24
  - One minus the estimated portion of premium required for retention. Please see Section 12 of the Actuarial Memorandum for a discussion of our retention assumptions.
- Line 25
  - Product of Lines 23 and 24.
- Line 26
  - Adjustment for the anticipated impact of the federal risk adjustment program.
- Line 27
  - Final Base Rate for the Standard Silver Plan, calculated as the product of Lines 25 and 26.

Aetna Life Insurance Company
Connecticut Individual Market Index Rate Development
Serff # AETN-129004040
HIOS Product ID: 39159CT008

			Individual PPO	Small Group HMO
1)	**Member Months (Nov 11-Oct 12)**		258,611	348,099
2)	**Paid Claims PMPM (Nov 11-Oct 12)**		$145.81	$300.22
3)	Normalize:			
	a) Weighted Average A/G Claims Factor (Age 45)	/	1.0737	1.1127
	b) Benefit Relativity to Silver Plan	x	1.1082	0.8690
	c) EHB Adjustment	x	1.0207	1.0050
	d) Common Rating Area Adjustment	/	1.0966	1.0801
	e) Duration Adjustment	x	1.0811	1.0000
4)	Normalized PMPM Claims Subtotal	=	**$151.44**	**$218.17**
5)	Guaranteed Issue (IVL)/ Community Rating (SG)	x	1.4471	1.0175
6)	Market Level Risk Adjustment	x	1.0000	1.0000
7)	**Comparative HCR Claims per Segment**	=	**$219.14**	**$221.99**
8)	Individual Uninsured Pent up Demand	x	1.0440	
9)	Allowed Claim Trend - Rate		10.00%	
	No. of Months		26	
10)	Claim Trend Factor	x	**1.2294**	
11)	Network Recontracting Adjustment	x	0.9883	
12)	Non-Tobacco User Adjustment	x	1.0000	
13)	**Silver Claim Rate**	=	**$277.97**	
14)	Age Scale Normalization to 21 on HHS curve	x	0.7731	
15)	Rating Area Normalization to 1.0 on Rating Area Curve	x	1.0000	
16)	**Normalized Claim Rate for Silver Plan**	=	**$214.89**	
17)	Pediatric Dental	+	$1.93	
18)	**Normalized Claim Rate for Silver Plan w/ Pediatric Dental**	=	**$216.82**	
19)	Adjustment for 3-child Family member cap	x	1.0060	
20)	Adjustment to Base Silver Plan	x	1.0305	
21)	**Silver Base Claim Rate**	=	**$224.78**	
22)	Market-level Reinsurance	x	0.9080	
23)	Expected Net Claims	=	**$204.09**	
24)	1 - Retention	/	0.7301	
25)	Base Premium before 3 R	=	**$279.54**	
26)	Market-level Risk Adjustment	x	1.0000	
27)	**Silver Base Premium Rate**	=	**$279.54**	

Aetna Life Insurance Company
Exhibit G: Adjustments for Changes in Population Morbidity

The projected claims level for the 2014 individual market needs to reflect changes in the average morbidity of the insured population. Adjustments are required for the impact of:

- removing medical underwriting
- adopting guaranteed issue of coverage
- delayed entry of the currently insured
- increased first-year utilization (pent-up demand) among the currently uninsured population that will enter the individual market in 2014

The approach taken to estimate the impact of these changes is discussed below.

1. Guaranteed Issue Adjustment

A key provision of the Affordable Care Act is that all individual policies effective on or after January 1, 2014 are offered on a guaranteed issue basis, with rate differentiation for a plan limited to differences in rating area, age, and tobacco-use. In the pre-2014 Individual market, policy availability and rates vary by rating area, age, health status, and gender. The morbidity profile of the individual market will change in 2014 due to the impact of these rating changes and other healthcare reform provisions, including the individual mandate, advanced premium tax credits, and cost sharing subsidies.

A profile (size and morbidity) of the population in Connecticut is constructed along the following dimensions to estimate the impact of these market changes:

- Current coverage segment – Individual Non-Grandfathered, Individual Grandfathered, Small Group, High Risk, and Uninsured
- Health Status
- Age Band
- Income Level

The population associated with each intersection of the above dimensions is developed from data provided by McKinsey and Company. The morbidity of each coverage segment is initially developed based on the following sources:

- Individual Non-Grandfathered, Individual Grandfathered, Small Group – Aetna historical experience
- High Risk – Wakeley Consulting Group risk score data
- Uninsured – Medical Expenditure Panel Survey

This analysis excludes population segments with income less than 133% of the Federal Poverty Level (FPL) since these individuals are expected to be eligible for Medicaid and would not be part of the 2014 individual market.

We adjust the aggregate morbidity for each coverage segment to incorporate information from the SOA study “Cost of the Newly Insured Under the Affordable Care Act “and to reflect our best estimate of the relative morbidity of each coverage type. Based on internal risk adjustment models and Aetna experience, we estimate that the average small group morbidity is approximately 175% that of the individual membership. We believe the overall morbidity of the current uninsured population is equivalent to that of the current individual population. This estimate is reasonable given the SOA study mentioned above. The allowed costs in the SOA study appear to include changes in demographic mix, and as such, are not directly comparable to the values our modeling requires.

Once the profile of the population is constructed, a market migration model is used to assign each coverage segment to a 2014 insurance segment. This assignment is performed by calculating the perceived cost of each available coverage choice and assuming that the individuals in each intersection make the optimal choice.[1] The model allows assumptions to be made on the value assigned to insurance coverage and the variability in member choices from the optimal decision.

The resulting 2014 individual market morbidity profile is calculated as the weighted average of the relative morbidities of the members electing non-grandfathered individual market coverage for the 2014 policy year. A summary of the pre-2014 population and resultant individual market profile follows. This summary includes the adjustments discussed below for delayed entry of the currently insured and pent-up demand.

Connecticut	Pre-2014		2014 Non-Grandfathered Individual		
	Population ('000s)	Morbidity Relativity*	Population ('000s)	Population as % of Total	Morbidity Relativity*
UNINSURED	280	100%	53	49%	140%
INDIVIDUAL	192	101%	29	27%	109%
Individual - Grandfathered	21	106%	4	4%	107%
Individual - Non-Grandfathered	171	100%	25	23%	109%
SMALL GROUP	444	175%	24	22%	186%
HIGH RISK	3	400%	3	2%	400%
TOTAL	918	140%	109	100%	151%

*Morbidity relativities assume that the current non-grandfathered morbidity is 100%.

2. Adjustment to Reflect Delayed Entry due to Policy-Year Renewal Timing

We expect that existing non-grandfathered members will be able to maintain underwritten policies until the first policy anniversary after December 31, 2013 – which could be as late as December 2014. This impacts the composition of the single risk pool in 2014 (vs. the model's assumption that all underwritten individual polices terminate at the end of 2013). We adjust the model to assume only half the current individual market that would otherwise enter the single risk pool actually does due to this delayed entry.

While we anticipate higher insurance rates in 2014 will cause the healthiest portion of the current individual market to remain in pre-2014 plans as long as possible, we have assumed that the impact is evenly spread across the current individual population. We do not adjust the assumed migration by age – so the impact of delayed entry could be larger than indicated by the above results.

3. Pent-Up Demand for the Newly Insured

We expect that individuals purchasing coverage in 2014 who do not currently have health insurance will have deferred needed care in the past. Regardless of the relative morbidity of this population, we expect that they will have a higher level of utilization in the first year of coverage as they take advantage of increased access to the health care system.

We reviewed historical Aetna experience in the individual market segregated by whether applicants had health insurance coverage prior to purchasing a policy from Aetna. Based on an analysis of this data, we

[1] An individual in the pre-2014 individual grandfathered insurance segment would compare the perceived costs associated with retaining their grandfathered policy (premium + expected out-of-pocket medical costs), moving into the post-2014 individual market (premium + expected out-of-pocket medical costs – available subsidies), or going uninsured (mandate tax + expected out-of-pocket medical costs).

conclude that premiums should be 20% higher than average for applicants who did not have prior coverage. This data includes medically-underwritten business over a variety of policy durations.

The 20% difference between average claims and claims for individuals who previously were uninsured is similar to the 15% impact discussed in a 1995 University of Minnesota report. Recognizing that the Aetna experience is limited to a medically underwritten population which could overstate this impact, we assume that the utilization for currently uninsured members in 2014 will be 15% greater than the current market average.

This assumption increases the relative morbidity of the currently uninsured population by 15% from the otherwise-assumed level. The results discussed above include this higher utilization level for members who do not have prior insurance coverage. We also consider model results using a 0% assumption for pent-up demand to isolate the impact of this factor. The guaranteed issue factor assuming a 0% change in utilization due to pent up demand is 1.447. The impact of pent-up demand is calculated as the multiplicative difference between 1.447 and the 1.510 indicated above, or 4.4%.

Aetna Life Insurance Company
Exhibit H: Projected MLR

The 2014 MLR expected for this product is 81.5%. This estimate does not include a credibility adjustment and is based on projected 2014 experience for plans that comply with the ACA market reform requirements. The following table details this calculation.

		Individual	Formula
(a)	Member Months	N/A	
(b)	Premium (pmpm)	$363.56	
(c)	Medical Cost (pmpm) (1)	$265.44	
(d)	Medical Benefit Ratio (MBR)	73.01%	= (c) / (b)
(e)	Quality Improvement Activities (pmpm)	$2.18	= (b) x 0.6 % (2)
(f)	Taxes and Fees (pmpm)	$35.23	= (b) x 9.69% (3)
(g)	Adjusted Premium (pmpm)	$328.33	= (b) - (f)
(h)	Adjusted Claims (pmpm)	$267.62	= (c) + (e)
	Medical Loss Ratio (MLR)	**81.5%**	= (h) / (g)

(1) Medical Costs are net of reinsurance recoveries estimated at $26.90 PMPM (or 9.20% of incurred claims).
(2) Spending on quality improvement activities is estimated to be 0.6% of premium.
(3) Taxes and fees are estimated to be 9.69% of premium.

NOTE: ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses.

Values reflect current actuarial projections and will differ from the final reported MLR.

This projection applies to the products included in this filing and is a standalone calculation for the 2014 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

Actuarial Memorandum and Certification
In Support of Unified Rate Review Template

General Information

Company Identifying Information:
- Company Legal Name: Aetna Life Insurance Company
- State: Connecticut
- HIOS Issuer ID: 39159
- Market: Individual
- Effective Date: 1/1/2014

Company Contact Information:
- Primary Contact Name: Joseph Bochicchio
- Primary Contact Telephone Number: 860-273-1795
- Primary Contact Email Address: BochicchioJ@aetna.com

Proposed Rate Increase(s)

No rate increase is proposed in this filing.

Experience Period Premium and Claims

Paid Through Date: The experience is paid through February 2013. The experience period shown is 1/1/2012 – 12/31/2012.

Premiums (net of MLR Rebate) in Experience Period: The premiums shown are date-of-service premiums from our actuarial experience dataset. For the Individual Connecticut Minimum Loss Ratio pool in 2012, the expected rebates were 2.4% of premium and were adjusted out of the premiums.

Allowed and Incurred Claims Incurred During the Experience Period:
- The medical cost analysis systems that provide estimates of completed allowed claims as well as utilization and unit cost metrics do not readily distinguish between Grandfathered and Non-Grandfathered blocks of business. Therefore, we used reports that include both portions of the existing experience block to estimate the relationship between incurred paid claims and incurred allowed claims. We also used this data to estimate the unit cost and utilization metrics and to allocate total incurred claims to the medical cost categories shown.
- In order to segregate non-grandfathered experience, we rely on a member-level data set which takes longer to construct that reports at higher levels of aggregation. As such, the experience data used for reporting on premium and incurred claims is paid through February 28, 2013. This data source does not provide detail on utilization levels or claims by service type. We use a different data source to calculate those values; that data is paid through March 31, 2013. The unit cost and utilization detail is considered to be reliable with three months of runoff.
- The Allowed claims are completed using the relationship between paid and completed paid claims, with data quality edits to ensure that allowed amounts are not skewed by the factors. The method tends to be less reliable for recent time periods, similar to paid completion.

- Incurred But Not Paid (IBNP) reserves are estimated using actuarial principles and assumptions that consider historical and projected claim submission patterns, historical and projected claim processing time, medical cost trends, utilization of health care services, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors. For the experience period, we used two months of paid claim runoff to reduce the reliance on reserve estimates in the most recent incurred months. The IBNP reserves represent approximately 2% of the experience period claims.
- The IBNP completion factor is based on the claims set reported on WS1. This is an appropriate basis for developing the IBNP factors because this basis includes most of the experience reported on WS1 and the claims for members living in Connecticut.

Benefit Categories

The benefit categories used generally align with the instructions (dated March 18, 2013). Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, while Outpatient Hospital includes outpatient surgical as well as emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses. Other includes home health care, mental health care, medical pharmacy expenses, as well as laboratory and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

Projection Factors

Changes in the Morbidity of the Population Insured: The projected change in the morbidity of the population is based on modeling described in further detail in the actuarial memorandum included in the rate filing dated May 29, 2013. It includes the impact of:

- Guaranteed Issue (based on a market migration model),
- the Duration Adjustment (reflecting current durational mix),
- and Individual Uninsured Pent-Up Demand (incorporating first-year impact of previously uninsured participants).

Trend Factors (cost/utilization): The trends utilized for the projections for Connecticut were developed based on Small Group experience for PPO plans for the Connecticut market. Actual historical net claims are reviewed at the market level. The data utilized in the trend analysis was based on the claim data incurred from January 2009 – December 2012 paid through December 2012. To develop the pricing trend for 2012, the aggregate net trend for Calendar Year 2012 is normalized for area, seasonality, demographics and plan design. Additional adjustments are made based on items that were believed to have had an effect on the experience data such as changes in provider reimbursements, benefits and an increase in claims due to seasonal flu and snow. The changes in unit price contracted for professional services and the estimated increase in claims expected as a result of seasonal flu and snow were developed by our Medical Economics Unit. The pricing trend for 2013 and 2014 is developed by applying the value of the expected changes to the above listed items to the 2012 pricing trend.

Changes in Benefits / Demographics / Other Adjustments: The expected mix of business for 2014 was projected and used to determine a projected market average rate. The effect of the change in

mix of business due to differences in benefits, demographics, and area is shown in the "Other" adjustment column.

Credibility Manual Rate Development

We relied fully upon our experience data and have therefore not provided manual rating assumptions.

Credibility of Experience

Aetna's standard for full credibility is 24,000 member months. The Connecticut experience exceeds this threshold.

Paid to Allowed Ratio

We are projecting the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 63%:

Tier	Projected Membership Distribution	Projected Average Premium	Actuarial Value
Catastrophic	11.4%	$177	60%
Bronze	67.2%	$356	60%
Silver	19.3%	$487	70%
Gold	2.1%	$477	80%
Total	100.0%	$364	63%

Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM:

Aetna is projecting a neutral impact of risk adjustment. We expect that we will have membership enrolled at approximately the market morbidity.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):

We are projecting an assessment of $5.25 per member per month and reinsurance payments of $26.90 per member per month for a net impact of recovering $21.65 per member per month. Projected reinsurance recoveries were based on internal tools used to price stop-loss coverage on large group business, which is reasonably similar to the projected block in that it is guaranteed issue and not medically underwritten. These projections reflect the anticipated demographic mix of 2014 enrollment.

Non-Benefit Expenses and Profit & Risk

Non-benefit expense and profit & risk loads are determined on a PMPM and percentage of premium basis. We calculate the expected equivalent percentage of premium to determine the required premium level. Premiums in this market reflect this target percentage for expenses and profit but differ between the two products to reflect differences in anticipated administrative expenses other than exchange user fees.

Administrative Expense Load: Projected PMPM costs of $52.15 for general administrative expenses, which includes 3.5% for commissions, for the Aetna PPO product and Co-Branded PPO product. These projections are derived from corporate experience for individual products and projections of Aetna's individual market enrollment in 2014 and changes in Aetna's cost structure from the 2012 experience.

Profit (or Contribution to Surplus) & Risk Margin: 3% AFIT profit margin

Taxes and Fees: Projected PMPM costs of $0.07 Risk Adjuster Program Fee and $0.17 PMPM for Patient Center Outcomes Research Fee, plus 2.6% Health Insurer Fee, 1.62% FIT and 2.06% State Premium Tax. We also project Exchange user fees of 1.9% based on an assumption that 53% of the membership in this market enrolls through the Marketplace.

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is 81.5%, not including the credibility adjustment.

Index Rate

The index rate for the experience and projected periods are set equal to the actual and projected allowed claims, respectively, less non-EHB benefits. The non-EHBs in the experience period are coverage for an adult eye exam every 12 months and an optional dental rider. The non-EHBs in the projection period are coverage for an adult eye exam every 12 months.

Historical claims for the dental rider are derived from a separate reporting system. We treat the full amount of these claims as non-EHBs. Non-EHB claims for the adult eye exams are estimated based on Aetna's historical claims costs for this service.

This index rate reflects the projected mix of business by plans. The AV pricing values for each plan were set based on the actuarial value and cost-sharing design of the plan as well as the plan's provider network, delivery system characteristics, and utilization management practices. Rates do not differ for any characteristic other than those allowable under the regulations as described in as described in 45 CFR Part 156, §156.80(d)(2). Administrative cost variation between the Aetna PPO and Co-Branded PPO products were considered in development of AV pricing values; no variation in administrative costs is considered for plans within a product..

After reviewing the morbidity of our under age 30 enrollment across our book of business, and after considering the impact of the members eligible to enroll in the plan due to hardship, we have priced our catastrophic premiums to be approximately 25% below our bronze premium levels.

AV Metal Values

Information regarding AV Metal Value determination, including certifications, was previously provided in the memorandum included with the rate filing dated May 29, 2013.

The AV Metal Values for the On-Exchange and their Off-Exchange counterpart plans are based on standard plan design parameters established by Access Health Connecticut. In accordance with a

waiver obtained by Access Health Connecticut, the minimum AV differential between the 70 percent and the 73 percent silver plan variations is less than the two percent required under federal law. The AV Metal Values for the Co-Branded PPO plans are preliminary and an amended URRT will be submitted at a later date to reflect the final benefit designs and pricing.

AV Pricing Values

The fixed reference plan is 39159CT0080002. Benefit factors were developed taking into account whether a specific plan covers pediatric dental benefits, the expected benefit category weights, the plan cost sharing and in-network discounts and steerage to preferred providers (where applicable). The Co-Branded PPO plans also reflect lower administrative expenses specific to the product. No further adjustments are reflected in the AV pricing values beyond the catastrophic plan adjustment discussed above.

The AV Pricing Values for the Co-Branded PPO plans are preliminary and an amended URRT will be submitted at a later date to reflect the final benefit designs and pricing.

Membership Projections

The current membership distribution is not meaningful given the magnitude of market changes taking effect on January 1, 2014. Projections were entered at the product level rather than the plan level. Please see the section above on Paid to Allowed Ratio for projections by metallic tier. We assume that total enrollment will be similar to our current membership. We also have developed a distribution of membership by metal level based on modeling of market enrollment choices but have not developed detailed projections of membership by plan or variant to project membership subject to the cost-sharing subsidy. As such, membership is allocated within each metal level on an equal basis to each plan and then to each cost sharing variation within each Silver plan.

Terminated Products

The following products will be closed to new sales prior to 1/1/2014 and are included in the Terminated Products reporting column in Worksheet 2:

- 39159CT001
- 39159CT004
- 39159CT005
- 39159CT006
- 39159CT007

Due to the late guidance, we have listed the terminated products separately but all their experience is still combined into the first terminated product column.

Warning Alerts

Total Premium (TP) differs between Worksheets 1 and 2 by $170, or 0.0001%. This is due to rounding of premiums and the need to allocate member months and dollars evenly to the plans reported at the product level.

Total Allowed Claims (TAC) does not differ between Worksheets 1 and 2. However, the spreadsheet indicates a Warning because it incorrectly subtracts Risk Adjustment and Reinsurance from Worksheet 1 before comparing to Worksheet 2.

Historical Rate Increases are not populated for New Products based on the guidance in instructions dated March 18, 2013. They are also not populated for Terminated Products based on verbal guidance in American Academy of Actuaries call of April 18, 2013, as well as the impracticability of reporting meaningful historical rate increases for a combination of products.

Actuarial Certification

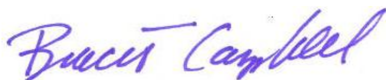
The Actuarial certification for the methodology used to calculate the AV Metal Value for each plan offered under the QHP has been provided separately in the required certification templates. The Actuarial certification for the methodology used to calculate the AV Metal Value for all other plans will be provided in the rate filing dated May 29, 2013. As noted above, the On-Exchange and their Off-Exchange counterpart plans are based on Standard Plan design parameters established by Access Health Connecticut. In accordance with a waiver obtained by Access Health Connecticut, the minimum AV differential between the 70 percent and the 73 percent silver plan variations is less than the two percent required under federal law.

I hereby certify that the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) was determined appropriately based on the claims expected to be paid for non-EHB benefits and the expected cost sharing and administrative expenses thereupon.

I hereby certify that the index rate is developed in accordance with federal regulations and the index rate and allowable modifiers are used in the development of plan specific premium rates.

In preparing the Part I Unified Rate Review Template, I relied upon information provided by Katherine Musler, FSA MAAA. The information provided consisted of guidance regarding methodology and data definitions to ensure compliance with all guidance and instructions received to date.

The Part I Unified Rate Review Template does not demonstrate the process used by Aetna to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated 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.



Bruce T. Campbell, FSA, MAAA

May 29, 2013
Date