Filing at a Glance

Company:	Aetna Life Insurance Company
Product Name:	DC ALIC PPO SG 2015
State:	District of Columbia
TOI:	H15G Group Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15G.003 Small Group Only
Filing Type:	Rate
Date Submitted:	06/13/2014
SERFF Tr Num:	AETN-129582423
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	AETN-129582423
Implementation Date Requested:	01/01/2015
Author(s):	Andrew Owen, Bruce Campbell, Barbara Hill, David Walker, Cynthia Parenteau, Brenda Dinnald, Robert Jackson, Amit Ghambir, Caitlin Bollbach, Amy Ovuka
Reviewer(s):	Efren Tanhehco (primary), Alula Selassie
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *District of Columbia* **Filing Company:** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *DC ALIC PPO SG 2015*
Project Name/Number: *2015 Exchanges - Aetna/ALIC*

General Information

Project Name: 2015 Exchanges - Aetna
Project Number: ALIC
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 06/16/2014
State Status Changed:
Created By: Barbara Hill
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: David Walker

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: Includes forms for products to be offered to Small Groups on the DC Health Benefits Exchange.

Filing Description:

Aetna Life Insurance Company 1Q15 Small Group PPO rate filing for DC.
The corresponding forms filing was submitted separately. The SERFF ID Number is AETN-129570411.

Company and Contact

Filing Contact Information

Cynthia Parenteau, P&RA Consultant
151 Farmington Ave
Hartford, CT 06156

ParenteauC@Aetna.com
860-267-2217 [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:

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Rate Information

Rate data applies to filing.

Filing Method:	Review & Approval
Rate Change Type:	Decrease
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	01/01/2014
Filing Method of Last Filing:	Review & Approval

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number 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	Decrease	-13.700%	-13.700%	$-85,041	100	$534,600	-3.300%	-19.900%

State: *District of Columbia* ***Filing Company:*** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*
Product Name: *DC ALIC PPO SG 2015*
Project Name/Number: *2015 Exchanges - Aetna/ALIC*

Rate Review Detail

COMPANY:

Company Name: Aetna Life Insurance Company
HHS Issuer Id: 77422

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
DC ALIC PPO SG 2015	77422DC007		100

Trend Factors:

FORMS:

New Policy Forms: GR-96792-SB-5250 02, GR-96792-SB-5253 02, GR-96792-SB-5255 02, GR-96792-SB-5257 02, GR-96792-SB-5259 02, GR-96792-SB-5261 02, GR-96792-SB-5263 02, GR-96792-SB-5265 02
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 302,103
Benefit Change: None
Percent Change Requested: Min: -19.9 Max: -3.3 Avg: -13.7

PRIOR RATE:

Total Earned Premium: 3,297,000.00
Total Incurred Claims: 2,481,000.00
Annual $: Min: 2,242.00 Max: 14,640.00 Avg: 4,510.00

REQUESTED RATE:

Projected Earned Premium: 534,612.00
Projected Incurred Claims: 416,300.00
Annual $: Min: 2,391.00 Max: 12,304.00 Avg: 5,346.00

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		DC ALIC PPO SG 2015	GR-96792-SB-5250 02, GR-96792-SB-5253 02, GR-96792-SB-5255 02, GR-96792-SB-5257 02, GR-96792-SB-5259 02, GR-96792-SB-5261 02, GR-96792-SB-5263 02, GR-96792-SB-5265 02	Revised	Previous State Filing Number: AETN-128972263 Percent Rate Change Request:	AE_DC_SG_77422_Rates_ON_v1.xlsm, DC SG Rate Manual - 1Q15 SHOP ALIC.pdf,

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Attachment AE_DC_SG_77422_Rates_ON_v1.xlsm is not a PDF document and cannot be reproduced here.

2015 District of Columbia
Small Group Premium Rate Manual

The following steps are used to calculate premium rates. Rates are determined using the prescribed member build-up approach, with a cap of 3 dependent children. For each member, including only the 3 oldest dependent children under age 21, calculate the Member Rate as follows:

1. **Market Index Rate** – Starting premium rate.

2. **Member Age Factor** – Rate factor for each member Age.

3. **Plan Relativity Factor** – Rate factor for each unique plan design.

   The product identifier will identify the plan. For each product identifier, there will be a plan relativity factor.

4. **Area Factor -** Rate factor to reflect differences in cost by geographic area.
   DC has only one area, therefore the area factor is 1.000.

5. **Effective Date Factor** – Premium rate level adjustment factor to reflect differences in cost by effective date.

6. **Final Member Premium** (1 x 2 x 3 x 4 x 5 steps above)
   Format will be the same as base rate table.

Add up the Member Rate for each covered member, subject to the dependent child cap, to determine the total premium for the policy.

Market Index Rate, Area, Tobacco and Effective Date Factor Tables

Rating Tables Effective 1/1/2015

Market Index Rate	372.53

Area Factor Table

Name	Area Factors
Washington	1.0000

Effective Date Factor Table

Effective Date	Factor
01/01/2015 - 3/31/2015	1.0000
04/01/2015 - 6/30/2015	1.0220
07/01/2015 - 9/30/2015	1.0445
10/01/2015 - 12/31/2015	1.0675

Age Factor Table

Age	Factor
<21	0.6540
21	0.7270
22	0.7270
23	0.7270
24	0.7270
25	0.7270
26	0.7270
27	0.7270
28	0.7440
29	0.7600
30	0.7790
31	0.7990
32	0.8170
33	0.8360
34	0.8560
35	0.8760
36	0.8960
37	0.9160
38	0.9270
39	0.9380
40	0.9750
41	1.0130
42	1.0530
43	1.0940
44	1.1370
45	1.1810
46	1.2270
47	1.2750
48	1.3250
49	1.3770
50	1.4310
51	1.4870
52	1.5450
53	1.6050
54	1.6680
55	1.7330
56	1.8010
57	1.8710
58	1.9440
59	2.0200
60	2.0990
61	2.1803
62	2.1803
63	2.1803
64	2.1803
65+	2.1803

Plan Relativity Factor Table

PPO Plans				
Actively Marketed Plans 01/01/15				
HIOS Plan ID	Metal Tier	PLAN NAME	Plan Relativity Factor	AV Factor
77422DC0070013	Gold	DC Gold OAMC 90 50	1.26193	0.813
77422DC0070005	Gold	DC Gold OAMC 2000 70%	1.06371	0.790
77422DC0070025	Gold	DC Gold OAMC SJ 1500	1.16023	0.787
77422DC0070009	Gold	DC Gold OAMC 70 50	1.18401	0.784
77422DC0070017	Silver	DC Silver OAMC 2000 90 50 HSA	1.00000	0.693
77422DC0070026	Silver	DC Select Silver OAMC SJ 2500	1.03119	0.695
77422DC0070021	Silver	DC Silver OAMC 5000 70%	0.88191	0.687
77422DC0070001	Bronze	DC Bronze OAMC 5400	0.81795	0.582

Note:
Rates will be reduced where necessary to ensure compliance with regulatory requirements, including the 3:1 federal requirement and the DC 4% incremental limit.

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Supporting Document Schedules

Bypassed - Item:	Actuarial Justification
Bypass Reason:	This is not a new form filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	ALIC DC SG 2015 Memo and Cert.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	ALIC DC SG 2015 Memo and Cert.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	The filing is made by Aetna.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	This is the initial submission of the rate revision.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter All Filings
Comments:	
Attachment(s):	AETNA 2015 DC Small Group RateFilingCoverLetter.pdf DC SG SHOP Cover Letter - ALIC 1Q15.pdf
Item Status:	

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Status Date:	

Satisfied - Item:	DISB Actuarial Memorandum Dataset
Comments:	
Attachment(s):	Additional Actuarial Data Template - DC SG PPO VALUES.xlsx
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	This is not a P & C Filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	This is not a P & C Filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	AE_DC_SG_77422_URRT_BOTH_2015_v1.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	Additional Supporting Documentation
Comments:	

SERFF Tracking #:	*AETN-129582423*	***State Tracking #:***		***Company Tracking #:***	*AETN-129582423*

State:	*District of Columbia*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only*		
Product Name:	*DC ALIC PPO SG 2015*		
Project Name/Number:	*2015 Exchanges - Aetna/ALIC*		

Attachment(s):	DC_SG_PPO Exhibit A-2 Plan Designs and Screenshots.pdf DC SG ALIC 2015Aetna AVCCert.pdf ALIC SG Consumer Summary.pdf Exhibit D - Projected Membership Distribution by County.pdf Exhibit A-1 Product Portfolio.pdf Exhibit B - Projected Membership Distribution by Plan.pdf Exhibit C - Calculation of Plan Base Rates from Projected Index Rate.pdf Exhibit E - Demographic Changes.pdf Exhibit J - Projected MLR.pdf Exhibit F - Projected Age Gender Distribution.pdf Exhibit G - Projected Area Distribution.pdf Exhibit H - Projected Tobacco Usage.pdf Exhibit K - Additional Plan Base Rate Calculations.pdf Part II Justification (Plain Language Summary) ALIC SG.pdf DC SG PPO rate filing check list.pdf
Item Status:	
Status Date:	

Satisfied - Item:	FOIA Letter
Comments:	
Attachment(s):	FOIA 2015 Request DC ALIC SG ON.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	AETN-129582423	**State Tracking #:**		**Company Tracking #:**	AETN-129582423

State:	District of Columbia	**Filing Company:**	Aetna Life Insurance Company
TOI/Sub-TOI:	H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only		
Product Name:	DC ALIC PPO SG 2015		
Project Name/Number:	2015 Exchanges - Aetna/ALIC		

Attachment Additional Actuarial Data Template - DC SG PPO VALUES.xlsx is not a PDF document and cannot be reproduced here.

Attachment AE_DC_SG_77422_URRT_BOTH_2015_v1.xlsm is not a PDF document and cannot be reproduced here.

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	Aetna Life Insurance Company
State:	District of Columbia
HIOS Issuer ID:	77422
Market:	Small Group
Policy Form:	
Effective Date:	01/01/2015
Filing Reference Number:	AETN-129582423

Company Contact Information:

Name:	David M. Walker
Telephone Number:	(215) 775-0083
Email Address:	WalkerD9@Aetna.com

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

1) Provide support for the development of the Part I Unified Rate Review Template;
2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with the Aetna Life Insurance Company in the District of Columbia (DC) beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available on the Federally Facilitated Exchange in DC.

2. Proposed Rate Change

Monthly premium rates for all Small Group Market products in DC are being revised for effective dates January 1, 2015 through December 31, 2015. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Aetna is proposing a total average decrease of 13.7%. This change reflects the premium and member weighted average change by plan based on Worksheet 2 of the URRT. The actual increase by plan ranges from -19.9% to -3.3% as seen in the table below.

HIOS Plan-ID	Plan	Metallic Tier	Rate Increase
77422DC0070013	DC Gold OAMC 90 50	Gold	-19.5%
77422DC0070005	DC Gold OAMC 2000 70%	Gold	-15.6%
77422DC0070025	DC Gold OAMC SJ 1500	Gold	N/A
77422DC0070009	DC Gold OAMC 70 50	Gold	-19.9%
77422DC0070017	DC Silver OAMC 2000 90 50 HSA	Silver	-15.5%
77422DC0070026	DC Select Silver OAMC SJ 2500	Silver	N/A
77422DC0070021	DC Silver OAMC 5000 70%	Silver	-15.7%
77422DC0070001	DC Bronze OAMC 5400	Silver	-3.3%

A. Reason for Rate Change(s):
Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- Revisions to our assumptions about population morbidity and the projected population distribution;
- Changes in cost sharing levels to ensure that plans comply with Actuarial Value requirements; and
- Changes in provider networks and contracts.

3. Experience Period Premium and Claims

A. Paid Through Date:
The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through February 28, 2014.

B. Premiums (Net of MLR Rebate) in Experience Period:
Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered individual business in DC. Based on internal projections and the MLR Annual Reporting Form for Calendar Year 2013, the expected rebate for the DC Small Group MLR Pool for 2013 is approximately 0.81% of premium. As such, no MLR rebates are adjusted out of the premiums earned in 2013 and reported on Worksheet 1 of the Part I URRT.DC

C. Allowed and Incurred Claims Incurred During the Experience Period:
Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level details and allow us to distinguish between Grandfathered and Non-Grandfathered blocks of business.

Incurred claims are developed through the process of estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends,

claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off to reduce the impact of IBNP estimates in the most recent incurred month. As a result, the IBNP reserves account for approximately 4.4% of the experience period incurred claims.

4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated March 20, 2014. 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.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The projected change in the morbidity of the population is based on modeling for the projected impact on the individual and small group market of:

- Guaranteed Issue (based on a market migration model)
- Pent-Up Demand for the current uninsured population that will enter the small group market

We also adjust the experience period claims to account for estimated differences between the morbidity of our current business and the overall individual and small group market in DC.

B. Changes in Benefits:

These products include additional benefits to bring them into compliance with DC Essential Health Benefits (EHBs). The benefit changes determined to have an impact on rates from the experience period include the following:

- Expansion of DME benefits
- Coverage for nutritional formula
- Expansion of infertility coverage
- Coverage for eye glasses for children
- Home health care and private duty nursing

The estimated net allowed impact of these changes relative to the current combined individual and small group base period experience is approximately 1.2% of claims cost.

C. Changes in Demographics:

Experience data was normalized for projected changes in the 2015 age gender mix using Aetna demographic factors. The projected enrollment by age was based on a blend of the initial enrollment in

Individual products in 2014 and Small Group experience from 2013. While this increases the average rate, this does not cause an increase to age specific rates.

D. Other Adjustments:
The expected mix of business for 2015 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.

E. Trend Factors (Cost/Utilization):
Anticipated annual trend from the experience period to the rating period for the product line is as follows:

Component	Unit Cost	Utilization	Benefit Changes Utilization	Total Trend
Total	5.4%	3.5%	5.5%	**15.1%**

a. Medical and Pharmacy Trend

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that will start in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived from the federal risk adjustment program factors. The amount shown above is the annualized impact.

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in the table above are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend as noted above.

6. Credibility Manual Rate Development
We did not rely on our market single risk pool experience data reported in Section 1, Worksheet 1 of the URRT.

A. Source and Appropriateness of Experience Data Used:
The source data for our manual rate is the experience incurred from January 2013 to December 2013 and paid through February 2014 for Aetna Life Insurance Company in the DC and Virginia Individual and Small Group market. Aetna does not consider the District of Columbia experience alone to be credible.

In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combined was considered in developing the index rate.

The individual and small group market experience were combined to establish a common rate but for Federal MLR purposes the individual and small group markets will remain separate in the District. The Individual and Small Group experience used as the basis for the manual rate were adjusted for changes in population risk morbidity, benefits, and demographic age normalizations.

B. Adjustments Made to the Data:
The data is adjusted for the projected changes in network, provider contracts, and claims adjudication.

C. Inclusion of Capitation Payments:
No services provided in 2015 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

7. Credibility of Experience
No credibility is assigned to the experience data. This is due to the use of alternate experience data.

8. Paid-to-Allowed Ratio
We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 68.5% demonstrated below from Worksheet II of the URRT.

Total Incurred claims, payable with issuer funds	$2,102,733
Total Allowed Claims (TAC)	$3,070,649
Paid to Allowed Ratio	0.685

The projected average premium is based on a 1.0 rating area, average age 40, and member distribution by plan as shown in Exhibit B.

Tier	Projected Membership Distribution	Projected Average Premium	Actuarial Value
Bronze	18%	$306	58%
Silver	70%	$363	69%
Gold	12%	$436	79%
Total	100.0%	$361	69%

9. Risk Adjustment and Reinsurance
We developed a market base rate that represents the average market morbidity expected in 2015. 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.

There will be no reinsurance recoveries, as the reinsurance program only applies to individual products. This filing is for a small group product.

10. Non-Benefit Expenses and Profit & Risk

The Retention Portion of the Market Base Rate is 22.51%. This was developed from the following items and approximated as shown:

1. Taxes and Fees 7.89% comprised of:
    a. Premium Taxes of 2.75 %
    b. Patient Centered Outcomes Research Fund of $0.17 per member per month, converted to 0.04%
    c. d. Health Insurer Fee of 3.0%
        i. 1.95% paid post-tax as the Health Insurer Fee
        ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
    e. No Exchange User Fee for SHOP participation.
    f. Federal Income Tax of 2.1%, assuming 35% tax rate
2. Commissions of 4.02% of premium
3. General Administrative Expenses of $29.91, converted to 6.70% of premium based upon an expected average premium level

Of the above total general administration expenses,

    a. 0.60 % is classified as Quality Improvement Activities under 45 CFR Part 158.

4. Risk Charge of 3.90%

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

The Risk Charge of 3.90% is in line with the amount allowed in the Risk Corridor calculation.

11. Projected Loss Ratio

The expected loss ratio for these products is 77.49%. This is consistent with the effective retention target of 22.51% of premium. As noted below, Aetna projects an MLR in excess of the minimum regulatory requirement.

A projection of the MLR for this product is provided in Exhibit J. This projection includes anticipated experience for this product for the 12 months in 2015 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 84.78% as illustrated in Exhibit J.

12. Average Annual Premium

Based on the plan adjusted index rate of $445.51 as shown in Worksheet 2 of the URRT, the average annual premium for this product is $5,346.

13. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Individual market in DC through Aetna Life Insurance Company. Rates for plans that may be renewed outside the single risk pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing and will be submitted in a separate filing as necessary.

The experience reported on Worksheet 1 includes all non-grandfathered experience that is part of the Individual Market in DC, and includes transitional policies, Conversion policies, and association plans issued to individuals.

14. Index Rate

The index rate for the projection period is set equal to the projected allowed claims. The 2015 plans do not cover any non-EHBs.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and 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 45 CFR Part 156, §156.80(d)(2).

15. Market-Adjusted Index Rate

Exhibit K illustrates the development of the Market Adjusted Index Rate. The three adjustments (Transitional Reinsurance, Risk Adjustment, and Exchange User Fees) were discussed previously. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

16. Plan-Adjusted Index Rates

Exhibit K illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The Plan Adjusted Index Rates are displayed in Column 15. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The result of these analyses is the cost sharing adjustment (1.0 indicates full coverage of allowed claims) in Column 8. In Column 9, we applied an adjustment to reflect the impact of the different levels of cost sharing on the use of medical services. These adjustments are based on the induced utilization factors used in the Risk Adjustment program, and have been normalized to result in an aggregate factor of 1.0 when applied to the projected 2015 membership.

B. Provider Network, Delivery System, and Utilization Management:

The network adjustment (Column 6) reflects the estimated impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences, and estimated the expected impact on allowed claims.

C. Benefits in addition to EHBs:

The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). These products do not provide coverage for non-EHBs.

D. Non-Tobacco Adjustment:

Per DISB instructions, we applied no load for tobacco usage.

E. Catastrophic Plan Eligibility:

We are not filing any catastrophic plans in the small group market.

F. Distribution and Administrative Costs:

We applied an adjustment to load the rate for the expected cost impact of limiting billable members to three dependents younger than age 21. This adjustment is reflected in Column 13. Columns 14a and 14b reflect the projected administrative costs and profit margin. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Reinsurance Contribution, Risk Adjustment

User Fee, and Exchange User Fee, which are reflected elsewhere. These expense and profit assumptions do not vary by plan.

17. Calibration

A. Age Curve Calibration:

The age factors are based on the DC specific age scale. The factors are shown in Exhibit F.

We projected an average age factor for the 2015 membership of 1.2373. We determined a calibration factor of .808 by determining the average age factor (using the DC specific age curve) for the projected enrollment by age and taking its reciprocal. The average age factor is a member-weighted average; the projected age distribution is based on a blend of the initial enrollment in Individual products in 2014 and Small Group experience from 2013.

Based on Aetna's Individual and Small Group experience, we estimated that billing for no more than three dependents under age 21 requires a 0.50% increase to the base rate.

B. Geographic Factor Calibration:

Exhibit D summarizes the rating area definitions and factors. DC only has one rating area and an area factor of 1.0. Exhibit G displays the projected membership by area and the projected average area factor of 1.0.

18. Consumer-Adjusted Premium Rate Development

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 will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

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

As an example of this calculation, consider a family living in DC that enrolls in the DC Silver OAMC 2000 90_50 HSA plan. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6. The rate for this family is calculated as:

Member Age	42	40	13	11	8	6
Market Base Rate	$526.41	$526.41	$526.41	$526.41	$526.41	$526.41
Age Factor	1.053	0.975	0.654	0.654	0.654	0.654
Area Factor	1	1	1	1	1	1
Tobacco Factor	N/A	N/A	N/A	N/A	N/A	N/A
Plan Factor	0.708	0.708	0.708	0.708	0.708	0.708
Final Rate	$392.45	$363.38	$243.74	$243.74	$243.74	N/A

The family's final monthly rate is the sum of the member rates, or $1,487.07. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example. Since we apply no tobacco load in DC, we did include a tobacco factor in the above calculation.

19. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV Calculator. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material

impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values. Exhibit A-2 provides a summary of the plan designs as well as AV screenshots from the calculator.

20. AV Pricing Values

The fixed reference plan is 77422DC0070017 (DC Silver OAMC 2000 90_50 HSA plan). Benefit factors were developed taking into account the allowable rating characteristics and discussed above and illustrated in Exhibit K. The resulting plan factors are displayed in Column 20 of Exhibit C. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. 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:

a) State- and product-specific service category weights;
b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and, copays
c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

21. Membership Projections

The model discussed in the "Claims Development and Morbidity Adjustments" section below 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.

Exhibit K summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through February 2014, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans. We assumed that total enrollment will be similar to our current enrollment.

22. Terminated Products

The following products will be closed to new sales prior to January 1, 2015, and are included in the Terminated Products reporting column in Worksheet 2:

- 77422DC0070003 (Aetna Bronze OAMC 6350 RE)
- 77422DC0070007 (Aetna Gold OAMC 2000 70% RE)
- 77422DC0070011 (Aetna Gold OAMC 70/50 RE)
- 77422DC0070015 (Aetna Gold OAMC 90/50 RE)
- 77422DC0070019 (Aetna Silver OAMC 2000 90/50 HSA RE)
- 77422DC0070023 (Aetna Silver OAMC 5000 70% RE))

Consistent with the URRT instructions, experience for all terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

23. Plan Type

All plans are consistent with the plan type indicated in Worksheet 2.

24. Warning Alerts

The URRT as submitted does not include any Warning Alerts.

25. Benefit Design

This filing includes the following standard plans: one Bronze, six Silver, and four Gold. These plans will be offered through the Exchange and will include 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 Exhibit A and B. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

26. Marketing

As described above, all of these plans will be made available through the Exchange.

27. 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.

28. Renewability

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

29. Claims Development and Morbidity Adjustments

A key provision of the PPACA is that all individual policies effective on or after January 1, 2014 are offered on a guaranteed issue basis without rating for pre-existing medical conditions, with product-level rate differentiation limited by the actuarial value requirements of the four metallic tiers, and rating variations limited to age, network and rating area.

In the pre-January 1, 2014 Individual market environment in DC, rates varied by network, rating area, age, gender, and the medically underwritten health-status, and coverage could be denied based on medical underwriting exams. In addition to the elimination of medical underwriting, PPACA-related rating changes including the individual mandate, advanced premium tax credits, and cost sharing subsidies will motivate more people to purchase individual insurance. As a result of the changes in product issuance, rating, and financial assistance available to individuals without group insurance, the morbidity profile of the individual insurance market in DC changed in 2014. The adjustment for this change was discussed in section 5 A above.
We are using this projection to set our prices at the anticipated market morbidity levels.

30. Company Financial Condition

As of December 31, 2013, the total adjusted capital (TAC) held by Aetna Life Insurance Company was approximately $3.5 billion. This amount is disclosed in the Company's statutory financial statement dated December 31, 2013. 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

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT 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, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, David M. Walker, am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of DC, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:

    a. ASOP No. 5, Incurred Health and Disability Claims
    b. ASOP No. 8, Regulatory Filings for Health Plan Entities
    c. ASOP No. 12, Risk Classification
    d. ASOP No. 23, Data Quality
    e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
    f. ASOP No. 41, Actuarial Communications.

2. The Projected Index Rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
    b. Developed in compliance with the applicable Actuarial Standards of Practice,
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
    d. Neither excessive, deficient, nor unfairly discriminatory.

3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.

4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.

June 12, 2014

David M. Walker, ASA, MAAA — Date
Aetna

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	Aetna Life Insurance Company
State:	District of Columbia
HIOS Issuer ID:	77422
Market:	Small Group
Policy Form:	
Effective Date:	01/01/2015
Filing Reference Number:	AETN-129582423

Company Contact Information:

Name:	David M. Walker
Telephone Number:	(215) 775-0083
Email Address:	WalkerD9@Aetna.com

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

1) Provide support for the development of the Part I Unified Rate Review Template;
2) Provide support for the assumptions and rate development applicable to the products supported by the policy forms referenced above;
3) Request approval of the resulting monthly premium rates for the products supported by the policy forms referenced above; and
4) Provide summaries of the benefit details for the products/plan designs referenced by this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.

These rates are for plans issued in conjunction with the Aetna Life Insurance Company in the District of Columbia (DC) beginning January 1, 2015. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be available on the Federally Facilitated Exchange in DC.

2. Proposed Rate Change

Monthly premium rates for all Small Group Market products in DC are being revised for effective dates January 1, 2015 through December 31, 2015. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Aetna is proposing a total average decrease of 13.7%. This change reflects the premium and member weighted average change by plan based on Worksheet 2 of the URRT. The actual increase by plan ranges from -19.9% to -3.3% as seen in the table below.

HIOS Plan-ID	Plan	Metallic Tier	Rate Increase
77422DC0070013	DC Gold OAMC 90 50	Gold	-19.5%
77422DC0070005	DC Gold OAMC 2000 70%	Gold	-15.6%
77422DC0070025	DC Gold OAMC SJ 1500	Gold	N/A
77422DC0070009	DC Gold OAMC 70 50	Gold	-19.9%
77422DC0070017	DC Silver OAMC 2000 90 50 HSA	Silver	-15.5%
77422DC0070026	DC Select Silver OAMC SJ 2500	Silver	N/A
77422DC0070021	DC Silver OAMC 5000 70%	Silver	-15.7%
77422DC0070001	DC Bronze OAMC 5400	Silver	-3.3%

A. Reason for Rate Change(s):
Rates for these products are updated to reflect the following:

- Impact of medical claim trend (including increases in provider unit costs and increased utilization of medical cost services);
- Revisions to our assumptions about population morbidity and the projected population distribution;
- Changes in cost sharing levels to ensure that plans comply with Actuarial Value requirements; and
- Changes in provider networks and contracts.

3. Experience Period Premium and Claims

A. Paid Through Date:
The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2013 through December 31, 2013 and paid through February 28, 2014.

B. Premiums (Net of MLR Rebate) in Experience Period:
Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered individual business in DC. Based on internal projections and the MLR Annual Reporting Form for Calendar Year 2013, the expected rebate for the DC Small Group MLR Pool for 2013 is approximately 0.81% of premium. As such, no MLR rebates are adjusted out of the premiums earned in 2013 and reported on Worksheet 1 of the Part I URRT.DC

C. Allowed and Incurred Claims Incurred During the Experience Period:
Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level details and allow us to distinguish between Grandfathered and Non-Grandfathered blocks of business.

Incurred claims are developed through the process of estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends,

claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off to reduce the impact of IBNP estimates in the most recent incurred month. As a result, the IBNP reserves account for approximately 4.4% of the experience period incurred claims.

4. Benefit Categories

The benefit categories used generally align with the Federal instructions dated March 20, 2014. 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.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The projected change in the morbidity of the population is based on modeling for the projected impact on the individual and small group market of:

- Guaranteed Issue (based on a market migration model)
- Pent-Up Demand for the current uninsured population that will enter the small group market

We also adjust the experience period claims to account for estimated differences between the morbidity of our current business and the overall individual and small group market in DC.

B. Changes in Benefits:

These products include additional benefits to bring them into compliance with DC Essential Health Benefits (EHBs). The benefit changes determined to have an impact on rates from the experience period include the following:

- Expansion of DME benefits
- Coverage for nutritional formula
- Expansion of infertility coverage
- Coverage for eye glasses for children
- Home health care and private duty nursing

The estimated net allowed impact of these changes relative to the current combined individual and small group base period experience is approximately 1.2% of claims cost.

C. Changes in Demographics:

Experience data was normalized for projected changes in the 2015 age gender mix using Aetna demographic factors. The projected enrollment by age was based on a blend of the initial enrollment in

Individual products in 2014 and Small Group experience from 2013. While this increases the average rate, this does not cause an increase to age specific rates.

D. Other Adjustments:
The expected mix of business for 2015 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.

E. Trend Factors (Cost/Utilization):
Anticipated annual trend from the experience period to the rating period for the product line is as follows:

Component	Unit Cost	Utilization	Benefit Changes Utilization	Total Trend
Total	5.4%	3.5%	5.5%	**15.1%**

a. Medical and Pharmacy Trend

Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

The change in projected utilization trend due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that will start in 2014. The federal risk adjustment program factors are an appropriate source to account for the expected change in utilization associated with changes in benefits. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived from the federal risk adjustment program factors. The amount shown above is the annualized impact.

Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. The trends noted in the table above are for our current pharmacy network and current formulary. Changes to the current network and formulary are included in the Other Trend as noted above.

6. Credibility Manual Rate Development
We did not rely on our market single risk pool experience data reported in Section 1, Worksheet 1 of the URRT.

A. Source and Appropriateness of Experience Data Used:
The source data for our manual rate is the experience incurred from January 2013 to December 2013 and paid through February 2014 for Aetna Life Insurance Company in the DC and Virginia Individual and Small Group market. Aetna does not consider the District of Columbia experience alone to be credible.

In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combined was considered in developing the index rate.

The individual and small group market experience were combined to establish a common rate but for Federal MLR purposes the individual and small group markets will remain separate in the District. The Individual and Small Group experience used as the basis for the manual rate were adjusted for changes in population risk morbidity, benefits, and demographic age normalizations.

B. Adjustments Made to the Data:
The data is adjusted for the projected changes in network, provider contracts, and claims adjudication.

C. Inclusion of Capitation Payments:
No services provided in 2015 are expected to be covered by capitation arrangements. We have adjusted the experience data to incorporate our best-estimate of the impact of moving to fee for service payment approaches.

7. Credibility of Experience
No credibility is assigned to the experience data. This is due to the use of alternate experience data.

8. Paid-to-Allowed Ratio
We project the following distribution of membership by metallic tier, resulting in a projected paid to allowed ratio of approximately 68.5% demonstrated below from Worksheet II of the URRT.

Total Incurred claims, payable with issuer funds	$2,102,733
Total Allowed Claims (TAC)	$3,070,649
Paid to Allowed Ratio	0.685

The projected average premium is based on a 1.0 rating area, average age 40, and member distribution by plan as shown in Exhibit B.

Tier	Projected Membership Distribution	Projected Average Premium	Actuarial Value
Bronze	18%	$306	58%
Silver	70%	$363	69%
Gold	12%	$436	79%
Total	100.0%	$361	69%

9. Risk Adjustment and Reinsurance
We developed a market base rate that represents the average market morbidity expected in 2015. 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.

There will be no reinsurance recoveries, as the reinsurance program only applies to individual products. This filing is for a small group product.

10. Non-Benefit Expenses and Profit & Risk

The Retention Portion of the Market Base Rate is 22.51%. This was developed from the following items and approximated as shown:

1. Taxes and Fees 7.89% comprised of:
    a. Premium Taxes of 2.75 %
    b. Patient Centered Outcomes Research Fund of $0.17 per member per month, converted to 0.04%
    c. d. Health Insurer Fee of 3.0%
        i. 1.95% paid post-tax as the Health Insurer Fee
        ii. 1.05%, charged as a corporate tax of 35% on the 1.95% pre-tax charge
    e. No Exchange User Fee for SHOP participation.
    f. Federal Income Tax of 2.1%, assuming 35% tax rate
2. Commissions of 4.02% of premium
3. General Administrative Expenses of $29.91, converted to 6.70% of premium based upon an expected average premium level

Of the above total general administration expenses,

    a. 0.60 % is classified as Quality Improvement Activities under 45 CFR Part 158.

4. Risk Charge of 3.90%

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

The Risk Charge of 3.90% is in line with the amount allowed in the Risk Corridor calculation.

11. Projected Loss Ratio

The expected loss ratio for these products is 77.49%. This is consistent with the effective retention target of 22.51% of premium. As noted below, Aetna projects an MLR in excess of the minimum regulatory requirement.

A projection of the MLR for this product is provided in Exhibit J. This projection includes anticipated experience for this product for the 12 months in 2015 and does not include a credibility adjustment. We expect this to be equivalent to a Loss Ratio with Federal Adjustments of 84.78% as illustrated in Exhibit J.

12. Average Annual Premium

Based on the plan adjusted index rate of $445.51 as shown in Worksheet 2 of the URRT, the average annual premium for this product is $5,346.

13. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Individual market in DC through Aetna Life Insurance Company. Rates for plans that may be renewed outside the single risk pool (due to either being grandfathered or permissible transitional offerings) are not covered in this filing and will be submitted in a separate filing as necessary.

The experience reported on Worksheet 1 includes all non-grandfathered experience that is part of the Individual Market in DC, and includes transitional policies, Conversion policies, and association plans issued to individuals.

14. Index Rate

The index rate for the projection period is set equal to the projected allowed claims. The 2015 plans do not cover any non-EHBs.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are set based on the actuarial value and cost-sharing design of the plan, the impact of induced utilization, and 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 45 CFR Part 156, §156.80(d)(2).

15. Market-Adjusted Index Rate

Exhibit K illustrates the development of the Market Adjusted Index Rate. The three adjustments (Transitional Reinsurance, Risk Adjustment, and Exchange User Fees) were discussed previously. They are developed as multiplicative adjustments to paid claims for the Essential Health Benefits, and are applied as multiplicative adjustments to the index rate, which differs from the basis on which the adjustments were developed by the paid to allowed ratio.

16. Plan-Adjusted Index Rates

Exhibit K illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The Plan Adjusted Index Rates are displayed in Column 15. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value and Cost Sharing:

We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. We also reviewed the projected experience and the projected membership by plan to estimate an overall paid-to-allowed ratio. The result of these analyses is the cost sharing adjustment (1.0 indicates full coverage of allowed claims) in Column 8. In Column 9, we applied an adjustment to reflect the impact of the different levels of cost sharing on the use of medical services. These adjustments are based on the induced utilization factors used in the Risk Adjustment program, and have been normalized to result in an aggregate factor of 1.0 when applied to the projected 2015 membership.

B. Provider Network, Delivery System, and Utilization Management:

The network adjustment (Column 6) reflects the estimated impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences, and estimated the expected impact on allowed claims.

C. Benefits in addition to EHBs:

The products discussed in this filing provide coverage for only those benefits defined as Essential Health Benefits (EHB). These products do not provide coverage for non-EHBs.

D. Non-Tobacco Adjustment:

Per DISB instructions, we applied no load for tobacco usage.

E. Catastrophic Plan Eligibility:

We are not filing any catastrophic plans in the small group market.

F. Distribution and Administrative Costs:

We applied an adjustment to load the rate for the expected cost impact of limiting billable members to three dependents younger than age 21. This adjustment is reflected in Column 13. Columns 14a and 14b reflect the projected administrative costs and profit margin. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Reinsurance Contribution, Risk Adjustment

User Fee, and Exchange User Fee, which are reflected elsewhere. These expense and profit assumptions do not vary by plan.

17. Calibration

A. Age Curve Calibration:

The age factors are based on the DC specific age scale. The factors are shown in Exhibit F.

We projected an average age factor for the 2015 membership of 1.2373. We determined a calibration factor of .808 by determining the average age factor (using the DC specific age curve) for the projected enrollment by age and taking its reciprocal. The average age factor is a member-weighted average; the projected age distribution is based on a blend of the initial enrollment in Individual products in 2014 and Small Group experience from 2013.

Based on Aetna's Individual and Small Group experience, we estimated that billing for no more than three dependents under age 21 requires a 0.50% increase to the base rate.

B. Geographic Factor Calibration:

Exhibit D summarizes the rating area definitions and factors. DC only has one rating area and an area factor of 1.0. Exhibit G displays the projected membership by area and the projected average area factor of 1.0.

18. Consumer-Adjusted Premium Rate Development

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 will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

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

As an example of this calculation, consider a family living in DC that enrolls in the DC Silver OAMC 2000 90_50 HSA plan. Assume that the parents are ages 42 and 40 and have children ages 13, 11, 8, and 6. The rate for this family is calculated as:

Member Age	42	40	13	11	8	6
Market Base Rate	$526.41	$526.41	$526.41	$526.41	$526.41	$526.41
Age Factor	1.053	0.975	0.654	0.654	0.654	0.654
Area Factor	1	1	1	1	1	1
Tobacco Factor	N/A	N/A	N/A	N/A	N/A	N/A
Plan Factor	0.708	0.708	0.708	0.708	0.708	0.708
Final Rate	$392.45	$363.38	$243.74	$243.74	$243.74	N/A

The family's final monthly rate is the sum of the member rates, or $1,487.07. Consistent with the limit on the number of billable dependents, no premium will be charged for the youngest family member in this example. Since we apply no tobacco load in DC, we did include a tobacco factor in the above calculation.

19. AV Metal Values

The AV Metal Values on Worksheet 2 were based on the AV Calculator. Adjustments were made to account for plan design features that could not be entered into the AV Calculator and have a material

impact on the AV. These adjustments were developed using an acceptable alternative method as outlined in 45 CFR Part 156, §156.135 and as discussed in the accompanying certification regarding the development of the AV metal values. Exhibit A-2 provides a summary of the plan designs as well as AV screenshots from the calculator.

20. AV Pricing Values

The fixed reference plan is 77422DC0070017 (DC Silver OAMC 2000 90_50 HSA plan). Benefit factors were developed taking into account the allowable rating characteristics and discussed above and illustrated in Exhibit K. The resulting plan factors are displayed in Column 20 of Exhibit C. We have not adjusted the benefit factors based on morbidity differences or benefit selection.

A plan factor to adjust the market base rate for differences in plan-specific expected claims was calculated. 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:

a) State- and product-specific service category weights;
b) Rating factors for various levels of cost-sharing options, including deductibles, coinsurance, and, copays
c) Utilization adjustments within the federal risk adjuster methodology are used to estimate utilization differences by metal tier.

21. Membership Projections

The model discussed in the "Claims Development and Morbidity Adjustments" section below 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.

Exhibit K summarizes the membership projections by plan and plan variation. Membership projections are based on historical experience, enrollment in ACA-compliant plans through February 2014, and our expectations for future sales as additional members move to these plans from grandfathered and transitional plans. We assumed that total enrollment will be similar to our current enrollment.

22. Terminated Products

The following products will be closed to new sales prior to January 1, 2015, and are included in the Terminated Products reporting column in Worksheet 2:

- 77422DC0070003 (Aetna Bronze OAMC 6350 RE)
- 77422DC0070007 (Aetna Gold OAMC 2000 70% RE)
- 77422DC0070011 (Aetna Gold OAMC 70/50 RE)
- 77422DC0070015 (Aetna Gold OAMC 90/50 RE)
- 77422DC0070019 (Aetna Silver OAMC 2000 90/50 HSA RE)
- 77422DC0070023 (Aetna Silver OAMC 5000 70% RE))

Consistent with the URRT instructions, experience for all terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

23. Plan Type

All plans are consistent with the plan type indicated in Worksheet 2.

24. Warning Alerts

The URRT as submitted does not include any Warning Alerts.

25. Benefit Design

This filing includes the following standard plans: one Bronze, six Silver, and four Gold. These plans will be offered through the Exchange and will include 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 Exhibit A and B. All benefit and cost sharing parameters comply with DC benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

26. Marketing

As described above, all of these plans will be made available through the Exchange.

27. 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.

28. Renewability

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

29. Claims Development and Morbidity Adjustments

A key provision of the PPACA is that all individual policies effective on or after January 1, 2014 are offered on a guaranteed issue basis without rating for pre-existing medical conditions, with product-level rate differentiation limited by the actuarial value requirements of the four metallic tiers, and rating variations limited to age, network and rating area.

In the pre-January 1, 2014 Individual market environment in DC, rates varied by network, rating area, age, gender, and the medically underwritten health-status, and coverage could be denied based on medical underwriting exams. In addition to the elimination of medical underwriting, PPACA-related rating changes including the individual mandate, advanced premium tax credits, and cost sharing subsidies will motivate more people to purchase individual insurance. As a result of the changes in product issuance, rating, and financial assistance available to individuals without group insurance, the morbidity profile of the individual insurance market in DC changed in 2014. The adjustment for this change was discussed in section 5 A above.
We are using this projection to set our prices at the anticipated market morbidity levels.

30. Company Financial Condition

As of December 31, 2013, the total adjusted capital (TAC) held by Aetna Life Insurance Company was approximately $3.5 billion. This amount is disclosed in the Company's statutory financial statement dated December 31, 2013. 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

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT 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, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, David M. Walker, am an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of the State of DC, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:

    a. ASOP No. 5, Incurred Health and Disability Claims
    b. ASOP No. 8, Regulatory Filings for Health Plan Entities
    c. ASOP No. 12, Risk Classification
    d. ASOP No. 23, Data Quality
    e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
    f. ASOP No. 41, Actuarial Communications.

2. The Projected Index Rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
    b. Developed in compliance with the applicable Actuarial Standards of Practice,
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
    d. Neither excessive, deficient, nor unfairly discriminatory.

3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.

4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments were made to reflect benefit features not handled by the AV Calculator, as outlined in the attached certification required by 45 CFR Part 156, §156.135.

June 12, 2014

David M. Walker, ASA, MAAA — Date
Aetna

CHESTER A. MCPHERSON
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPT. OF INSURANCE, SECURITIES, AND BANKING
810 FIRST STREET, N. E., SUITE 701
WASHINGTON, DC 20002

Re: DC Small Group Rate Filing

DEAR COMMISSIONER MCPHERSON:

New Marketplace Dynamics
As you know, some of the most significant provisions of the Affordable Care Act (ACA) went into effect on January 1, 2014. These provisions, including guarantee issue, limitations on age rating and minimum benefit requirements, have fundamentally changed the way the Small Group market operates.

As the health care environment continues to evolve, our focus continues to be on delivering competitively priced products and services that deliver value.

We strongly believe the rates we are filing for 2015 will be competitive with, the products offered by other carriers in the market. The submitted rates demonstrate our commitment to offering affordable products and services that meet the needs of consumers in the District of Columbia.

Factors Impacting Premiums for 2015

A number of factors are represented in the rates we are filing today. These factors include:

- **Medical costs:** Medical costs are the primary driver of the premiums people pay. Medical costs vary by region and include utilization and unit costs for hospital care, outpatient care and doctor services. They also include reimbursement for prescription drugs, lab and X-ray fees.
- **Risk pool changes:** Our rates for 2014 included projections around anticipated experience. This rate filing uses actual experience to date (which is limited) as well as projections based on previous performance in the Small Group market.
- **Critical system and operational investments:** Expenses include investments necessary to implement and comply with the provisions of the ACA. These investments also include improvements to our claims and billing systems, enhancements to our customer service model, and advancements in technology.

All of our submitted rates are inclusive of the ACA-mandated taxes and fees, which now account for, on average, 6% of the full premium that consumers pay.

Aetna is committed to affordability
Aetna is taking a number of steps to 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. Of course, consumers also benefit from the ACA's medical loss ratio requirement, which provides additional protection in the form of rebates if our medical cost trend predictions are not accurate.

Thank you in advance for your review and consideration.

Thomas J. Grote
President, Capitol Market
Aetna
thomas.grote@aetna.com
509 Progress Drive
Linthicum, MD 21090

980 Jolly Road
Mail Code U12S
Blue Bell, PA 19422
(215)-775-0083
Fax: (215)-775-6441

June 12, 2015

Mr. Efren Tanheco
Supervising Actuary
District of Columbia Department of Insurance & Securities Regulation
810 First Street NE, 6th Floor
Washington, DC 20002

Subject: Aetna Life Insurance Company - NAIC Number 60054
Small Group Premium Rate Filing – DC On Exchange
Effective dates January 1, 2015 – December 31, 2015

Dear Mr. Tanheco:

I am writing to request approval of the attached Rate Filing for plans offered to Small Groups by Aetna Life Insurance Company sold on the DC Exchange. This filing is for effective dates January 1, 2015 – December 31, 2015. This filing contains the benefit plans and rating methodology. The average rate revision proposed is a decrease of 13.7%.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group Market and conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010.

This filing is for Aetna's Small GroupPPO Medical Expense coverage.

The following supporting documentation is also included:

- DC Rate Filing Checklist
- An Actuarial Memorandum including supporting exhibits, documentation and Actuarial Certification
- NAIC Transmittal Form

The forms filing has been submitted under separate cover and the SERFF Filing ID # is AETN-129570411.

The purpose of this rate filing is to comply with regulatory rate filing requirements. This filing is not intended to be used for other purposes. . If you need additional information, please contact me by telephone at (215) 775-0083, or via e-mail at WalkerD9@Aetna.com.

Sincerely,

David M. Walker

Form Numbers – Small Group PPO

GR-96792-SB-5250 02
GR-96792-SB-5253 02
GR-96792-SB-5255 02
GR-96792-SB-5257 02
GR-96792-SB-5259 02
GR-96792-SB-5261 02
GR-96792-SB-5263 02
GR-96792-SB-5265 02

Aetna Life Insurance Company
HIOS Issuer ID: 77422
Exhibit A-2

District of Columbia Small Group Portfolio | Summary of Benefits

Contents

NOTE: This exhibit includes benefit summaries for plans without the "PD" suffix. Plans with the "PD" suffix are identical to plans without the suffix except that they cover pediatric dental benefits.

Summary of Benefits Covered

DC GOLD OAMC 2000 70%

District of Columbia

Gold Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance *(Member Responsibility)*	30%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$4,500	$9,000
Familiy	$9,000	$18,000
	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	50% after deductible
Specialist Visit	$30 per visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible	50% after deductible
Emergency Room Services	$250 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $30/visits 41+	25%/visits 1-40; 40%/visits 41+
Imaging (CT/PET Scans, MRIs)	30% after deductible	50% after deductible
Rehabilitative Speech Therapy	30% after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	0%	50% after deductible
X-rays and Diagnostic Imaging	$10 per visit	50% after deductible
Skilled Nursing Facility	30% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	No	No
Generics	$4, deductible waived	50% after deductible
Preferred Brand Drugs	$50	50% after deductible
Non-Preferred Brand Drugs	50% after deductible	50% after deductible
Specialty Drugs (i.e. high-cost)	50% up to $500	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	75.79%	78.14%				
OOP Maximum ($)	$4,500.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☐	☐		$30.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	70%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	70%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$10.00	☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.8%
Metal Tier:	Gold
Option 3 DedCopay adj	0.2%
Final AV	79.0%

This product, DC Gold OAMC 2000 70%, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 79.0%

Summary of Benefits Covered

DC GOLD OAMC 70/50

District of Columbia

Gold Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$0	$5,000
Family	$0	$10,000
Coinsurance *(Member Responsibility)*	30%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	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	50% after deductible
Specialist Visit	$50 per visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30%	50% after deductible
Emergency Room Services	$300 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $40/visits 41+	25%/visits 1-40; 40%/visits 41+
Imaging (CT/PET Scans, MRIs)	$300 per visit	50% after deductible
Rehabilitative Speech Therapy	$50 per visit	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	$15 per visit	50% after deductible
X-rays and Diagnostic Imaging	$50 per visit	50% after deductible
Skilled Nursing Facility	30%	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30%	50% after deductible
Outpatient Surgery Physician/Surgical Services	30%	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	T1A: $5; T1: $15	50% after deductible
Preferred Brand Drugs	$50	50% after deductible
Non-Preferred Brand Drugs	$100	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	67.41%	71.04%				
OOP Maximum ($)	$5,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$300.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$300.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$15.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$50.00	☑	☑		
Skilled Nursing Facility	☐	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.07	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$300.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.2%
Metal Tier:	Gold
Option 3 DedCopay adj	0.2%
Final AV	78.4%

This product, DC Gold OAMC 70/50, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.4%

Summary of Benefits Covered

DC GOLD OAMC 90/50

District of Columbia

Gold Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$0	$5,000
Family	$0	$10,000
Coinsurance *(Member Responsibility)*	10%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5,000	$10,000
Familiy	$10,000	$20,000
	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	50% after deductible
Specialist Visit	$50 per visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10%	50% after deductible
Emergency Room Services	$300 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $40/visits 41+	25%/visits 1-40; 40%/visits 41+
Imaging (CT/PET Scans, MRIs)	$300 per visit	50% after deductible
Rehabilitative Speech Therapy	$50 per visit	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 per visit	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	$15 per visit	50% after deductible
X-rays and Diagnostic Imaging	$50 per visit	50% after deductible
Skilled Nursing Facility	10%	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10%	50% after deductible
Outpatient Surgery Physician/Surgical Services	10%	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	T1A: $5; T1: $15	50% after deductible
Preferred Brand Drugs	$50	50% after deductible
Non-Preferred Brand Drugs	$100	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	79.59%	71.04%	
OOP Maximum ($)	$5,000.00		
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$300.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☐	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$50.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☐	☐		$300.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$50.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$50.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$15.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$50.00	☑	☑		
Skilled Nursing Facility	☐	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☐	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.07	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$300.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.1%
Metal Tier:	Gold
Option 3 DedCopay adj	0.2%
Final AV	81.3%

This product, DC Gold OAMC 90/50, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 81.3%

Summary of Benefits Covered

DC GOLD OAMC SJ 1500

District of Columbia

Gold Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$1,500	$2,000
Family	$3,500	$4,000
Coinsurance *(Member Responsibility)*	0%	20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$3,500	$4,500
Familiy	$7,000	$9,000
	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	20% after deductible
Specialist Visit	$40 per visit after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible	20% after deductible
Emergency Room Services	$200 per visit after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $40/visits 41+	20% after deductible
Imaging (CT/PET Scans, MRIs)	$40 per visit after deductible	20% after deductible
Rehabilitative Speech Therapy	$40 per visit after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$40 per visit after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	20% after deductible
Laboratory Outpatient and Professional Services	0%	20% after deductible
X-rays and Diagnostic Imaging	0% after deductible	20% after deductible
Skilled Nursing Facility	0% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	T1A: $3; T1: $5	50% after deductible
Preferred Brand Drugs	$30	50% after deductible
Non-Preferred Brand Drugs	$60	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			91.26%			
OOP Maximum ($)			$3,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	98%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$4.04	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$60.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$300.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.5%
Metal Tier:	Gold
Option 3 DedCopay adj	0.2%
Final AV	78.7%

This product, DC Gold OAMC SJ 1500, satisfies the HHS guidelines for a Gold plan with an Actuarial Value of 78.7%

Summary of Benefits Covered

DC SILVER OAMC 2000 90/50 HSA

District of Columbia

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,000	$5,000
Family	$4,000	$10,000
Coinsurance *(Member Responsibility)*	10%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,250	$10,000
Familiy	$12,500	$20,000
	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% after deductible	50% after deductible
Specialist Visit	10% after deductible	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	10% after deductible	50% after deductible
Emergency Room Services	10% after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	10% after deductible	25%/visits 1-40; 40%/visits 41+
Imaging (CT/PET Scans, MRIs)	10% after deductible	50% after deductible
Rehabilitative Speech Therapy	10% after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	10% after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	10% after deductible	50% after deductible
X-rays and Diagnostic Imaging	10% after deductible	50% after deductible
Skilled Nursing Facility	10% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	10% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	T1A: $5; T1: $15	50% after deductible
Preferred Brand Drugs	$50	50% after deductible
Non-Preferred Brand Drugs	$100	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			85.60%			
OOP Maximum ($)			$6,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑	90%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	90%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑		
Specialist Visit	☑	☑	90%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	90%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	90%		☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	90%		☑	☑		
X-rays and Diagnostic Imaging	☑	☑	90%		☑	☑		
Skilled Nursing Facility	☑	☑	90%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	90%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	90%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$12.07	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$300.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.1%
Metal Tier:	Silver
Option 3 DedCopay adj	0.2%
Final AV	69.3%

This product, DC Silver OAMC 2000 90/50 HSA, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 69.3%

Summary of Benefits Covered

DC SILVER OAMC 5000 70%

District of Columbia

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Coinsurance *(Member Responsibility)*	30%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,350	$12,700
Familiy	$12,700	$25,400
	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	50% after deductible
Specialist Visit	$60 per visit	50% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	30% after deductible	50% after deductible
Emergency Room Services	$400 per visit	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $40/visits 41+	25%/visits 1-40; 40%/visits 41+
Imaging (CT/PET Scans, MRIs)	30% after deductible	50% after deductible
Rehabilitative Speech Therapy	$30 per visit after deductible	50% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$30 per visit after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient and Professional Services	$30 per visit	50% after deductible
X-rays and Diagnostic Imaging	$60 per visit	50% after deductible
Skilled Nursing Facility	30% after deductible	50% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	30% after deductible	50% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	No	No
Generics	T1A: $5; T1: $15	50% after deductible
Preferred Brand Drugs	$50	50% after deductible
Non-Preferred Brand Drugs	$100	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$5,000.00	$500.00				
Coinsurance (%, Insurer's Cost Share)	66.80%	64.90%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☐	☐		$400.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$30.00	☑	☑		
X-rays and Diagnostic Imaging	☐	☐		$60.00	☑	☑		
Skilled Nursing Facility	☑	☑	70%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$12.07	☑	☑		
Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
Option 3 DedCopay adj	0.2%
Final AV	68.7%

This product, DC Silver OAMC 5000 70%, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 68.7%

Summary of Benefits Covered

DC SILVER OAMC SJ 2500

District of Columbia

Silver Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$2,500	$3,000
Family	$5,000	$6,000
Coinsurance *(Member Responsibility)*	0%	20%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$6,600	$10,000
Familiy	$13,200	$20,000
	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	20% after deductible
Specialist Visit	$40 per visit after deductible	20% after deductible
All Inpatient Hospital Services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible	20% after deductible
Emergency Room Services	$200 per visit after deductible	Paid as In-Network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	$25/visits 1-40; $40/visits 41+	20%
Imaging (CT/PET Scans, MRIs)	$40 per visit after deductible	20% after deductible
Rehabilitative Speech Therapy	$40 per visit after deductible	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$40 per visit after deductible	20% after deductible
Preventive Care/Screening/Immunization	0%	20% after deductible
Laboratory Outpatient and Professional Services	0% after deductible	20% after deductible
X-rays and Diagnostic Imaging	0% after deductible	20% after deductible
Skilled Nursing Facility	0% after deductible	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% after deductible	20% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	20% after deductible

Pharmacy	In-Network	Out-of-Network
Pharmacy Deductible		
Individual	N/A	N/A
Family	N/A	N/A
Generics	T1A: $5; T1: $15	50% after deductible
Preferred Brand Drugs	$45	50% after deductible
Non-Preferred Brand Drugs	$75	50% after deductible
Specialty Drugs (i.e. high-cost)	$300	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			88.65%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$200.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$200.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	98%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$12.07	☑	☑		
Preferred Brand Drugs	☑	☐		$45.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$75.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$300.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.3%
Metal Tier:	Silver
Option 3 DedCopay adj	0.2%
Final AV	69.5%

This product, DC Silver OAMC SJ 2500, satisfies the HHS guidelines for a Silver plan with an Actuarial Value of 69.5%

Summary of Benefits Covered

DC BRONZE OAMC 5400

District of Columbia

Bronze Plan

Summary of Features	In-Network	Out-of-Network
Deductible		
Individual	$5,400	$12,700
Family	$10,800	$25,400
Coinsurance *(Member Responsibility)*	0%	50%
	$0 once out-of-pocket max. is satisfied	
Out-of-Pocket Maximum		
Individual	$5400	$15,000
Familiy	$10,800	$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	25%/visits 1-40; 40%/visits 41+
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	N/A	N/A
Family	N/A	N/A
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	Not covered

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,400.00			
Coinsurance (%, Insurer's Cost Share)			82.63%			
OOP Maximum ($)			$5,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$20.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☑	0%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	0%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	0%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.0%
Metal Tier:	Bronze
Option 3 DedCopay adj	0.2%
Final AV	58.2%

This product, DC Bronze OAMC 5400, satisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 58.2%

Unique Plan Design - Issuer AV
Supporting Documentation and Justification

State: DC
HIOS Issuer ID: 77422
HIOS Product Ids: 77422DC007

HIOS Plan Ids: 77422DC0070001
77422DC0070005
77422DC0070009
77422DC0070013
77422DC0070017
77422DC0070021
77422DC0070025
77422DC0070026

1) Justification for use of Issuer AV:

Per 156.135, the AV must be certified by member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

(1) Option 1 - Certify that the plan was entered correctly and not vary materially from standard options entered
(2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2)]
(3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3)]

Aetna benefit plans were analyzed vs the AVC to determined when Option 2 vs Option 1 certification was necessary. Five underlying calculators were built to support population of the OP facility, S
ER, Rx generic rows in the AVC and average coinsurance cells. These all support Option 2 certifications. In addition, all Aetna plans were run with coinsurance entered on each row where applic
This was done even if the unique coinsurance on the row was the same as the average coinsurance in row 11. This methodology prevents the OP facility/physician splitting methodology from bein
invoked which we do not believe is appropriate for our benefit plans. The output from this consistently applied process reflects our certified Actuarial Values.

2) Regulatory permitted alternate method used:

(2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2)]
(3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3)]

3) Confirmation that only in-network cost sharing including multitier networks, was considered:

Confirmed. Only in-network cost sharing information was used.

4) Description of standardized plan population data used:

Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the S
in 2015.

5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:

Average Coinsurance
The 2014/2015 AVC does not appropriately calculate an average coinsurance. Therefore, we calculate and effective average coinsurance across copay and coinsurance rows using the AVC continuance table weights and unit costs. This methodology is similar to that embedded in the 2015 preliminary AVC.

OP Facility Benefit Plan Fit Process
OP facility has two subcategories of OP surg - hospital and OP surg- freestanding. The equivalent coinsurance for each was set as the plan copay divided by the unit cost. The adjusted equivalent was then calculated for each copay/deduct combination. It was adjusted to account for the portion of cost less than the deduct that was at 0% coinsurance in the model as compared to the portion s It was validated that these adjusted equivalence factors did not vary materially based on the underlying continuance table used. The average coinsurance of the row was calculated based on the we of the internal subcategories.

Rx Generic Tier1a
Using internal cost data, the distribution of Rx generic costs between Tier1a and Tier1 was determined. An weighted average adjusted copay/coins was then calculated based on this distribution an adjusted for the relative drug cost level between the tiers.

6) If the method described in 156.135.(b).(3) was used, description of the data and method used to develop the adjustments:

For deduct and then copay plans, an adjustment was made for the underlying assumption in the model that plans are copay then deduct. Adjustment was determined based on methodology in the 2015 preliminary AVC.

Certification Language:
The development of the actuarial value is based on one of the acceptable alternative methods outlines in 156.135.(b).(2) or 156.135.(b).(3) for those benefits that deviate from parameters of the AV calculator and have a material impact on the AV.

The analysis was
(i) conducted by a member of the American Academy of Actuaries
(ii) performed in accordance with generally accepted actuarial principles and methodologies

Actuary Signature: *David Walker*
Actuary Printed name: David Walker, ASA MAAA
Date: 06/11/2014

Aetna Life Insurance Company

Consumer Summary

Small Group PPO Medical Expense Benefit Plans
Renewal Period for which Rates are Effective: January 1, 2015 – December 31, 2015
Proposed Rate Increase/Decrease: -13.7%
5 Year History of Rate Increases/Decreases for this Product: No prior changes; first issued January 2014

Justification for Rate Increase/Decrease in Plain Language

Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts. Additional information is shown in the Rate Filing Justification Part II.

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit D
Projected Membership Distribution by County

Rating Area	Counties	Current Membership Distribution	Current Area Factor	Projected Membership Distribution	Projection Area Factor	Pricing Area Factor
1	District of Columbia	100.0%	1.0000	100.0%	1.0000	1.0000

Current Area Normalization Factor	1.0000

Note:
Current Area Normalization Factor computed as the weighted average of Current Area Factors by current membership distribution.

Projected Area Normalization Factor	1.0000

Note:
Projected Area Normalization Factor computed as the weighted average of Current Area Factors by projected membership distribution.

Area Shift Factor	1.0000

Note:
Area Shift Factor computed as the ratio of the Projected Area Normalization Factor over the Current Area Normalization Factor. Factor represents the impact due to the shift of the population distribution across areas.

Projected Network Factor	1.0000

Note:
Projected Network Factor computed as the weighted average of Projected Area Factors by projected membership distribution.

Network Shift Factor	1.0000

Note:
Network Shift Factor computd as the ratio of the Projected Network Factor over the Projected Area Normalization Factor. Factor represents the impact due to network changes from the experience period to rating period.

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit A
Product Portfolio

HIOS Plan-ID	Network	Plan	Metallic Tier	Actuarial Value	Exchange Offering
77422DC0070013	Full Network	DC Gold OAMC 90 50	Gold	81.31%	Yes
77422DC0070005	Full Network	DC Gold OAMC 2000 70%	Gold	79.02%	Yes
77422DC0070025	Full Network	DC Gold OAMC SJ 1500	Gold	78.73%	Yes
77422DC0070009	Full Network	DC Gold OAMC 70 50	Gold	78.36%	Yes
77422DC0070017	Full Network	DC Silver OAMC 2000 90 50 HSA	Silver	69.33%	Yes
77422DC0070026	Full Network	DC Select Silver OAMC SJ 2500	Silver	69.50%	Yes
77422DC0070021	Full Network	DC Silver OAMC 5000 70%	Silver	68.73%	Yes
77422DC0070001	Full Network	DC Bronze OAMC 5400	Bronze	58.22%	Yes

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit B
Projected Membership Distribution by Plan

HIOS Plan-ID	Plan	Metallic Tier	Projected Membership Distribution
77422DC0070013	DC Gold OAMC 90 50	Gold	2.99%
77422DC0070005	DC Gold OAMC 2000 70%	Gold	2.99%
77422DC0070025	DC Gold OAMC SJ 1500	Gold	2.99%
77422DC0070009	DC Gold OAMC 70 50	Gold	2.99%
77422DC0070017	DC Silver OAMC 2000 90 50 HSA	Silver	23.25%
77422DC0070026	DC Select Silver OAMC SJ 2500	Silver	23.25%
77422DC0070021	DC Silver OAMC 5000 70%	Silver	23.25%
77422DC0070001	DC Bronze OAMC 5400	Bronze	18.28%

Metallic Tier	Projected Membership Distribution
Platinum	0%
Gold	12%
Silver	70%
Bronze	18%
Catastrophic	0%

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit C
Calculation of Plan Base Rates from Projected Index Rate

	(1)	(2)	(3)	(4)	(5) = (1)*((2)+(3)+(4))	(6)	(7)	(8)	(9)	(10)	(11)	(12) = (5)*(6)*(7)*(8)*(9)*(10)*(11)
HIOS ID	**Plan Name**	**Index Rate**	**Risk Adjustment**	**Reinsurance**	**Exchange User Fees**	**Market Adjusted Index Rate**	**Network Adjustment**	**Benefits in Excess of EHB**	**Cost Sharing**	**Utilization Adjustment**	**Non-Tobacco Adjustment**	**Catastrophic Eligibility**	**Incurred Claims**
77422DC0070013	DC Gold OAMC 90 50	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.813	1.098	1.000	1.000	452.97
77422DC0070005	DC Gold OAMC 2000 70%	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.790	0.953	1.000	1.000	381.82
77422DC0070025	DC Gold OAMC SJ 1500	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.787	1.043	1.000	1.000	416.46
77422DC0070009	DC Gold OAMC 70 50	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.784	1.069	1.000	1.000	425.00
77422DC0070017	DC Silver OAMC 2000 90 50 HSA	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.693	1.021	1.000	1.000	358.95
77422DC0070026	DC Select Silver OAMC SJ 2500	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.695	1.050	1.000	1.000	370.15
77422DC0070021	DC Silver OAMC 5000 70%	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.687	0.908	1.000	1.000	316.56
77422DC0070001	DC Bronze OAMC 5400	$501.74	1.000	1.011	1.000	$507.22	1.000	1.000	0.582	0.994	1.000	1.000	293.60

(13)	(15)	(16)	(17)	(18)	(19)		
		= (12)*(13)/(1-(15))			= (16)*(17)*(18)		
Tier Adjustment	**Admin Costs**	**Plan Adjusted Index Rate**	**Age**	**Area**	**Consumer Adjusted Index Rate**	**AV Pricing Value**	**Projected Member Months**
0.995	22.5%	$581.66	0.808	1.000	$470.10	0.893	183
0.995	22.5%	$490.29	0.808	1.000	$396.26	0.753	183
0.995	22.5%	$534.78	0.808	1.000	$432.22	0.821	183
0.995	22.5%	$545.74	0.808	1.000	$441.08	0.838	183
0.995	22.5%	$460.93	0.808	1.000	$372.53	0.708	1,423
0.995	22.5%	$475.31	0.808	1.000	$384.15	0.730	1,423
0.995	22.5%	$406.50	0.808	1.000	$328.54	0.624	1,423
0.995	22.5%	$377.01	0.808	1.000	$304.71	0.579	1,119

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit E
Claim Impact due to Demographic Changes

	Current Distribution		Projected Distribution		Demographic Factor	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0	1.09%	0.41%	0.25%	0.18%	1.050	0.939
1	0.55%	0.41%	0.25%	0.20%	1.050	0.939
2	0.41%	0.68%	0.29%	0.24%	0.601	0.596
3	0.14%	0.68%	0.32%	0.23%	0.601	0.596
4	0.27%	0.55%	0.24%	0.24%	0.601	0.596
5	0.27%	0.14%	0.29%	0.37%	0.570	0.565
6	0.14%	0.55%	0.25%	0.26%	0.570	0.565
7	0.41%	0.14%	0.32%	0.36%	0.570	0.565
8	0.41%	0.27%	0.42%	0.27%	0.570	0.565
9	0.68%	0.41%	0.34%	0.31%	0.570	0.565
10	0.68%	0.68%	0.22%	0.36%	0.578	0.565
11	0.14%	0.27%	0.28%	0.28%	0.578	0.565
12	0.27%	0.41%	0.41%	0.37%	0.578	0.565
13	0.55%	0.41%	0.28%	0.29%	0.578	0.565
14	0.14%	0.14%	0.41%	0.40%	0.578	0.565
1	0.14%	0.00%	0.42%	0.30%	0.606	0.615
16	0.41%	0.27%	0.42%	0.28%	0.606	0.615
17	0.14%	0.14%	0.35%	0.29%	0.606	0.615
18	0.27%	0.41%	0.32%	0.40%	0.606	0.615
19	0.27%	0.27%	0.67%	0.61%	0.606	0.615
20	0.00%	0.55%	0.59%	0.81%	0.451	0.741
21	0.00%	0.00%	1.04%	0.72%	0.451	0.741
22	0.55%	0.96%	0.62%	0.84%	0.451	0.741
23	0.96%	0.41%	0.61%	0.75%	0.451	0.741
24	1.50%	1.09%	0.60%	0.61%	0.451	0.741
25	1.78%	1.91%	0.60%	0.56%	0.460	1.106
26	1.50%	1.78%	1.14%	1.49%	0.460	1.106
27	1.91%	2.87%	0.76%	1.12%	0.460	1.106
28	1.50%	1.91%	0.83%	0.97%	0.460	1.106
29	2.05%	1.37%	0.78%	0.83%	0.460	1.106
30	1.78%	2.60%	0.60%	0.71%	0.519	1.197
31	2.05%	1.50%	0.70%	0.97%	0.519	1.197
32	1.09%	1.37%	0.77%	0.87%	0.519	1.197
33	1.50%	2.05%	0.64%	0.76%	0.519	1.197
34	1.78%	2.19%	0.57%	0.81%	0.519	1.197
35	1.50%	0.96%	0.61%	0.85%	0.630	1.197
36	1.64%	1.64%	0.77%	0.85%	0.630	1.197
37	1.64%	0.68%	0.54%	0.82%	0.630	1.197
38	1.37%	0.27%	0.68%	1.00%	0.630	1.197
39	0.82%	1.37%	0.77%	0.93%	0.630	1.197
40	0.82%	0.96%	0.77%	0.98%	0.790	1.197
41	1.09%	1.09%	0.91%	0.93%	0.790	1.197
42	0.68%	1.23%	0.86%	1.00%	0.790	1.197
43	1.23%	0.68%	0.86%	1.07%	0.790	1.197
44	1.64%	0.27%	0.82%	1.18%	0.790	1.197
45	0.68%	0.41%	0.90%	1.11%	1.000	1.269
46	0.55%	0.82%	0.88%	1.23%	1.000	1.269
47	0.27%	1.09%	0.95%	1.01%	1.000	1.269
48	0.82%	0.27%	0.83%	1.17%	1.000	1.269
49	0.96%	0.41%	0.93%	1.00%	1.000	1.269
50	0.55%	0.41%	1.03%	1.28%	1.370	1.460
51	0.00%	0.41%	0.96%	1.32%	1.370	1.460
52	0.82%	0.41%	0.93%	1.23%	1.370	1.460
53	0.68%	0.55%	1.01%	1.28%	1.370	1.460
54	0.27%	0.14%	1.01%	1.35%	1.370	1.460
55	0.55%	0.55%	1.03%	1.28%	1.757	1.745
56	0.55%	0.96%	1.41%	1.30%	1.757	1.745
57	0.14%	0.41%	1.14%	1.41%	1.757	1.745
58	0.55%	0.14%	1.13%	1.26%	1.757	1.745
59	0.55%	0.14%	1.10%	1.43%	1.757	1.745
60	0.55%	0.27%	0.95%	1.27%	2.218	2.128
61	0.41%	0.27%	1.01%	1.10%	2.218	2.128
62	0.55%	0.27%	1.03%	1.34%	2.218	2.128
63	0.55%	0.14%	1.21%	1.14%	2.218	2.128
64	0.55%	0.82%	0.73%	0.91%	2.218	2.128
65+	1.23%	0.68%	0.82%	0.73%	3.200	2.700

Current Demographic Factor	0.9988

Note:
Current Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

Projected Demographic Factor	1.2063

Note:
Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

Claim Impact due to Demographic Changes	1.2077

Note:
Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Current Demographic Factor

Aetna Life Insurance Company
SERFF Filing # AETN-129582423
HIOS Product ID: 77422DC007
Exhibit J
Projected MLR

			Formula
(a)	Projected 2015 Claims (pmpm)	$346.94	
(b)	Required Premium (pmpm)	$447.61	
(c)	2015 Projected MBR	77.51%	= (a)/(b)
(d)	QIA	$2.69	= (b)* 0.60%
(e)	HIF Tax	$13.43	= (b)* 3.00%
(f)	State Premium Tax	$12.31	= (b)* 2.75%
(g)	PCORF	$0.18	= (b)* .04%
(h)	FIT	$9.40	= (b)* 2.10%
(i)	Exchange User Fee	$0.00	= (b)* 0.00%
(j)	Total Taxes & Fees	$35.32	= (e) + (f) + (g) + (h) + (i)
(k)	Adjusted Premium	$412.29	= (b) - (j)
(l)	Adjusted Claims	$349.63	= (a) + (d)
(m)	Projected MLR	84.80%	= (l) / (k)

Aetna Life Insurance Company
HIOS ISSUER ID: 77422

Exhibit F
Projected Age/Gender Distribution

Age	Male	Female	DC Age Factor
0-20	7.36%	7.04%	0.654
21	1.04%	0.72%	0.727
22	0.62%	0.84%	0.727
23	0.61%	0.75%	0.727
24	0.60%	0.61%	0.727
25	0.60%	0.56%	0.727
26	1.14%	1.49%	0.727
27	0.76%	1.12%	0.727
28	0.83%	0.97%	0.744
29	0.78%	0.83%	0.760
30	0.60%	0.71%	0.779
31	0.70%	0.97%	0.799
32	0.77%	0.87%	0.817
33	0.64%	0.76%	0.836
34	0.57%	0.81%	0.856
35	0.61%	0.85%	0.876
36	0.77%	0.85%	0.896
37	0.54%	0.82%	0.916
38	0.68%	1.00%	0.927
39	0.77%	0.93%	0.938
40	0.77%	0.98%	0.975
41	0.91%	0.93%	1.013
42	0.86%	1.00%	1.053
43	0.86%	1.07%	1.094
44	0.82%	1.18%	1.137
45	0.90%	1.11%	1.181
46	0.88%	1.23%	1.227
47	0.95%	1.01%	1.275
48	0.83%	1.17%	1.325
49	0.93%	1.00%	1.377
50	1.03%	1.28%	1.431
51	0.96%	1.32%	1.487
52	0.93%	1.23%	1.545
53	1.01%	1.28%	1.605
54	1.01%	1.35%	1.668
55	1.03%	1.28%	1.733
56	1.41%	1.30%	1.801
57	1.14%	1.41%	1.871
58	1.13%	1.26%	1.944
59	1.10%	1.43%	2.020
60	0.95%	1.27%	2.099
61	1.01%	1.10%	2.181
62	1.03%	1.34%	2.181
63	1.21%	1.14%	2.181
64	0.73%	0.91%	2.181
65+	0.82%	0.73%	2.181

Projected Age Premium Impact Factor	1.2373

Note:
Projected Age Premium Impact Factor computed as the weighted average of DC Age Factor by projected membership distribution.

Dependent Age Cap Factor	1.0050

Note:
The expected shortfall in premium collected due to limiting the number of ratable dependents on a policy; computed as the estimated premium for all projected enrolled members less the premium for un-ratable dependents.

Age Calibration Factor	1.2435

Note:
Age Calibration Factor computed as the product of the Projected Age Premium Impact Factor and the Dependent Age Cap Factor.

Note:
Rates will be reduced where necessary to ensure compliance with regulatory requirements, including the 3:1 federal requirement and the DC 4% incremental limit.

Aetna Life Insurance Company
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Exhibit G
Projected Area Distribution

Rating Area	Projected Membership Distribution	Area Factor
1	100.0%	1.000

Projected Area Calibration Factor	1.0000

Note:
Projected Area Calibration Factor computed as the weighted average of Area Factors by Projected Membership Distribution.

Aetna Life Insurance Company
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Exhibit H
Projected Tobacco Usage

Age Bracket	Projected Membership Distribution	Premium Load	Projected Tobacco Usage
< 20	14%	0%	10%
20 - 24	6%	0%	10%
25 - 29	9%	0%	10%
30 - 34	7%	0%	10%
35 - 39	8%	0%	10%
40 - 44	9%	0%	10%
45 - 49	10%	0%	10%
50 - 54	11%	0%	10%
55 - 59	13%	0%	10%
60 - 64	11%	0%	10%
65	2%	0%	10%

Tobacco Calibration Factor	1.0000

Note:
The Tobacco Calibration Factor computed as the weighted average of the product of the Premium Load and Projected Tobacco Usage by the projected member distribution of age bracket.

Aetna Life Insurance Company
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Exhibit K
Additional Plan Base Rate Calculations

(1)	(2)	(3)	(4)	(5) = (1)*((2)+(3)+(4))	(6)	(7a)	(7b)	(8)	(9)	(10)	(11)	(12) = [(5)+(7a)]*(6)*(7b) *(8)*(9)*(10)*(11)
Plan ID	**Plan Name**	**Index Rate**	**Risk Adjustment**	**Reinsurance**	**Exchange User Fees**	**Market Adjusted Index Rate**	**Nework Adjustment**	**Benefits Other than EHBs**		**Cost Sharing**	**Utilization Adjustment**	**Non-Tobacco Adjustment**	**Catastrophic Eligibility**	**Incurred Claims**
77422DC0070013	DC Gold OAMC 90 50	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.813	1.098	1.000	1.000	452.97
77422DC0070005	DC Gold OAMC 2000 70%	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.790	0.953	1.000	1.000	381.82
77422DC0070025	DC Gold OAMC SJ 1500	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.787	1.043	1.000	1.000	416.46
77422DC0070009	DC Gold OAMC 70 50	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.784	1.069	1.000	1.000	425.00
77422DC0070017	DC Silver OAMC 2000 90 50 HSA	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.693	1.021	1.000	1.000	358.95
77422DC0070026	DC Select Silver OAMC SJ 2500	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.695	1.050	1.000	1.000	370.15
77422DC0070021	DC Silver OAMC 5000 70%	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.687	0.908	1.000	1.000	316.56
77422DC0070001	DC Bronze OAMC 5400	$501.74	1.000	1.011	1.000	$507.22	1.000	-	1.000	0.582	0.994	1.000	1.000	293.60

(13)	(14a)	(14b)	(15)	(16)	(17)	(18)	(19)	(20)	
			=[(12)*(13)+ (14a)]/ [1-(14b)]				=(15)*(16)* (17)*(18)/(19)		
				Calibration Adjustments					
Dependent Cap Adjustment	**Admin Costs**		**Plan Adjusted Index Rate**	**Age**	**Area**	**Average Trend Factor**	**Plan Base Rate**	**Plan Relativity Factor**	**Projected Member Months**
0.995	-	22.5%	$581.66	0.808	1.000	1.000	$470.10	1.2619	183
0.995	-	22.5%	$490.29	0.808	1.000	1.000	$396.26	1.0637	183
0.995	-	22.5%	$534.78	0.808	1.000	1.000	$432.22	1.1602	183
0.995	-	22.5%	$545.74	0.808	1.000	1.000	$441.08	1.184	183
0.995	-	22.5%	$460.93	0.808	1.000	1.000	$372.53	1	1,423
0.995	-	22.5%	$475.31	0.808	1.000	1.000	$384.15	1.0312	1,423
0.995	-	22.5%	$406.50	0.808	1.000	1.000	$328.53	0.8819	1,423
0.995	-	22.5%	$377.01	0.808	1.000	1.000	$304.71	0.8179	1,119

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF or Microsoft Word file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company____Aetna Life Insurance Company_____

SERFF tracking number__AETN-129582423_____

Submission Date_____June 11, 2014_____

Product Name____DC ALIC PPO SG 2015_____

Market Type (Individual/Small Group)_____Small Group_____

Rate Filing Type (Rate Increase / New Filing)__Rate Increase_____

Scope and Range of the Increase:

The __-13.7__% increase is requested because: Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts.

This filing will impact:

# of DC policyholders___283_____ # of DC covered lives___510_____

The average, minimum, and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved ___-13.7____%
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved __-19.9 (decrease)____%
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved__-3.3 (decrease)_____%

Individuals within the group may vary from the aggregate of the above increase components as a result of:__N/A_____

Financial Experience of Product

The overall financial experience of the product includes:

__These plans were first sold in 2014 and financial experience has not yet developed.

The rate increase will affect the projected financial experience of the product by:
___The rate revision is not expected to impact the profitability of the product.

_____

_____

Components of Increase
The request is made up of the following components:

Trend Increases – __9.1_% of the _-13.7__% total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

   This component is _3.5_% of the __-13.7_% total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

   This component is 5.4__% of the __-13.7_% total filed increase.

Other Increases – _-20.9_% of the __-13.7__% total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

   This component is __0___% of the __-13.7_% total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

   This component is _-17.7_____% of the __-13.7_% total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

   This component is _-2.8_% of the __-13.7_% total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

   This component is _-0.1__% of the __-13.7_% total filed increase.

5. Other – Defined as:
   __Changes in other retention such as commissions, changes in claim costs from benefit slope changes and morbidity assumptions._

   This component is _-1.0_% of the __-13.7_% total filed increase.

Aetna Life Insurance Company

Rate Filing Check List
Filing # AETN- 129582423
HIOS Product ID: 77422DC007
Policy Forms: GR-96792-SB-5250 02 et al.
Small Group PPO Medical Expense Benefit Plans

Based on the DC Health Benefit Exchange Authority, Health Insurance Rate Filing Requirements, below is the check list for our rate filing.

1. Cover Letter

Please see attached Cover Letter.

2. For Renewal Filings, One Page Consumer Summary

The Rate Justification Part II (Plain Language Summary) is found in the Supplementary Documentation along with the additional Consumer Summary information.

3. Actuarial Memorandum

A. Description of Benefits

This filing covers PPO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME and vision. All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements. Please refer to the referenced policy forms for detailed benefit language.

The rate filing contains worksheets and instructions for calculating the premium rates for the benefit plans available from Aetna Life Insurance Company (ALIC). The metal level and actuarial value for each plan design was determined using the AV calculator developed and made available by HHS.

The age curve used in DC is the age curve from Appendix A of the DC Exchange Carrier Reference Manual. Aetna does not consider the District of Columbia experience alone to be credible. In order to obtain sufficient credibility, the State of Virginia and District of Columbia experience combine was considered in developing the index rate. As further guidance and information is received, we reserve the right to submit revisions to these assumptions.

B. Issue Age Range

Policies will be issued to all ages.

C. Marketing Method

These plans will be made available through the District of Columbia Health Benefit Exchange.

D. Premium Basis

Member level rating will be used, with a cap of 3 dependent children under age 21.

E. Nature of Rate Change and Proposed Rate/Methodology Change

The proposed rate revision averages -13.7%. Additional details are shown in the Actuarial memorandum and Supporting Documentation.

F. For Each Change, Indication if New or Modified

The changes are shown on a by-plan basis in the Supporting Documentation.

G. For Each Change Comparison to Status Quo

The changes are shown on a by-plan basis in the Supporting Documentation.

H. Summary of How Each Proposed Modification Differs from Corresponding Current/Approved Rate/Methodology

The changes are shown on a by-plan basis in the Supporting Documentation.

I. Annual Rate Change for DC Policyholders

The proposed annual rate change is -8.8%.

J. Base Period Experience

i. The base experience period used is from 1/1/2013 to 12/31/2013 and paid through 2/28/2014.
ii. In order to obtain sufficient credibility, and due to the merge of the individual and small group pool, the base period experience used is the grandfathered and non-grandfathered ALIC Individual business and the non-grandfathered small group business in the District of Columbia and State of Virginia markets of Aetna Life Insurance Company (ALIC). We have no grandfathered experience for ALIC small group.
iii. IBNR reserves represent 4.4% of the experience period claims.
iv. No adjustments were made for large claims.

K. Projected Base Period Experience

i. Demonstrate and support each adjustment made to the base period experience for removal of claims for services covered during the base period that are not an essential health benefit; addition of cost for services not covered during the base period, that represent essential health benefits required to be covered during the projection period.

No adjustment was made.

ii. Describe and provide support for the development of each of the following projection factors applied to the base period:

1. **Medical and prescription drug trends including a description of the methodology used for calculating, data relied upon, and all adjustments made to the data and quantitative support.**

   Trends are shown in Worksheet I of the URRT. Additional background is provided in Section 5.E. of the Actuarial Memorandum.

2. **Projected changes in the underlying demographics of the population anticipated to be insured in the merged individual and small group pool, including a description of the factors used to adjust the base period experience.**

   Please see Exhibit E, "Demographic Changes" in the Supporting Documentation.

3. **Projected changes in the average morbidity of the population anticipated to be insured in the merged individual and small group pool, including but not limited to the separately identifying the impact of guaranteed issue, premium and cost sharing subsidies, a mandate that most individuals obtain coverage, pent-up demand, and termination of current high risk pools.**

   The change in morbidity is shown in Worksheet I of the URRT and discussed in Section 5 of the Actuarial Memorandum.

4. **The impact on the utilization due to projected changes in average cost sharing in force across the merged individual and small group pool.**

   No adjustment is made on the impact on the utilization.

L. Manual Rate Development

Please see Exhibit C in the Supporting Documentation. The Actuarial Memorandum provides additional support.

M. Credibility

DC experience was combined with State of Virginia experience, which we used with 100% credibility.

N. Projected Index Rate

i. The index rate represents the average allowed claim cost per member per month for coverage of essential health benefits for the market, prior to adjustment for payments and charges under the risk adjustment and transitional reinsurance programs, as defined by 45 CFR 156.80(d).
ii. Allowed claims were used as the basis for developing the index rate.
iii. We assumed 100% credibility for the combined DC/Virginia data.
iv. Due to the merge of the individual and small group pool, we expect that current small group members will migrate to individual market. So the expected distribution of membership of individual and small group will be 85% and 15%, respectively.

O. Market-wide Adjustments to the Index Rate

i. Support for the market-wide risk transfer payment/charge assumed.

We have assumed a neutral position for the risk program with zero payments and receipts.

ii. Support for the market-wide adjustment for assessments and recoveries under the transitional reinsurance program.

For the small group market, we assume that there will be no benefits to Aetna from the transitional reinsurance program.

iii. The amount of any federal or District of Columbia Exchange user fees PMPM.

No Exchange user fees have been included to develop the index rate.

P. Plan Level Adjustments to the Index Rate

i. Adjustments to reflect the actuarial value and cost sharing design of each plan.

Please see Exhibits A-1, A-2, and K included in Supplementary Documentation.

ii. Support for any differences at the plan level due to provider network, delivery system characteristics, and utilization management practices.

The estimated claim impact associated with the restructuring of our network arrangements was determined by repricing state-specific claims experience for the commercial medical products issued by Aetna Life Insurance Company for all fully insured market segments - Large Group, Small Group, and Individual - using the revised/renegotiated fee schedules applicable to participating facilities and providers. Claim repricing also considered changes to network composition including such changes as tiering of participating facilities and providers. Additionally, the estimated impact on voluntary claims incurred through non-participating facilities and providers is based on reduced reimbursement levels, as allowable by state regulations. For purposes of determining the projected savings amount, the distribution of paid claims is based on Aetna Life Insurance Company state-specific Small Group experience. The final claim impact assumption was developed as the weighted average expected savings by category.

iii. Support for additional costs added for benefits provided that are in addition to essential health benefits.

The EHB adjustment was developed by applying the state-specific medical/Rx claim distribution to the total medical impact and total Rx impact.

iv. The expected impact of the specific eligibility categories for a catastrophic plan offered in the individual market.

Not applicable

Q. Non-Benefit Expenses

Please see the "Non-Benefit Expenses and Profit & Risk" section in the Actuarial Memorandum.

R. Filed Loss Ratio

Please see Exhibit J in the Supplementary Documentation. A target medical loss ratio (claims divided by premium) of 77.49% was used to price the rates in the filing. This is expected to produce a Loss Ratio with Federal adjustments of 84.78%, excluding any credibility adjustments.

S. Actuarial Certification

The Actuarial Certification is included in the Actuarial Memorandum.

T. District of Columbia Loss Ratio Analysis

i. **Evaluation Period**
ii. **Earned Premium**
iii. **Claims**
iv. **Number of Claims**

Please see the Additional Data Template in Supporting Documentation.

v. **Loss Development Factors**

Please see the Additional Data Template in Supporting Documentation.

vi. **Loss Ratio Demonstration**

Please see the "Projected Loss Ratio" section in the Actuarial Memorandum.

vii. **Permissible Loss Ratio**

Please see the "Projected Loss Ratio" section in the Actuarial Memorandum.

viii. **Credibility Analysis**

We considered the experience for DC and Virginia combined to be 100% credible.

ix. **Determination of Overall Annual Rate Change**

The overall annual rate change was determined by weighting the plans by membership.

U. District of Columbia and Countrywide Experience

i. **Earned Premium**
ii. **Number of Contracts/Policyholders**
iii. **History of Past Rate Changes**

Please see the "Projected Loss Ratio" section in the Actuarial Memorandum.

4. Rate Table

Please see attached District of Columbia Small Group rate table.

June 6, 2014

District of Columbia, Department of Insurance
810 First St. NE, Suite 701
Washington, DC 20002
Attention: Freedom of Information Officer

Re: FOIA Confidential Treatment Request
QHP Application Submission

Aetna Life Insurance Company

Dear Sir or Madam:

Aetna Life Insurance Company (Aetna) has recently submitted or will shortly be submitting documentation required in connection with the 2015 Qualified Health Plan (QHP) Certification, for the District of Columbia Health Insurance SHOP.

Aetna hereby requests that the following information contained in the filing referenced above be treated as confidential and protected from disclosure under the District of Columbia, Freedom of Information Act- Exemptions From Disclosure, pursuant to DC ST § 2-534.

- Business Rules Template: all fields
- Prescription Drug Formulary Template: all fields
- Rate Template: all fields
- Service Area Template: all fields
- Uniform Rate Review (Data Collection) Template: all fields
- URRT Part 3 Actuarial Memorandum and Certification

Disclosure of this confidential trade secret, commercial, and/or financial information pursuant to the FOIA or otherwise would substantially harm the competitive position of Aetna in the marketplace, and would negatively impact the overall health of the health insurance marketplace and ultimately the consumer. The information is held in strict confidence by Aetna and is not disclosed publicly. It is not known or otherwise generally available in the public. The information would be of tremendous value to Aetna's competitors because it reveals confidential and proprietary strategic information.

We respectfully ask that this information not be disclosed to any member of the public prior to release of similar information with respect to all other carriers which submit requests for 2015 Qualified Health Plan (QHP) Certification.

If for whatever reason public disclosure of the reference filing is scheduled to occur earlier than we have requested, we respectfully request to be notified so that, if deemed appropriate, we can take steps to protect our interests.

We appreciate your attention to this designation and request.

Sincerely,

James E. Brown