

SERFF Tracking Number: AETN-127321037 State: New York
Filing Company: Aetna Health Inc. (NY) State Tracking Number: 2011070177
Company Tracking Number:
TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005D Individual - HMO
Health Maintenance (HMO)
Product Name: NY Individual Advantage Direct Pay HMO
Project Name/Number: /

Filing at a Glance

Company: Aetna Health Inc. (NY)

Product Name: NY Individual Advantage Direct SERFF Tr Num: AETN-127321037 State: New York
Pay HMO

TOI: HOrg02I Individual Health Organizations - SERFF Status: Closed-APPR State Tr Num: 2011070177
Health Maintenance (HMO) Approved

Sub-TOI: HOrg02I.005D Individual - HMO Co Tr Num: State Status:

Filing Type: Rate Adjustment pursuant to Reviewer(s): [REDACTED]
Section 4308(c) [REDACTED]

Authors: [REDACTED] Disposition Date: 10/18/2011

Date Submitted: 07/22/2011 Disposition Status: APPR Approved

Implementation Date Requested: 01/01/2012

Implementation Date: 01/01/2012

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact: 15.4%

Filing Status Changed: 10/18/2011

Deemer Date:

State Status Changed:

Submitted By: [REDACTED]

Created By: [REDACTED]

PPACA: Not PPACA-Related

Corresponding Filing Tracking Number:

PPACA Notes: null

Filing Description:

Rate Filing Aetna Individual Advantage Direct Pay HMO effective January 1, 2012.

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Company and Contact

Filing Contact Information

[REDACTED]
 [REDACTED]
 151 Farmington Ave
 Hartford, CT 06156

Filing Company Information

Aetna Health Inc. (NY) CoCode: 95234 State of Domicile: New York
 60 Charles Lindbergh Boulevard Group Code: 1 Company Type:
 Suite 105 Group Name: State ID Number:
 Uniondale, NY 11553-3645 FEIN Number: 22-2663623
 (999) 999-9999 ext. [Phone]

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Health Inc. (NY)	\$0.00		

State Specific

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Statutory Individual HMO
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, "File and Use" Rate Adjustment,

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Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: Prior Approval Rate Adjustment

6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.): No

7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No

8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No

9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No

SERFF Tracking Number: AETN-127321037 State: New York
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 Company Tracking Number:
 TOI: HOrg021 Individual Health Organizations - Health Maintenance Sub-TOI: HOrg021.005D Individual - HMO
 (HMO)
 Product Name: NY Individual Advantage Direct Pay HMO
 Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: Review & Approval
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 24.300%
Effective Date of Last Rate Revision: 01/01/2010
Filing Method of Last Filing: File and Use

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Aetna Health Inc. (NY)	Increase	15.400%	15.400%	\$2,195,667	1,471	\$30,558,433	23.600%	12.500%
Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	1,775							
Policy Holders:	1,471							

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 (HMO)
 Product Name: NY Individual Advantage Direct Pay HMO
 Project Name/Number: /

Rate Review Details

COMPANY:

Company Name: Aetna Health Inc. (NY)
 HHS Issuer Id: 50138
 Product Names: Individual Advantage Direct Pay HMO
 Trend Factors: 12.4% medical trend

FORMS:

New Policy Forms:
 Affected Forms:
 Other Affected Forms: HI ASTATHCRInd 01 NY & HMO/NY INDADVCO-2 7/04

REQUESTED RATE CHANGE

INFORMATION:

Change Period: Annual
 Member Months: 23,567
 Benefit Change: None
 Percent Change Requested: Min: 12.5 Max: 22.9 Avg: 15.4

PRIOR RATE:

Total Earned Premium: 24,446,747.00
 Total Incurred Claims: 23,503,937.00
 Annual \$: Min: 1,135.00 Max: 1,261.00 Avg: 1,259.00

REQUESTED RATE:

Projected Earned Premium: 32,754,100.00
 Projected Incurred Claims: 26,952,097.00

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Annual \$: Min: 1,277.00 Max: 1,550.00 Avg: 1,453.00

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)		
Comments:		
Attachment: Aetna DP HMO_checklist_2012.pdf		

	Item Status:	Status Date:
Satisfied - Item: Actuarial Memorandum/Actuarial Certification		
Comments:		
Attachments: Aetna DP HMO Actuarial Certification_2012.pdf Aetna DP HMO Actuarial Memorandum_2012_REDACTED.pdf Aetna DP HMO Actuarial Memorandum_2012.pdf		

	Item Status:	Status Date:
Satisfied - Item: Standard Exhibit 1 - General Information		
Comments: Submitting revised Exhibit 3.		
Attachments: Aetna DP HMO Standard Exhibits 1-3_2012.pdf Aetna DP HMO Exhibit 3_revised 20110817.pdf		

	Item Status:	Status Date:
Bypassed - Item: Standard Exhibit 2 - FOIL Exemption Request		

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Bypass Reason: See Exhibit 1. Foil Exemption Request included in file attached to Standard Exhibit 1.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Standard Exhibit 3 - Narrative Summary
Bypass Reason: See Exhibit 1. Narrative Summary included in file attached to Standard Exhibit 1.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 4 - Summary of Proposed Percentage Rate Changes
Comments:
Attachment:
 Aetna DP HMO Standard Exhibits 4-5_2012.pdf

Item Status: **Status Date:**

Bypassed - Item: Standard Exhibit 5 - Distribution of Contracts Affected by Proposed Rate Adjustments
Bypass Reason: Please see Standard Exhibit 4 attached file for Distribution of Contracts Affected by Proposed Rate Adjustments,
Comments:

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 6 - Summary of Policy Form and Product Changes
Comments:
Attachment:

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Aetna DP HMO Standard Exhibits 6-7_2012.pdf

Item Status: **Status Date:**

Bypassed - Item: Standard Exhibit 7 - Historical Data
Bypass Reason: Please refer to Exhibit 8 - Historical Data and Standardized Premium.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Initial Notice of Proposed Rate Adjustment
Comments:
Attachment:
 Individual NY HMO rate increase proposal letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Final Notice of Proposed Rate Adjustment
Comments:
Attachment:
 Individual NY HMO Final Approved Rate Notice.pdf

Item Status: **Status Date:**

Satisfied - Item: Rate Manual
Comments:
 Revised rate manual reflecting approved rate increases.
Attachment:
 Aetna DP HMO Rate Manual_2012_rev2011_10_14.pdf

Item Status: **Status Date:**

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Satisfied - Item: Exhibit 8 - Historical Data and Standardized Premium

Comments:

Attachments:

Aetna DP HMO Standard Exhibits 8_2012_REDACTED.xls
Aetna DP HMO Standard Exhibits 8_2012.xls

Item Status:

**Status
Date:**

Satisfied - Item: Response to Objection Letter dated August 23, 2011

Comments:

Attachment:

Aetna Direct Pay HMO Rate Filing_response 20110913.pdf

NEW YORK INSURANCE DEPARTMENT

Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law

As of 7/26/2010

Use for all medical rate filings submitted pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law.

Do not use for (a) non-community rated business, (b) specified disease coverage as described in Section 52.15 of Regulation 62 (11 NYCRR 52), or (c) for limited benefits health insurance as described in Section 52.10 of Regulation 62.

Do not use for the following which are traditional prior approval rate filings (Sections 3231(d) or 4308(b) of the Insurance Law): (a) a new form or rider filing, (b) a contract language change filing, (c) an initial rate not currently in the rate manual but within the approved variable contract language, (d) a new or revised commission schedule filing, and (e) changes to the composition of an approved rating region.

Do not use for a new or revised experience rating formula filing.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
REQUEST FOR FOIL EXEMPTION		Companies are reminded to clearly indicate any request that the actuarial memorandum and any supporting attachments are to be treated as confidential pursuant to article 6 of the New York Public Officers Law (FOIL).	Aetna DP HMO Standard Exhibits 1-3_2012.pdf
DEFINITIONS	a.	<p>Company refers to the licensed entity submitting the rate filing.</p> <p>b. A company's commercial book of business includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplement. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.</p> <p>c. Loss ratio refers to incurred claims divided by earned premiums for a given period of time. The incurred claims includes the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered lives assessments, and the HCR A surcharge. Incurred claims do not include any administrative expenses. Earned premiums do not include any adjustment for assessments or taxes.</p> <p>d. Rate applicability period refers to the length of time the rates in a rate table are assumed to remain in effect.</p> <p>(i) Example 1: A non-rolling rate table is developed to be effective January 1, 2011 and is expected to be revised January 1, 2012. The rate applicability period for this table is January 1, 2011 – December 31, 2011.</p> <p>(ii) Example 2: A rolling rate table is developed for issues and renewals in January – March 2011 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2011 (mid renewal date)</p>	N/A

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Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law

		<p>through February 15, 2012. If all policyholders must have a first of the month effective date, then the rate applicability period can be considered as February 1, 2011 through February 1, 2012.</p> <p>e. Standardized earned premium is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level. (Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarter 2011 and 1st and 2nd quarter 2012. The 2nd quarter 2011 rates have already been approved. Therefore, the 2nd quarter 2011 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2nd quarter 2011 rate tables.)</p>	
<p>ROLLING RATE STRUCTURE</p>	<p>a.</p>	<p>Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates).</p> <p>b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period.</p> <p>c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates).</p>	<p>Aetna DP HMO Rate Manual_2012.pdf</p>
<p>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</p>	<p>a.</p>	<p>A company can revise a previously approved non-rolling rate table provided that:</p> <p>(i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or</p> <p>(ii) The proposed effective date of the rate table is at least 6 months after the date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and the financial results have deteriorated resulting in an underwriting loss on the company's entire New York State commercial book of insured business. Documentation of the underwriting loss on the company's entire New York State commercial book of insured business needs to be included in the rate submission.</p> <p>b. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii) the first two rate tables included in the previously approved rate filing are not revised, and (iii) the financial results have deteriorated resulting in an underwriting loss on the company's entire New York State commercial book of insured business. Documentation of the underwriting loss on the company's entire New York State commercial book of insured business needs to be included in the rate submission. (Example: A rolling rate filing was submitted and approved that</p>	<p>Aetna DP HMO Rate Manual_2012.pdf</p>

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Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law

		included quarterly rolling rate tables for 1 st , 2 nd , 3 rd and 4 th quarter of 2011. The company can not revise the 1 st and 2 nd quarter 2011 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3 rd and 4 th quarter 2011 and 1 st and 2 nd quarter 2012.)	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	Aetna DP HMO Actuarial Memorandum_2012.pdf
Summary Template		Complete and submit as an attachment to the filing (in Excel format) the Department’s Excel summary template for each base medical policy form included in the rate filing. a. Indicate for each base medical policy form the other base medical policy forms this form is aggregated with for rate setting purposes. b. The effective date of rate change refers to the proposed effective date of the non-rolling rate table, and/or the proposed effective date of the first rolling rate period of a rolling rate structure. c. The rate guarantee period refers to a non-rolling rate table and/or to the first rate table of a rolling rate structure. (If the rate guarantee period for the rolling rate structure is not the same for each rolling rate period, the actuarial memorandum must discuss this and explain why the length of the rate guarantee periods are not the same.) d. The weighted average rate change percentage requested (from the current rate charged the policyholder to the proposed rate to be charged that same cohort of policyholders) for the indicated base medical policy form including all associated riders. The weighting should be based on members. For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for 1 st , 2 nd , 3 rd , and 4 th quarter of 2011. Rates are for a 12 month period. Indicate the average rate change percentage from the 1 st quarter of 2010 rate tables to the 1 st quarter 2011 rate tables.) e. For the number of policyholders affected and the number of covered lives affected, indicate the affect of all the rate tables of a rolling rate structure included in the rate filing (but not more than 12 months of issues and renewals if more than 12 months of rolling rate tables are included in the rate filing). f. The expected loss ratio for each base medical policy form includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the result of the first rolling rate period of the rolling rate structure.	Aetna DP HMO Standard Exhibits 8_2012.pdf

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Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law

		<p>g. The experience entered for the two indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.</p> <p>(i) Each experience period is to be for 12 months (or shorter if a new form).</p> <p>(ii) The ending date of the recent experience period can not be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2011. The recent experience period can not have an ending date earlier than June 30, 2010, i.e., 12 months prior to July 1, 2011.)</p> <p>(iii) The incurred claims for each of the two experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period.</p> <p>(iv) The prior experience period is required only if the rate filing includes a rate table that is to become effective July 1, 2011 or later (e.g., includes: a rolling (or non-rolling) rate table for July 2011 or later or a rolling rate table for 3rd quarter 2011 issues/renewals or later).</p> <p>h. Enter the annual composite medical trend assumption used for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown.</p> <p>i. For each base medical policy form (including the impact of associated riders), discuss the estimated increase in the incurred claims pmpm over the last 3 years and the estimated increase in the premium rate over the same 3 year period. (Example: Over the last 3 years the incurred claims pmpm has increased about 30% and the premium rates have increased about 32%.)</p>	
<p>Justification of Rates</p>	<p>§3231(e) §4308(c) 11NYCRR52.40 11NYCRR52.42 (HMOs) 11NYCRR52.45 11NYCRR59.5(b) 11NYCRR360.11</p>	<p>a. Description of proposed changes in rates, including the following:</p> <p>(i) The member weighted average proposed percentage change over the current rates charged to the policyholder for each base medical policy form, including the impact of all associated riders available to that policy form. This is to be shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. Include comparable information for rate changes implemented during the prior 24 months.</p> <p>(ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The</p>	<p>All items requested are addressed in the supporting exhibits/ documentation.</p>

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		<p>rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2011. The change from each of the 2nd quarter 2011 rolling rate tables to the corresponding 3rd quarter 2011 rolling rate table is to be indicated.)</p> <ul style="list-style-type: none"> (iii) The percentage change due to any change in the projected loss ratio from the prior rate filing for such base medical policy form or rider. Indicate the prior and proposed projected loss ratios used and the impact of the change. (iv) The percentage change due to any change to the tier structure relationships included in this rate filing. Include justification for such changes. (v) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing. Include justification for such changes. (vi) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. <p>b. Include the following:</p> <ul style="list-style-type: none"> (i) For each non-rolling rate table: the current rate charged the policyholder, the proposed rate to be charged the policyholder, and the dollar and percentage change from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate filing. (ii) For each rolling rate table: the current rate charged the policyholder, the proposed rate to be charged the policyholder, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate filing. (Example: The rate filing includes a new rate table for third quarter 2011 and rates are for 12 month periods. Show the rates for the third quarter 2010, the proposed rates for the third quarter 2011, and the dollar and percentage change from third quarter 2010 rates to the proposed third quarter 2011 rates.) <p>c. For each policy form included in the rate filing, indicate which other policy forms are aggregated with this form for premium rate setting purposes. This is to be indicated separately for the base medical policy forms and for each of the rider forms. Rate tables for all such aggregated forms must be included in the same rate filing. Refer to section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for requirement to aggregate substantially similar policy forms for small group policy forms and for individual policy forms.</p>	
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		<p>d. Indicate if the policy form aggregation has changed from the prior rate filing for any policy form or rider form included in this rate filing. If yes, explain the change, the rationale for the change, and the percentage rate impact this change has on this policy form and on the policy forms previously aggregated with this policy form.</p> <p>e. Provide New York State experience for the base medical policy form, and for the permitted aggregation this policy form belongs to. The experience information should be for the indicated base medical policy form and all associated riders. The following information is to be included:</p> <p>(i) Applicable experience for a recent 12 month experience period and for the immediately prior 12 month experience period (or shorter period if a new form).</p> <ol style="list-style-type: none"> 1. The ending date of the recent experience period can not be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing includes rolling rate tables for 3rd and 4th quarter 2011 and 1st and 2nd quarter 2012. The recent experience period can not have an ending date earlier than June 30, 2010, i.e., 12 months prior to July 1, 2011). 2. The prior experience period is required only if the rate filing includes a rate table that is to become effective July 1, 2011 or later (e.g., includes: a rolling (or non-rolling) rate table for July 2011 or later or a rolling rate table for 3rd quarter 2011 issues/renewals or later). <p>(ii) Member months for each of the two experience periods.</p> <p>(iii) Earned premiums for each of the two experience periods (in \$ and \$mpm).</p> <p>(iv) Standardized earned premium for each of the two experience periods (in \$ and \$mpm). Provide a description of how the earned premiums were converted to standardized earned premiums, and provide documentation and supporting exhibits showing how the standardized premiums were developed for each experience period.</p> <p>(v) Paid claims for each of the two experience periods (in \$ and \$mpm).</p> <p>(vi) Incurred claims for each of the two experience periods (in \$ and \$mpm).</p> <ol style="list-style-type: none"> 1. The incurred claims for each of the two experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. 2. Provide a clear description of how the incurred claims were developed for the experience periods, and how many run-out months were reflected in the unpaid claim estimates. <p>(vii) Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) for each of the two experience</p>	
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		<p>periods (in \$ and \$mpm).</p> <ul style="list-style-type: none"> (viii) Ratio of incurred claims to earned premiums for each of the two experience periods. (ix) Ratio of incurred claims to standardized earned premiums for each of the two experience periods. (x) Ratio of administrative expenses (including commissions and premium taxes but excluding state and federal income taxes) to earned premiums. (xi) Ratio of (administrative expenses + incurred claims) to earned premiums for each of the two experience periods. Administrative expenses include commissions and premium taxes but exclude state and federal income taxes. <p>On the Summary Template, include the New York statewide experience for each of the base medical policy forms, including associated riders. Include as part of the actuarial memorandum supplemental exhibits showing the New York State experience for each permitted aggregation of policy forms. If the rating differential between NY rating regions is being revised, the actuarial memorandum is to also include supplemental exhibits showing the NY statewide experience period results for the policy form aggregation(s) separately by each rating region and rating region aggregation.</p> <ul style="list-style-type: none"> f. Discuss the source data used to develop the claims projected for the renewal rate applicability period. <ul style="list-style-type: none"> (i) If the source data is actual claims experience, the experience period is to be at least 12 months long, and the unpaid claim reserve is to be based on at least 3 months of claims run-out beyond the end of the experience period. (ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data. (iii) Discuss the credibility of such source data. If the source is actual experience, discuss the credibility such data would have in this company's approved NY experience rating formula (or that of an affiliated company with an approved NY experience rating formula if this company does not have an approved NY experience rating formula). (iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables). Provide justification for each such adjustment. g. Indicate the assumed annualized claim trend projection factors used to project the 	
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		<p>source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure).</p> <ul style="list-style-type: none"> (i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. (ii) Provide justification for the assumed composite annual trend factors and the associated utilization and unit cost components. Discuss the impact and provide justification for any case mix change, intensity of service change, population change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. <p>h. Actuarial justification of the proposed rate changes for each base medical policy form and each rider form included in the rate filing.</p> <ul style="list-style-type: none"> (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for a rolling rate structure, how the percentage change from the existing 2nd quarter 2011 rate table to the proposed 3rd quarter 2011 rate table was developed for each rating element in the proposed rate table.) (ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3rd quarter 2011 rate table to the 4th quarter 2011 rate table). Provide justification for these changes between the rolling rate tables. (iii) Clearly show how the following were reflected in the proposed rate development, as applicable: <ol style="list-style-type: none"> 1. Standard Direct Pay and Healthy New York stop loss pools (Insurance Law sections 4321-a, 4322-a, and 4327); and 2. Regulation 146 (11 NYCRR 361) and Insurance Law section 3233 market stabilization pool. <p>i. If the percentage rate change by benefit option differs within a particular policy form (or rider form), include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the</p>	
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		<p>members selecting a particular benefit option. Any assumed variation in utilization by benefit option within a particular policy form (or rider form) must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the policy form, and can not be based on differences due to age, sex, health status or industry among the members selecting the different benefit options.</p> <p>j. If the percentage rate change by policy form differs within a permitted aggregation of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and can not be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms.</p> <p>k. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions.</p> <p>l. Indicate for each permitted policy form aggregation, within each rating region aggregation, the non-claim expense components incorporated into the proposed premium rates as a percentage of gross premiums after the proposed changes are implemented. This is to be shown for the non-rolling rate tables and/or the first rate table of each rolling rate structure. Include the following components:</p> <ul style="list-style-type: none"> (i) Administrative expenses; (ii) Commissions; (iii) Premium taxes; (iv) Pre-tax profit/contribution to surplus; (v) State income taxes; (vi) Federal income taxes; and (vii) Total of the above. 	
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		<p>Discuss how administrative expenses are allocated to the various market segments and product lines.</p> <p>m. Expected loss ratios are to be shown after the proposed rate changes. The expected loss ratio for each base medical policy form includes the impact of associated riders.</p> <p>(i) Indicate the expected loss ratio for each base medical policy form included in the rate filing for each rating region. For a rolling rate structure, this is to be shown for each rolling rate period included in the rate filing.</p> <p>(ii) Indicate the expected loss ratio for each permitted aggregation of base medical policy forms within each aggregation of rating regions. For a rolling rate structure, this is to be shown for each rolling rate period included in the rate filing.</p> <p>(iii) For a non-rolling rate table and/or the first rate table of a rolling rate structure, include a demonstration showing how these expected loss ratios were developed.</p>	
Minimum Loss Ratio Requirements	<p>§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)</p>	<p>a. The minimum loss ratio for community rated products, other than the official Medicare Supplement products, is as specified in section 3231(e)(1)(B) or 4308(c)(3)(A) of the Insurance Law (as amended June 8, 2010, chapter 107).</p> <p>b. The minimum loss ratio for the official Medicare Supplement products is:</p> <p>(i) Article 43 companies: as specified in section 4308(c)(3)(B) of the Insurance Law (as amended June 8, 2010, chapter 107); and</p> <p>(ii) Article 42 companies: as specified in section 52.45(i) of Regulation 62 (11 NYCRR 52).</p>	<p>Aetna DP HMO Actuarial Memorandum_2012.pdf</p> <p>DP HMO Rate Manual_2012.pdf</p>
Actuarial Certification	<p>11NYCRR52.40(a)(1)</p>	<p>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</p> <p>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.</p> <p>c. The expected loss ratio meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio for each permitted aggregation of policy forms within each permitted aggregation of rating regions.</p> <p>d. The benefits are reasonable in relation to the premiums charged.</p> <p>e. The rates are not unfairly discriminatory.</p>	<p>Aetna DP HMO Actuarial Certification_2012.pdf</p>
REVISED RATE MANUAL PAGES	<p>11NYCRR52.40(e)(2) 11NYCRR52.45(f) 11NYCRR59.5(b)</p>	<p>a. Table of contents*.</p> <p>b. Rate pages, including a page indicating the composition of each rating region*.</p> <p>c. Insurer/corporation name on each consecutively numbered rate page*.</p> <p>d. Identification by form number of each policy, rider, or endorsement to which the rates apply*.</p>	<p>Aetna DP HMO Rate Manual_2012.pdf</p>

NEW YORK INSURANCE DEPARTMENT

Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law

		<p>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits*.</p> <p>f. Description of revised rating classes, factors and discounts*.</p> <p>g. Examples of rate calculations*.</p> <p>h. Commission schedule(s) and fees*.</p> <p>i. Underwriting guidelines and/or underwriting manual*.</p> <p>j. A page with the expected loss ratio(s) for each permitted aggregation of policy forms within each permitted aggregation of rating regions.</p> <p>* Can not request exemption from FOIL</p>	
NOTICE TO POLICYHOLDERS	§3231(e)(1)(A) §4308(c)(2)	<p>a. A sample copy of the initial written notice sent to policyholders of the proposed rate adjustment submitted to the Insurance Department.</p> <p>b. A sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.</p>	Aetna DP HMO Notification_2012.pdf
GUARANTEED RATES FOR HMO COVERAGE	11NYCRR52.42(b) a.	<p>To guarantee rates, the HMO must obtain the superintendent’s approval for any contract provision, remitting agent agreement or rider which limits the HMO to adjustment of rates only on a policy anniversary. This requirement applies to both group contracts and group remittance arrangements.</p> <p>b. For policies and riders subject to rolling rates, submit a copy of the approved policy or rider form that allows the HMO to use rolling rates and limits the HMO to adjusting rates only on a policy anniversary. Indicate the date the policy or rider form was approved by the Department and the form filing number.</p>	Aetna DP HMO Standard Exhibits 6-7.pdf
UNREASONABLE RATE INCREASES	PPACA §1003	<p>For rate increases that HHS has defined to be an “unreasonable rate increase”, submit all documentation required to be submitted to HHS and posted on the insurance company’s website for such rate filing.</p> <p>[Deferred until HHS publishes the definition of an unreasonable rate increase and the data to be submitted to HHS and posted on the company’s website.]</p>	N/A

Actuarial Certification

I, [REDACTED] am an actuary, an employee of Aetna Health, Inc., and a member of the American Academy of Actuaries.

I have examined the underlying records and/or summaries, reviewed the assumptions and methods used in their development, and did such tests and calculations as I considered necessary. I certify that to the best of my knowledge, this filing is in compliance with all applicable laws and regulations of the State of New York, Actuarial Standard of Practice No. 8, and the expected loss ratio requirements of the State of New York. I further certify that the benefits are reasonable in relation to the premiums charged, and the rates are not unfairly discriminatory.

[REDACTED]

[REDACTED]

Aetna Individual Products

7/15/2011

Date

Aetna Health, Inc.

Actuarial Memorandum

This filing pertains to Aetna Health, Inc. form: HI ASTATHCRInd 01 NY. Its purpose is to provide the benefit descriptions and Direct Pay HMO New York Individual Advantage Plans (NY IAP) premium rates.

We have attached copies of all pages of Direct Pay HMO NY IAP rate manual. Please note that pages containing rates have been provided for all 4 quarters governed by this filing. The rates filed include all previously approved PPACA adjustments. The proposed quarterly and annual rate adjustments are summarized in the following table:

Effective Date	Proposed Rate Increases	
	Quarterly	Annual
1Q2012	12.5%	12.5%
2Q2012	3.0%	15.9%
3Q2012	3.0%	19.4%
4Q2012	3.0%	22.9%

Our pricing model makes the following adjustments to normalize the premium and claims and assure the numerator and denominator of the loss ratio calculation are based on the same populations and mix of plan designs:

- We utilized Aetna's Direct Pay HMO NY IAP experience for the period March 1, 2010 through February 28, 2011 with data paid through April 30, 2011 in order to project claims for this filing.
- The medical trend assumptions are based on our large group experience. The current premium levels by renewal cohort are carried forward using filed rate changes on each cohort renewal month.
- We then look at projected calendar year loss ratios and renewal cohort loss ratios, and a rate increase is determined to meet New York's minimum loss ratio of 82% and achieve our target renewal cohort loss ratio.

The attached exhibit 8, 8A, 8B illustrate the historical experience, demonstrate the calculation of standardized premium, and detail the development of the proposed rate increases. The following table summarizes the expected loss ratio including breakdown of the non-claims expense component:

Aetna Health, Inc.

Direct Pay HMO NY IAP

Incurred Claims	██████████
Expenses	██████████
Premium Taxes	██████████
Commissions	██████████
FIT + Profit	██████████
Total	██████████

FIT = Federal Income Tax

Without expected credits from the Market Stabilization Pool and the Stop Loss Reimbursement, the Direct Pay HMO New York Individual Advantage Plans projected loss ratio for customers with rate increases effective for the 4 quarters provided in this filing (1Q2012-4Q2012) would be ██████████

As a result of the new pooling methodology established by the Fifth Amendment to Regulation 146, we have included a credit of ██████████ of premium for calendar year 2012 consistent with our filed plan for the use of these market stabilization pool amounts. Therefore, our projected loss ratio adjusted for this reimbursement from the pool is ██████████ (projected loss ratio less reimbursements). This reflects actual membership, premium, and claim experience. Note that we expect the loss ratio for all four quarters of renewal experience during calendar year 2012 including the ██████████ credit from the market stabilization pool to be in excess of the 82% statutory minimum. The claim trend assumptions underlying this analysis are ██████████

The administrative expense assumptions underlying this analysis are approximately ██████████ comprised of ██████████ for commissions, ██████████ for premium taxes with the remaining ██████████ for other selling and general administrative expenses.

The expense assumptions are consistent with the 2010 expense ratio from the New York Data requirements. Administrative expenses are based on the Aetna Health, Inc. of New York reported financial results and are allocated to the various market segments and product lines based upon membership in the segments and lines. Due to Aetna's legal entity structure, actual administrative expenses may be higher than illustrated above.

Aetna Health, Inc.

Actuarial Memorandum

This filing pertains to Aetna Health, Inc. form: HI ASTATHCRInd 01 NY. Its purpose is to provide the benefit descriptions and Direct Pay HMO New York Individual Advantage Plans (NY IAP) premium rates.

We have attached copies of all pages of Direct Pay HMO NY IAP rate manual. Please note that pages containing rates have been provided for all 4 quarters governed by this filing. The rates filed include all previously approved PPACA adjustments. The proposed quarterly and annual rate adjustments are summarized in the following table:

Effective Date	Proposed Rate Increases	
	Quarterly	Annual
1Q2012	12.5%	12.5%
2Q2012	3.0%	15.9%
3Q2012	3.0%	19.4%
4Q2012	3.0%	22.9%

Our pricing model makes the following adjustments to normalize the premium and claims and assure the numerator and denominator of the loss ratio calculation are based on the same populations and mix of plan designs:

- We utilized Aetna's Direct Pay HMO NY IAP experience for the period March 1, 2010 through February 28, 2011 with data paid through April 30, 2011 in order to project claims for this filing.
- The medical trend assumptions are based on our large group experience. The current premium levels by renewal cohort are carried forward using filed rate changes on each cohort renewal month.
- We then look at projected calendar year loss ratios and renewal cohort loss ratios, and a rate increase is determined to meet New York's minimum loss ratio of 82% and achieve our target renewal cohort loss ratio.

The attached exhibit 8, 8A, 8B illustrate the historical experience, demonstrate the calculation of standardized premium, and detail the development of the proposed rate increases. The following table summarizes the expected loss ratio including breakdown of the non-claims expense component:

Aetna Health, Inc.

Direct Pay HMO NY IAP

Incurred Claims	82.7%
Expenses	2.7%
Premium Taxes	1.9%
Commissions	0.0%
FIT + Profit	12.7%
Total	100.0%

FIT = Federal Income Tax

Without expected credits from the Market Stabilization Pool and the Stop Loss Reimbursement, the Direct Pay HMO New York Individual Advantage Plans projected loss ratio for customers with rate increases effective for the 4 quarters provided in this filing (1Q2012-4Q2012) would be 119.3%.

As a result of the new pooling methodology established by the Fifth Amendment to Regulation 146, we have included a credit of 25.0% of premium for calendar year 2012 consistent with our filed plan for the use of these market stabilization pool amounts. Therefore, our projected loss ratio adjusted for this reimbursement from the pool is 82.7% (projected loss ratio less reimbursements). This reflects actual membership, premium, and claim experience. Note that we expect the loss ratio for all four quarters of renewal experience during calendar year 2012 including the 25.0% credit from the market stabilization pool to be in excess of the 82% statutory minimum. The claim trend assumptions underlying this analysis are 12.4%.

The administrative expense assumptions underlying this analysis are approximately 4.6%, comprised of 0% for commissions, 1.9% for premium taxes with the remaining 2.7% for other selling and general administrative expenses.

The expense assumptions are consistent with the 2010 expense ratio from the New York Data requirements. Administrative expenses are based on the Aetna Health, Inc. of New York reported financial results and are allocated to the various market segments and product lines based upon membership in the segments and lines. Due to Aetna's legal entity structure, actual administrative expenses may be higher than illustrated above.

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

For Profit

A. Insurer Information:	Aetna Health, Inc. (NY) <small>Company submitting the rate adjustment request</small>	HMO <small>Type of insurer</small>	<input type="checkbox"/> Non Profit <small>Company NAIC Code</small> 95234
	151 Farmington Avenue, Hartford, CT 06156 <small>Company mailing address</small>		
B. Contact Person:	[REDACTED] <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>
C. Actuarial Contact (If different from above):	[REDACTED] <small>Actuary name, title</small>	[REDACTED] <small>Actuary phone number</small>	[REDACTED] <small>Actuary Email address</small>
D. New Rate Information (See Note #1):	January 1, 2012 to December 31, 2012 <small>New rate applicability period</small>	01/01/2012 <small>New rate effective date</small>	AETN 12731037 <small>SERFF Tracking Number</small>

E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	Individual
F. Provide responses for the following questions:	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	no
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	no
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Yes All Direct Pay HMO New York Individual Advantage Plans policyholders Notification sent July 22, 2011.
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	yes

Notes:

- (1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date. The Department reserves the right to reject any rate submission that has not been submitted at least 120 days prior to the proposed effective date.
- (2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should not include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.
Use the following SERFF filing types for rate adjustment filings:
 - * For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
 - * For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
 - * For all other prior approval filings: Normal Pre-Approval
- (3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

EXHIBIT 2: FOIL EXEMPTION REQUEST

Instructions:

1. A request that the New York State Insurance Department ("Department") exempt from public disclosure any information included in this submission, pursuant to New York Public Officers Law § 87(2)(d) (the "Trade Secret/Competitive Injury Exemption"), must be made by completing this exhibit.
2. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department.
3. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that:
 - (a) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied;
 - (b) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and
 - (c) where applicable, indicates where redactions would suffice to protect the exempt information.
- 4.

In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to protect the exempt information. Therefore, the Company should submit to the Department both the original document and a redacted version of the original document, which omits or blocks the information it wishes to exempt from disclosure.

A. Insurer Information: Aetna Health, Inc. (NY) 95234 AETN 12731037
Company submitting the rate adjustment request Company NAIC Code SERFF tracking number

B. FOIL Contact Person: [Redacted] [Redacted] [Redacted]
Name, title Phone number Email address

151 Farmington Avenue, Hartford, CT 06156 [Redacted]
Mailing address Fax number

C. List all documents, exhibits, and attachments separately, including the file names of computer files that are included with the application. Please indicate with an asterisk (*) those documents that you believe contain information subject to the Trade Secret/Competitive Injury Exemption. Any document without an asterisk will be deemed to be a public document.

* Actuarial Memorandum	PDF	Aetna DP HMO Actuarial Memorandum_2012.pdf
Actuarial Certification	PDF	Aetna DP HMO Actuarial Certification_2012.pdf
Table of Contents	PDF	Aetna DP HMO Rate Manual_2012.pdf
General Information	PDF	Aetna DP HMO Rate Manual_2012.pdf
Premium Rate Manual	PDF	Aetna DP HMO Rate Manual_2012.pdf
Table 1 – Medical Plan Benefit	PDF	Aetna DP HMO Rate Manual_2012.pdf
Premium Rates	PDF	Aetna DP HMO Rate Manual_2012.pdf
Table 1a - Medical Plans - 1Q12 Rate Summary	PDF	Aetna DP HMO Rate Manual_2012.pdf
Table 1b - Medical Plans - 2Q12 Rate Summary	PDF	Aetna DP HMO Rate Manual_2012.pdf
Table 1c - Medical Plans - 3Q12 Rate Summary	PDF	Aetna DP HMO Rate Manual_2012.pdf
Table 1d - Medical Plans - 4Q12 Rate Summary	PDF	Aetna DP HMO Rate Manual_2012.pdf
Index of Applicable Forms	PDF	Aetna DP HMO Rate Manual_2012.pdf
Underwriting and Marketing Guidelines	PDF	Aetna DP HMO Rate Manual_2012.pdf
Commissions Schedule and Incentive Fees	PDF	Aetna DP HMO Rate Manual_2012.pdf
Exhibit 1: General Information about the Rate Adjustment Submission	PDF	Aetna DP HMO Standard Exhibits 1-3_2012.pdf
Exhibit 2: FOIL Exemption Request	PDF	Aetna DP HMO Standard Exhibits 1-3_2012.pdf
Exhibit 3: Narrative Summary	PDF	Aetna DP HMO Standard Exhibits 1-3_2012.pdf
Exhibit 4: Summary of Proposed Percentage Rate Change to Existing Rate	PDF	Aetna DP HMO Standard Exhibits 4-5_2012.pdf
Exhibit 5: Distribution of Contracts Affected by Proposed Rate Adjustments	PDF	Aetna DP HMO Standard Exhibits 4-5_2012.pdf
Exhibit 6: Summary of Policy Form and Product Changes	PDF	Aetna DP HMO Standard Exhibits 6-7_2012.pdf
Exhibit 7: Listing of All Commercial and Medicare Products Sold by the Company	PDF	Aetna DP HMO Standard Exhibits 6-7_2012.pdf
*Exhibit 8: Historical Data by Each Policy Form Included in Rate Adjustment Filing	XLS	Aetna DP HMO Standard Exhibits 8_2012.xls
	XLS	Aetna DP HMO Standard Exhibits 8_2012 - redacted version.xls

D. Provide a separate list of all documents, exhibits, and attachments, of which a portion has been redacted, including the file names of computer files that are included with the application. The unredacted portion(s) of the redacted documents may be deemed to be public.

*Actuarial Memorandum	PDF	Aetna DP HMO Actuarial Memorandum_2012 - redacted version.pdf
*Exhibit 8: Historical Data by Each Policy Form Included in Rate Adjustment Filing	XLS	Aetna DP HMO Standard Exhibits 8_2012- redacted version.xls

E. Statement of necessity as discussed in Instructions # 3, above.
 We are requesting that the documents identified above with an asterisk (*) be exempted from public disclosure and that only the redacted versions be publicly released on request.
 The documents contain certain non-public, confidential and/or proprietary company information relating to our historical medical cost and premium information and forward looking medical cost trend, earnings other information that we deem could give our competitors insights into our future pricing and other strategies and allow them to unfairly target our customers.

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: Aetna Health, Inc. (NY)
NAIC Code: 95234
SERFF Tracking #: AETN 12731037

Submitted for your review is a rate filing for Aetna Health Inc.'s Individual HMO market segment for the state of New York. As we have in the past, we will work with the New York State Insurance Department to make sure these rate changes comply with all state regulations.

The proposed quarterly and annual rate adjustments are summarized in the following table and apply to all products governed in this filing:

Effective Date	Proposed Rate Increases	
	Quarterly	Annual
1Q2012	12.5%	12.5%
2Q2012	3.0%	15.9%
3Q2012	3.0%	19.4%
4Q2012	3.0%	22.9%

The proposed rate adjustments would take effect on the policyholder's next anniversary on or after the effective dates in the table above. The number of policyholder's affected by the proposed rate adjustment is 1,462.

The proposed premium increases are a direct result of increasing unit costs— or the actual cost of the health care services provided - and utilization, the amount of services provided. This is the result of increased medical and prescription drug costs and new medical technologies, as well as increased utilization.

Aetna takes our commitment to our customers seriously. We have taken a number of steps to try to keep our products as affordable as possible, such as:

- Reducing our administrative costs by cutting back on the number of plan designs we offer, focusing only on the most popular plans that meet the needs of the majority of our members.
- Developing relationships with health care providers that provide incentives for the quality of care they provide, and not the quantity.
- 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 are also dedicated to increasing transparency within the health care system, as well as helping our members best utilize the plans that they have. Members can also access Aetna Navigator, our secure member website, which allows members 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.

Exhibit 3: Narrative Summary

Company: Aetna Health, Inc.
 NAIC Code: 95234
 SERFF Tracking #: AETN 127321037

Aetna Health, Inc. is requesting a premium rate increase for its Individual Direct Pay HMO market segment for the state of New York.

The following is a summary of the proposed rate adjustment to be effective on the policyholder's next anniversary occurring on or after the effective dates shown:

Effective Date	Proposed Rate Increase	Number of Policyholders
01/01/2012	12.5% - 13.1%	727
04/01/2012	15.9% - 16.5%	324
07/01/2012	19.3% - 20.0%	369
10/01/2012	22.9% - 23.6%	51

The total number of policyholders affected by the proposed rate adjustment is 1,471 as of 3/31/2011.

Reason for Rate Change Request

The requested rates for Aetna's Individual Direct Pay HMO plans are directly related to a higher medical claim trend due to increases in unit costs and utilization. Based on a review of claims on this product from May 2010 to April 2011 compared to the prior period, we see the following cost trends:

Medical Expense Category	Distribution of Claim \$	Increase in Utilization	Increase in Unit Cost	Total Trend
Hospital Services	48%	6%	10%	17%
Physician Services	22%	5%	3%	8%
Rx	25%	7%	25%	34%
State Assessments	4%	7%	7%	15%
Total	100%	6%	12%	19%

Utilization represents the number of services per member per year. Increase in Unit Cost represents the change in dollar amount per claim. Increases in Unit Cost reflect changes in our contracted rates and prescription drug costs as well as the price escalation due to usage of more intensive services or expensive technologies.

Our experience indicates that total medical trend, weighted by paid claims, has increased by 19%. However, we think that our Individual Direct Pay HMO market segment past results are based on too few members to be a fully credible indication of future medical cost trend. For this rate filing, we have used 12.5% as the projected the change in medical cost. The 12.5% total medical trend assumption was developed from large group data over the period July 2007 – June 2010.

Our pricing projection and the resulting rate increases assume that 82.7% of premium is used for medical care. New York state law requires that at least 82% of premium must be used to pay medical member costs. The remaining 17.3% are used for administrative expenses and profit. These include (but are not limited to) customer service, processing and paying claims, medical

management programs, maintaining our provider networks, and complying with State and Federal regulations.

Aetna takes our commitment to our customers seriously. We have taken a number of steps to try to keep our products as affordable as possible, such as:

- Reducing our administrative costs by cutting back on the number of plan designs we offer, focusing only on the most popular plans that meet the needs of the majority of our members.
- Developing relationships with health care providers that provide incentives for the quality of care they provide, and not the quantity.
- 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 are also dedicated to increasing transparency within the health care system, as well as helping our members best utilize the plans that they have. Members can also access Aetna Navigator, our secure member website, which allows members 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.

EXHIBIT 4: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

Aetna Health, Inc. (NY)
Company submitting the rate adjustment request

95234
Company NAIC Code

AETN 127321037
SERFF tracking number

=> This Exhibit will be considered as a supplement to the Summary Narrative (Exhibit 3). It will be a public document, posted on the Department's website and made available to the public by the Department upon request.

=> This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

=> Submit separate exhibits by market segment such as Large Group, Small Group, Sole Proprietor, Individual, etc. If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is to be reported.

Submit separate exhibits by rating region if the rate changes differ by rating region.
Submit separate exhibits for each rolling rate table of a rolling rate structure.

=> The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.

=> The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).

=> The format of this exhibit is discussed below and should be tailored to the specific rate filing submission. Extend the worksheet to add more rows or tabs as needed.

A. BASE MEDICAL PLAN

Market Segment: Individual

=> Provide a list of proposed rate changes for each base medical plan type, by product name/street name.

Rating Region: All

=> The "proposed rate change" is just for the base medical product, excluding the impact of any riders.

- Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
- Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
- The weighted average should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

Rolling Rate Product

Policy Form #	Product Name	Product Street Name	Effective Period of New Rolling Rate *	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg
HI ASTATHCRInd 01 NY and HMO/NY INDADVCO-2 7/04	Direct Pay HMO New York Individual Advantage Plans	New York Individual Advantage HMO	Jan - Mar 2012	12.5%	13.1%	12.6%
HI ASTATHCRInd 01 NY and HMO/NY INDADVCO-2 7/04	Direct Pay HMO New York Individual Advantage Plans	New York Individual Advantage HMO	Apr - Jun 2012	15.9%	16.5%	15.9%
HI ASTATHCRInd 01 NY and HMO/NY INDADVCO-2 7/04	Direct Pay HMO New York Individual Advantage Plans	New York Individual Advantage HMO	Jul - Sep 2012	19.3%	20.0%	19.4%
HI ASTATHCRInd 01 NY and HMO/NY INDADVCO-2 7/04	Direct Pay HMO New York Individual Advantage Plans	New York Individual Advantage HMO	Oct - Dec 2012	22.9%	23.6%	23.0%

* The effective period of a new rolling rate may vary depending on the rolling structure (e.g., "January - March 2012" for a quarterly rolling rate structure.)

EXHIBIT 5: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS

Company Name: Aetna Health, Inc. (NY)
 NAIC Code: 95234
 SERFF Tracking #: AETN 127321037

Instructions:

- 1) The percentage rate change reported in Sections A and B reflect the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
- 2) The distribution is by number of contracts. The "Total # of Contracts as of date" should be the date of the latest annual or quarterly statement filed with the Department and should be the same date used in Exhibit 9, *Summary of Impact of Proposed Rate Adjustments on*
- 3) The Weighted Average percentage should be developed based on the distribution of contracts for that market segment/product and for the market segment in total.
- 4) The distribution table should be grouped by market segment (e.g., Large Group, Small Group, Individual, Sole Proprietor, Healthy NY). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is to be reported. Use the drop down list for entries of Market Segment or make your own entry.
- 5) Under each market segment, the table should provide the distribution by broad product type (e.g., HMO, POS, EPO, PPO, Indemnity, High Deductible/Consumer Driven, Medicare Supplement, etc.).
- 6) In Section A, provide the distribution of contracts affected by proposed rate change for all contracts (all renewal cohorts of a rolling structure affected by this rate submission are combined, by market segment/product).
- 7) In Section B, provide additional distribution information for each rolling rate cohort of a rolling rate structure affected by this rate submission (e.g., by quarter of renewal for a quarterly rolling rate structure).
- 8) Edit the worksheet to add more rows as needed.
- 9) This exhibit must be submitted as an Excel file, even if a version is submitted as a PDF file.

A. Distribution of Contracts by Proposed Rate Adjustment For All Contracts (including Rolling Rate and Non Rolling Rate Products)

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Contracts as of 03/31/2011	Number of Contracts with Proposed Percentage Rate Change at Renewal									
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%
	Individual	NY	HMO	15.4%	1449	0	0	0	0	714	684	51	0	0	0
	Individual	Other	HMO	14.9%	22	0	0	0	0	13	9	0	0	0	0
	Market Segment Total:			15.4%	1471	0	0	0	0	727	693	51	0	0	0

B. For a Rolling Rate Structure, Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort

Effective Period of New Rolling Rate*: 01/01/2012 - 03/31/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Contracts as of 03/31/2011	Number of Contracts with Proposed Percentage Rate Change at Renewal									
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%
	Individual	NY	HMO	12.6%	714	0	0	0	0	714	0	0	0	0	0
	Individual	Other	HMO	12.5%	13	0	0	0	0	13	0	0	0	0	0
	Market Segment Total:			12.6%	727	0	0	0	0	727	0	0	0	0	0

Effective Period of New Rolling Rate*: 04/01/2012 - 06/31/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Contracts as of 03/31/2011	Number of Contracts with Proposed Percentage Rate Change at Renewal									
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%
	Individual	NY	HMO	15.9%	321	0	0	0	0	0	321	0	0	0	0
	Individual	Other	HMO	15.9%	3	0	0	0	0	0	3	0	0	0	0
	Market Segment Total:			15.9%	324	0	0	0	0	0	324	0	0	0	0

Effective Period of New Rolling Rate*: 07/01/2012 - 09/30/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Contracts as of 03/31/2011	Number of Contracts with Proposed Percentage Rate Change at Renewal									
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%
	Individual	NY	HMO	19.4%	363	0	0	0	0	0	363	0	0	0	0
	Individual	Other	HMO	19.6%	6	0	0	0	0	0	6	0	0	0	0
	Market Segment Total:			19.4%	369	0	0	0	0	0	369	0	0	0	0

Effective Period of New Rolling Rate*: 10/01/2012 - 12/31/2012

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Contracts as of 03/31/2011	Number of Contracts with Proposed Percentage Rate Change at Renewal									
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%
	Individual	NY	HMO	23.0%	51	0	0	0	0	0	0	51	0	0	0
	Individual	Other	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0
	Market Segment Total:			23.0%	51	0	0	0	0	0	0	51	0	0	0

* The effective period of a new rolling rate may vary depending on the rolling structure (e.g., "01/01/2012 - 03/31/2012" for a quarterly rolling rate structure).
 Use the same format to provide the same information for each rolling rate cohort under each market segment.

Exhibit 6: Summary of Policy Form and Product Changes

Company Name: Aetna Health, Inc. (NY)
 NAIC Code: 95234
 SERFF Number: AETN 127321037

- This Exhibit summarizes all benefit/rate changes filed with the Health Bureau's Albany office.
- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Extend the worksheet to add more rows as needed.

A. List of rate filings that have been approved since the prior §3231(e)(1) or §4308(c) rate filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
AETN-126347445		0/16/2009	HI ASTATHCRInd 01 NY and HMO/NY INDADVCO-2 7/04	NY IAP	35.3% increase 1/2010-10/2010, 7.1% increase 11/2010-12/2010	01/19/2011

B. List of the rate filings that are currently pending with the Department and that impact the rate tables in this filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	
none						

C. List of policy forms or benefits discontinued since the prior §3231(e)(1) or §4308(c) rate filing that affected such prior §3231(e)(1) or §4308(c) rate filing.

SERFF #	NY State Tracking #	Date of Discontinuance	Policy Form #	Product/Rider Name (including Street Name)	Brief Description of Discontinued Benefits	Disposition Date
none						

D. List of remnants of the "file and use" submissions, which impact the rate tables in this filing.

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Rate Change	Rate Effective Date
none						

EXHIBIT 7: LISTING OF ALL COMMERCIAL AND MEDICARE PRODUCTS SOLD BY THE COMPANY

Company Name: Aetna Health, Inc. (NY)

NAIC Code: 95234

SERFF Tracking Number: AETN 127321037

Instructions:

- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Market segment is: Large Group, Small Group, Individual, Healthy New York, Medicare Supplement (official benefit designs), Medicare Advantage, and Medicare Part D Drugs.
- Product type is a broad category such as HMO, POS, EPO, PPO, Indemnity Fee For Service, Consumer Driven/High Deductible, Medicare Supplement, etc.
- Use the drop down list for entries of Market Segment and Product Type or enter other applicable items.
- Extend the worksheet to add more rows as needed.

Market Segment	Policy Form Number	Product Name as in Rate Manual	Product Street Name	Product Type
Individual	HI ASTATHCRInd 01 NY	Direct Pay HMO New York Individual Advantage Plans	New York Individual Advantage HMO	HMO

New York Individual Advantage Program
PO BOX 730
Blue Bell, PA 19422
Phone: 1-800-435-8742



<Date>

<Member Name>

<Address>

<City, State, Zip>

Member id: <insert>

Group# <insert>

Dear <Member Name>:

New York law requires that we send you notice when we ask the New York State Insurance Department (NYSID) to approve a rate increase. We want to let you know that we filed our proposed 2012 rates with the NYSID.

The following table reflects the range of the rate increase we requested for plans renewing during each of the following quarters for the Aetna HMO Individual Advantage Plans offered by Aetna Health Inc. These rates are intended to be effective upon renewal on or after January 1, 2012.

<u>Renewal Date</u>	<u>Range of Increase</u>	<u>Renewal Date</u>	<u>Range of Increase</u>
1 st Quarter, 2012:	12.5% to 13.1%	3 rd Quarter, 2012:	19.3% to 20.0%
2 nd Quarter, 2012:	15.9% to 16.5%	4 th Quarter, 2012:	22.9% to 23.6%

Why Rates Increase

Every year, we spend considerable time evaluating both medical cost history and rates to ensure we account for the current cost trends in the plan premium. The requested increase is directly related to the rising cost of health care services in New York. Specifically, Aetna's request is based upon:

- increased reimbursement rates paid to our network providers,
- higher pharmacy costs paid to drug companies,
- increased utilization of services by members, and
- the availability and increased use of more complicated high-technology or other expensive health care equipment and procedures.

Additional Information about Aetna's HMO Individual Advantage rate increase request is available on the web at <http://www.aetna.com/individuals-families-health-insurance/member-guidelines/stateprocess.html>.

30 Day Comment Period

You have the opportunity to submit written comments to the Insurance Department on Aetna's rate filing application and the proposed rate changes. **If you are interested in submitting comments, you must do so no later than August 22, 2011.** Comments can be submitted to the Insurance Department at:

Health Bureau-Premium Rate Adjustments
New York State Insurance Department
25 Beaver Street
New York, NY 10004
<http://www.ins.state.ny.us>
PremiumRateIncreases@ins.state.ny.us
1-800-342-3736

Comments should clearly identify that you are covered under the Aetna HMO Individual Advantage Plan offered by Aetna Health Inc. All submitted comments will be posted on the Insurance Department website and with personal identifying information removed.

Aetna can also review any comments and answer any questions you may have concerning these proposed rate changes. Please feel free to contact our Member Service Department by phone at 1-800-435-8742 or on the web at http://www.aetna.com/members/individuals/health/member_resources/contact_us.html.

You may also contact the Insurance Department for additional information.

Prior Notice of Rate Change Action

The Insurance Department may approve, modify, or disapprove our proposed rate changes. You will receive additional notice concerning the Insurance Department's approval or modification of our proposed rate changes and how your renewal is affected at least 60 days prior to your renewal date.

Sincerely,

Aetna Advantage Billing Department



New York Individual Advantage Program
PO Box 730
Blue Bell, PA 19422
Phone: 1-800-435-8742

<Date>

<Member Name>
<Address>
<City, State, Zip>

Member id: <insert>
Group# <insert>

RE: Premium Rates for 2012

Dear <<First Name, Last Name>>:

Notice of approved rate increase

We previously requested a rate increase from the New York State Insurance Department for your New York HMO Individual Advantage Plan offered by Aetna Health Inc. The Insurance Department has reviewed our rate request and approved a rate increase.

This is notice to inform you of your final approved rate, effective <<insert plan renewal date>>, your new rate will be <<\$0.00>>.

What you need to do next

There are many factors that are considered in the request and approval of health insurance premium rates. You have the right to shop around.

If you choose to continue your coverage in the New York HMO Individual Advantage plan, there is nothing you need to do at this time.

Please call us at 1-800-435-8742 for further information on your approved rate. A plan representative will be able to assist you.

Thank you for choosing us for your health insurance needs.

Sincerely,

Individual Billing



[REDACTED]
Local Employers & Consumers Actuarial, RS2A
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
[REDACTED]

September 13, 2011

[REDACTED]
New York State Insurance Department
25 Beaver Street - Health Bureau
New York, NY 10004-2319

Re: Aetna Direct Pay HMO Rate filing – SERFF No. AETN-127321037

Dear [REDACTED]

The purpose of this letter is to address your objection letter dated August 23, 2011 for the above referenced SERFF number.

Below is our response to your objections:

1. Experience Data Submitted in Exhibit 8

Objection: For the most recent experience period (March 2010 to February 2011), you show earned premiums of \$25.3 million and incurred claims of \$21.2 million. I realize that you have chosen a time period (the 12 months from March to February) that does not correspond to the end of a calendar year, nor the end of a calendar quarter, but it is still possible to make some comparisons.

The loss ratio report for 2010 shows \$25.1 million for earned premiums and \$22.7 million for incurred claims, and these figures appear to be reasonably close to the ones that you show. However, when I compare to the 2010 data requirements, I see larger differences. The 2010 data requirements have \$30.7 million for earned premiums and \$28.8 million for incurred claims. The claims difference may be largely due to Reg. 146 adjustments, which were \$5.6 million in 2010 according to the loss ratio reports. Please confirm if that is in fact the case. Also, can you explain the difference in the premiums (the \$25.3 million that you use versus the \$30.7 million in the data requirements)?

Response:

Comparison of 2010 Exhibit 8 Experience Premiums to 2010 NY Supplement

Adjustments to the Exhibit 8 Premium data compare it to the NY Supplement Data:

- Include the difference between in January and February 2010 experience premiums and the January and February 2011 experience data premiums.
- Include the MSP amount booked.

This is shown in the following comparison:

Exhibit 8 Pricing Premium w/o MSP 3/10-2/11	\$ 25.3
Adjust for difference in premium Jan- Feb 2010 – Jan-Feb 2011	0.2
MSP	<u>5.6</u>
Adjusted Experience Premium	\$ 31.1
Data Requirements	\$ 30.7

The premium difference is less than \$.4M, and is most likely due to the Data requirements being on a Paid basis, and the experience data being on a Date-of-Service.

Comparison of 2010 Exhibit 8 Experience Claims to 2010 NY Supplement

Adjustments to the experience claims to put them on the same basis as the 2010 NY Supplement:

- Adjust for the difference in claims between January and February, 2010 and January and February, 2011 in order to compare like time periods.
- Include MSP amounts for the pricing period.
- Replacing 2009 stop loss payment with 2010 payment.
- Replacing estimated Incurred-But-Not-Reported (IBNR) based on aggregate membership in financial statement (\$1.6M) with Direct Pay HMO specific claim completion triangle IBNR of (\$1.7M) as shown in the 2010 Loss Ratio report. The net difference is applied to the financial statement claims.
- The HCRA covered lives assessments/surcharges (HCRA GME) for HNY are reported in the Direct Pay HMO line of business in the financial statement data, whereas a portion is allocated to HNY in the pricing data. Therefore, we show an adjustment to the pricing data to match the HCRA GME overstatement in the Data Requirements.

With these adjustments the pricing experience data can be compared to the NY Supplement claims as shown in the following table.

Exhibit 8 Incurred Claims 3/09-2/10	\$ 21.2
Adjust difference claims between Jan–Feb 2010 less Jan-Feb 2011	0.1
MSP for Experience period	5.7
Add 2010 Stop Loss	3.0
Less 2009 Stop Loss	(2.6)
Adjustment for restatement of change in IBNR	0.1
Adjust HCRA GME allocated to DP HMO	0.9
2010 Adjusted Incurred Claims	\$28.4
Data Requirements Incurred Claims CY 2010	\$ 28.8

The comparison shows that the pricing data is within 1.4% of the financial statement data, after the above described adjustments. This is reasonable, considering that the pricing data includes 2 months claim lag and is valued at a different point in time.

2. Percent of Premium Profit Margin

Objection: Can you explain the rationale for the assumption of 12.7% of premium for profit and FIT? Also, what would the 12.7% be on an after-tax basis (that is, what portion of the 12.7% is for FIT)?

Response: We priced the business to exceed the 82% minimum loss ratio requirement. Historically the Direct Pay HMO experience has been extremely volatile with loss ratios of 81.6% (2007), 83.6% (2008), 100% (2009), and 90.3% (2010). While the 82% minimum loss ratio caps any profits, losses are not capped. The higher risk and volatility underlying this product line justifies a higher profit charge.

The 12.7% is what remains after the loss ratio and administrative expenses, and is available to meet the corporate pre-tax profit objectives and to satisfy Federal income tax obligations. Federal income tax obligations are approximately 35% of pre-tax profit.

3. Stop Loss Recoveries

Objection: You assume stop loss recoveries of 9.7% of claims. In your 2010 loss ratio report, the ratio of stop loss recoveries to claims before any stop loss recoveries and before any Reg. 146 adjustments was about 9.5%, so this assumption is reasonably close to that. However, your Direct Pay HMO stop loss recoveries PMPM have actually been increasing over the last 3 years. Also, in analysis performed by the New York State Insurance Department, we observed that Direct Pay HMO stop loss recoveries PMPM for all New York companies have increased by about 29% per year between 2007 and 2010. We would expect a similar trend going forward into 2011 and 2012, with the main driver here being the continuing decline in membership in the Direct Pay HMO plans. In light of this, please provide justification for the 9.7% assumption, or modify it.

Response: The stop loss recovery percent of 9.7% was derived directly from the data in the prior year stop loss reimbursement request submission. For 2010, the ultimate reimbursement amount of \$2,980,504 was divided by the submitted claims of \$30,614,930 to produce 9.7%. These amounts are audited by an independent party and provide an unambiguous source for this assumption. The stop loss reimbursements are subject to a high degree of potential variability from year to year. Some key sources of this variability are: the statistical variability of the incidence and amount of large claims, medical trend, stop loss reimbursement threshold leveraging, underlying morbidity changes in the insured population and the high degree of uncertainty with state funding levels. With all these sources of potential variability and the size of these insured blocks, we consider that the actual reimbursement percentage is a better choice than a trended or derived percentage for this assumption.

4. Claim Trend

Objection: You assume 12.4% based on recent large group experience. Please provide a summary of the most recent large group experience that substantiates this assumption.

Response: The 12.4% trend assumption comes from the period 7/08-6/10. Attached is our most recent experience period with a Date-of-Service through March 2011 and paid through June 2011.

5. Rate/Rule Schedule Tab in SERFF

Objection: We have been asked to review this for HHS for general reasonableness. In the Rate Review Detail section, the earned premiums of \$30,558,433 in the Prior Rate section appear to be high. These premiums would be for the 12 months from January 2011 to December 2011, just prior to the rate increase to be effective on 1/1/12. In Exhibit 8, you show earned premiums of \$25.3 million for March 2010 to February 2011. As the membership continues to decline on this block of business, and as there are not any rate increases in 2011, I was not expecting to see a figure so much higher than the \$25.3 million. Please review this and make changes if needed.

Response: In the Rate Review Detail, we had included estimated 2011 MSP of \$6.1 million in the premium. Excluding the MSP, the premium would be \$24,446,747. We will update SERFF to reflect this revision.

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this filing, please do not hesitate to contact me at the address or telephone number shown above.

Sincerely,



Senior Actuary

SERFF Tracking Number: AETN-127321037 State: New York
 Filing Company: Aetna Health Inc. (NY) State Tracking Number: 2011070177
 Company Tracking Number:
 TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005D Individual - HMO
 Health Maintenance (HMO)
 Product Name: NY Individual Advantage Direct Pay HMO
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/13/2011	Supporting	Rate Manual Document	10/14/2011	Aetna DP HMO Rate Manual_2012.pdf (Superseded)
07/13/2011	Supporting	Standard Exhibit 1 - General Document Information	08/17/2011	Aetna DP HMO Standard Exhibits 1-3_2012.pdf

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General

The attached pages contain worksheets and instructions for calculating the community rates for the Direct Pay HMO New York Individual Advantage Plans available from Aetna Health, Inc. (The Health Maintenance Organization of New York, Inc.). This filing is made in accordance with Insurance Law Section 4308 (c) Rate Applications. They include tables of adjustments for certain benefit variations and copayment options.

Premium Rate Manual

The following steps are used to calculate premium rates.

1. Medical Base Rate

Base Rate
\$1,261

2. Rate Increase Factor

The proposed annual rate factors are summarized in the following table:

Effective Date	Proposed Annual Rate Factors
1Q2012	112.5%
2Q2012	115.9%
3Q2012	119.4%
4Q2012	122.9%

3. Tier Adjustment Factor

Tier	Factor
Individual	1.00
Parent & Child(ren)	1.85
Husband & Wife	2.00
Family	3.10

4. Dependent Age Adjustment Factor

Dependent Age	Parent & Child(ren)	Family
0 to 26	1.000	1.000
0 to 30	1.030	1.030

5. **Area Factor Table** – factor to reflect differences in cost by geographic area.
 (Medical Rate + Rider Rates) x Area Factor = Rate for that Plan for that Rating Area

County	Area Factor
Bronx	1.000
Dutchess	1.000
Kings	1.000
Nassau	1.000
New York	1.000
Orange	1.000
Putnam	1.000
Queens	1.000
Richmond	1.000
Rockland	1.000
Suffolk	1.000
Sullivan	1.000
Ulster	1.000
Westchester	1.000
Broome	0.900
Cayuga	0.900
Onondaga	0.900
Oswego	0.900
Tioga	0.900
Other	0.900

6. **Rate Sheets** (1 x 2 x 3 x 4 x 5 steps above) rounded to the nearest dollar.

Benefit Summary

Table 1 - Medical Plans

PPID	Rating Area	Plan Type	PCP Copay	Specialist Copay	Hospital Copay	SPU Copay	ER Copay (waived if admitted)	Routine and Preventive Care Including Routine GYN Exam Copay	Chiro Rider (Copay)	I/P MH Copay	I/P Non-Bio MH Day Limit	O/P SA Rehab Copay	O/P SA Rehab Visits	O/P MH Copay	O/P Non-Bio MH Visits	Unltd Bio MH?	Prescription Drug	Parent & Child(ren) Couple Family
6032167	Greater New York	Non-Grandfathered	\$15	\$15	\$500 per admission	\$75	\$50	\$0	Not Covered	\$500 per admission	30 days per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	No	\$100/\$300 individual/Family deductible thereafter \$5 generic and \$10 brand	RATES ARE PROVIDED IN SECTION B
6032267	Binghamton / Syracuse	Non-Grandfathered	\$15	\$15	\$500 per admission	\$75	\$50	\$0	Not Covered	\$500 per admission	30 days per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	No	\$100/\$300 individual/Family deductible thereafter \$5 generic and \$10 brand	
6082767	Greater New York	Grandfathered	\$15	\$15	\$500 per admission	\$75	\$50	\$0	Not Covered	\$500 per admission	30 days per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	No	\$100/\$300 individual/Family deductible thereafter \$5 generic and \$10 brand	
6072716	Binghamton / Syracuse	Grandfathered	\$15	\$15	\$500 per admission	\$75	\$50	\$0	Not Covered	\$500 per admission	30 days per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	10% of REF	30 non-emergency & 3 emergency per calendar year	No	\$100/\$300 individual/Family deductible thereafter \$5 generic and \$10 brand	

Premium Rates

Rates for effective dates January 1, 2012 through December 31, 2012 are shown in pages B-2 through B-5. The rates apply to Direct Pay HMO New York Individual Advantage Plans, for both grandfathered and non-grandfathered members.

Pages B-2 through B-5 display year over year increases for 1st Quarter 2012 through 4th Quarter 2012, dollar difference, and percent increase for all medical plans for the four tier structures.

1Q2012 Rate Summary

Table 1a - Medical Plans

PPID	1Q2011 Parent & Child(ren) with dependent up to age 30				1Q2011 Family with dependent up to age 30				1Q2012 Parent & Child(ren) with dependent up to age 30				1Q2012 Family with dependent up to age 30				Percent Increase Single Premium Rate (1Q2012 / 1Q2011)	Percent Increase Parent & Child(ren) Premium Rate (1Q2012 / 1Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Percent Increase Couple Family Premium Rate (1Q2012 / 1Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Dollar Increase Parent & Child(ren) with dependent up to age 30				Dollar Increase Family with dependent up to age 30 Premium Rate (1Q2012 - 1Q2011)
	1Q2011 Single Premium Rate	1Q2011 Parent & Child(ren) Premium Rate	1Q2011 up to age 30 Premium Rate	1Q2011 Couple Premium Rate	1Q2011 Family Premium Rate	1Q2011 up to age 30 Premium Rate	1Q2012 Single Premium Rate	1Q2012 Parent & Child(ren) Premium Rate	1Q2012 up to age 30 Premium Rate	1Q2012 Couple Premium Rate	1Q2012 Family Premium Rate	1Q2012 up to age 30 Premium Rate	1Q2012 Single Premium Rate	1Q2012 Parent & Child(ren) Premium Rate	1Q2012 up to age 30 Premium Rate	1Q2012 Couple Premium Rate						1Q2012 Family Premium Rate	1Q2012 up to age 30 Premium Rate	Dollar Increase Single Premium Rate (1Q2012 - 1Q2011)	Dollar Increase Parent & Child(ren) Premium Rate (1Q2012 - 1Q2011)	
6032167	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,419	\$2,624	\$2,703	\$2,837	\$4,398	\$4,530	12.5%	13.1%	13.0%	12.5%	12.8%	12.7%	\$158	\$304	\$311	\$315	\$500	\$512		
6032267	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,277	\$2,362	\$2,433	\$2,554	\$3,958	\$4,077	12.5%	13.1%	13.0%	12.5%	12.8%	12.7%	\$142	\$274	\$280	\$284	\$450	\$461		
6082767	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,419	\$2,624	\$2,703	\$2,837	\$4,398	\$4,530	12.5%	13.1%	13.0%	12.5%	12.8%	12.7%	\$158	\$304	\$311	\$315	\$500	\$512		
6072716	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,277	\$2,362	\$2,433	\$2,554	\$3,958	\$4,077	12.5%	13.1%	13.0%	12.5%	12.8%	12.7%	\$142	\$274	\$280	\$284	\$450	\$461		

2Q2012 Rate Summary

Table 1b - Medical Plans

PPID	2Q2011 Parent & Child(ren) with dependent up to age 30				2Q2011 Family with dependent up to age 30		2Q2012 Parent & Child(ren) with dependent up to age 30				2Q2012 Family with dependent up to age 30		Percent Increase Single Premium Rate (2Q2012 / 2Q2011)	Percent Increase Parent & Child(ren) Premium Rate (2Q2012 / 2Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Percent Increase Couple Premium Rate (2Q2012 / 2Q2011)	Percent Increase Family Premium Rate (2Q2012 / 2Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Dollar Increase Single Premium Rate (2Q2012 - 2Q2011)	Dollar Increase Parent & Child(ren) with dependent up to age 30 Premium Rate				Dollar Increase Family Premium Rate (2Q2012 - 2Q2011)	Dollar Increase dependent up to age 30 Premium Rate (1Q2012 - 1Q2011)					
	Single Premium Rate	Parent & Child(ren) Premium Rate	up to age 30 Premium Rate	Couple Premium Rate	Family Premium Rate	30 Premium Rate	Single Premium Rate	Parent & Child(ren) Premium Rate	up to age 30 Premium Rate	Couple Premium Rate	Family Premium Rate	30 Premium Rate								\$200	\$383	\$392	\$400			\$632	\$648	\$180	\$345	\$353
6032167	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,461	\$2,703	\$2,784	\$2,922	\$4,530	\$4,666	15.9%	16.5%	16.4%	15.9%	16.2%	16.1%	\$200	\$383	\$392	\$400	\$632	\$648	\$180	\$345	\$353	\$360	\$569	\$583
6032267	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,315	\$2,433	\$2,506	\$2,630	\$4,077	\$4,199	15.9%	16.5%	16.4%	15.9%	16.2%	16.1%	\$180	\$345	\$353	\$360	\$569	\$583	\$180	\$345	\$353	\$360	\$569	\$583
6082767	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,461	\$2,703	\$2,784	\$2,922	\$4,530	\$4,666	15.9%	16.5%	16.4%	15.9%	16.2%	16.1%	\$200	\$383	\$392	\$400	\$632	\$648	\$180	\$345	\$353	\$360	\$569	\$583
6072716	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,315	\$2,433	\$2,506	\$2,630	\$4,077	\$4,199	15.9%	16.5%	16.4%	15.9%	16.2%	16.1%	\$180	\$345	\$353	\$360	\$569	\$583	\$180	\$345	\$353	\$360	\$569	\$583

3Q2012 Rate Summary

Table 1c - Medical Plans

PPID	3Q2011 Parent & Child(ren) with dependent up to age 30				3Q2011 Family with dependent up to age 30		3Q2012 Parent & Child(ren) with dependent up to age 30				3Q2012 Family with dependent up to age 30		Percent Increase Single Premium Rate (3Q2012 / 3Q2011)	Percent Increase Parent & Child(ren) Premium Rate (3Q2012 / 3Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Percent Increase Couple Premium Rate (3Q2012 / 3Q2011)	Percent Increase Family Premium Rate (3Q2012 / 1Q2011)	Percent Increase dependent up to age 30 Premium Rate (1Q2012 / 1Q2011)	Dollar Increase Single Premium Rate (3Q2012 - 3Q2011)	Dollar Increase Parent & Child(ren) Premium Rate (3Q2012 - 1Q2011)	Dollar Increase dependent up to age 30 Premium Rate (1Q2012 - 1Q2011)	Dollar Increase Couple Premium Rate (3Q2012 - 3Q2011)	Dollar Increase Family Premium Rate (3Q2012 - 1Q2011)	Dollar Increase dependent up to age 30 Premium Rate (1Q2012 - 1Q2011)
	3Q2011 Single Premium Rate	3Q2011 Parent & Child(ren) Premium Rate	3Q2011 up to age 30 Premium Rate	3Q2011 Couple Premium Rate	3Q2011 Family Premium Rate	3Q2011 up to age 30 Premium Rate	3Q2012 Single Premium Rate	3Q2012 Parent & Child(ren) Premium Rate	3Q2012 up to age 30 Premium Rate	3Q2012 Couple Premium Rate	3Q2012 Family Premium Rate	3Q2012 up to age 30 Premium Rate												
6032167	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,505	\$2,784	\$2,868	\$3,010	\$4,666	\$4,806	19.3%	20.0%	19.9%	19.3%	19.7%	19.6%	\$244	\$464	\$476	\$488	\$768	\$788
6032267	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,355	\$2,506	\$2,581	\$2,709	\$4,199	\$4,325	19.4%	20.0%	19.9%	19.3%	19.7%	19.6%	\$220	\$418	\$428	\$439	\$691	\$709
6082767	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,505	\$2,784	\$2,868	\$3,010	\$4,666	\$4,806	19.3%	20.0%	19.9%	19.3%	19.7%	19.6%	\$244	\$464	\$476	\$488	\$768	\$788
6072716	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,355	\$2,506	\$2,581	\$2,709	\$4,199	\$4,325	19.4%	20.0%	19.9%	19.3%	19.7%	19.6%	\$220	\$418	\$428	\$439	\$691	\$709

4Q2012 Rate Summary

Table 1d - Medical Plans

PPID	4Q2011 Parent & Child(ren) with dependent up to age 30				4Q2011 Family with dependent up to age 30		4Q2012 Parent & Child(ren) with dependent up to age 30				4Q2012 Family with dependent up to age 30		Percent Increase Parent & Child(ren) with dependent up to age 30 (4Q2012 / 4Q2011)	Percent Increase Parent & Child(ren) with dependent up to age 30 (1Q2012 / 1Q2011)	Percent Increase Couple (4Q2012 / 4Q2011)	Percent Increase Family (4Q2012 / 4Q2011)	Percent Increase dependent up to age 30 (1Q2012 / 1Q2011)	Dollar Increase Single (4Q2012 - 4Q2011)	Dollar Increase Parent & Child(ren) with dependent up to age 30			Dollar Increase Family (4Q2012 - 4Q2011)	Dollar Increase dependent up to age 30 (1Q2012 - 1Q2011)	
	4Q2011 Single Premium Rate	4Q2011 Parent & Child(ren) Premium Rate	4Q2011 up to age 30 Premium Rate	4Q2011 Couple Premium Rate	4Q2011 Family Premium Rate	4Q2011 up to age 30 Premium Rate	4Q2012 Single Premium Rate	4Q2012 Parent & Child(ren) Premium Rate	4Q2012 up to age 30 Premium Rate	4Q2012 Couple Premium Rate	4Q2012 Family Premium Rate	4Q2012 up to age 30 Premium Rate							Dollar Increase Parent & Child(ren) with dependent up to age 30 (4Q2012 - 4Q2011)	Dollar Increase Parent & Child(ren) with dependent up to age 30 (1Q2012 - 1Q2011)	Dollar Increase Couple (4Q2012 - 4Q2011)			Dollar Increase Family (4Q2012 - 4Q2011)
6032167	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,550	\$2,868	\$2,954	\$3,100	\$4,806	\$4,950	22.9%	23.6%	23.5%	22.9%	23.3%	23.2%	\$289	\$548	\$562	\$578	\$908	\$932
6032267	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,395	\$2,581	\$2,658	\$2,790	\$4,325	\$4,455	22.9%	23.6%	23.5%	22.9%	23.3%	23.2%	\$260	\$493	\$505	\$520	\$817	\$839
6082767	\$1,261	\$2,320	\$2,392	\$2,522	\$3,898	\$4,018	\$1,550	\$2,868	\$2,954	\$3,100	\$4,806	\$4,950	22.9%	23.6%	23.5%	22.9%	23.3%	23.2%	\$289	\$548	\$562	\$578	\$908	\$932
6072716	\$1,135	\$2,088	\$2,153	\$2,270	\$3,508	\$3,616	\$1,395	\$2,581	\$2,658	\$2,790	\$4,325	\$4,455	22.9%	23.6%	23.5%	22.9%	23.3%	23.2%	\$260	\$493	\$505	\$520	\$817	\$839

Index of Applicable Forms

Form	Form Description
HI ASTATHCRInd 01 NY	Direct Pay HMO New York Individual Advantage Plans PPACA
HMO/NY INDADVCOB-2 7/04	Direct Pay HMO New York Individual Advantage Plans Certificate of Coverage
HMO/NY INDADVSOB-2 7/04	Direct Pay HMO New York Individual Advantage Plans Schedule of Benefits
HMO/NY ENDORSE-INDADCLR-3 7/04	Direct Pay HMO New York Individual Advantage Plans Prescription Plan Endorsement

Outline of General Underwriting and Marketing Guidelines

Aetna Health, Inc. (New York), headquartered in Uniondale, New York, is licensed as a Health Maintenance Organization (HMO) pursuant to Article 44 of the New York State Public Health Law.

Aetna Health, Inc. has approximately 1,760 Direct Pay HMO New York Individual Advantage Plans members.

Aetna Health, Inc. offers its comprehensive health care benefits, to the residents of the Greater New York counties of: New York, Queens, Kings, Bronx, Suffolk, Nassau, Westchester, Putnam, Orange, Rockland, Richmond, Dutchess, Ulster and Sullivan; the Syracuse counties of: Onondaga, Oswego, and Cayuga; and the Binghamton counties of: Broome and Tioga.

Aetna Health, Inc. is an Individual Practice (IPA) model HMO that contracts with independent primary care physicians and specialists as well as with hospitals and ancillary providers.

Aetna Health, Inc. offers Direct Pay HMO New York Individual Advantage Plans to individuals with premium rates that are filed and approved, and compliant with all insurance laws, regulations and practices in the state of New York.

Commissions Schedule and Incentive Fees

Aetna Health, Inc. does not offer commissions or incentive fees on Direct Pay HMO Individual Advantage Plans business.