

Oxford Health Plans (NY), Inc.
New York Small Group HMO Plans
Narrative Summary of Requested Rate Changes – Effective 1st quarter 2013

We have prepared this Narrative Summary as further explanation of the letter you recently received from us outlining our annual proposed premium rate adjustment filing(s) with the New York State Department of Financial Services (DFS). This Narrative Summary will remain posted here, on our website, for a minimum of 30 calendar days from the date of our letter to you, our policyholder, or subscriber. Please review this information carefully and contact us or DFS, as indicated in our letter, with questions within 30 days.

Rate Component Overview

The main components of an insurer's annual premium are the medical costs and administrative expenses we incur for providing health care benefits coverage. A small percentage of the premium is also projected to be profit, which helps us to sustain and grow our business. Medical costs are the main portion of the premium and are accounted for in the minimum loss ratio (MLR)—the percentage of the premiums paid toward medical costs. Under New York state law, the MLR must be at least 82% of the premium charged for the product during the calendar year. This means that at least 82 cents of each premium dollar is to be paid toward medical costs.

Medical costs include items that are typically thought of as medical costs, such as physician office visits, inpatient and outpatient care, covered prescription drugs and new mandated benefits. Medical costs also include taxes and assessments associated with medical services. These items are sometimes referred to as "HCRA" or "GME." HCRA stands for the Health Care Reform Act and is a surcharge on hospital-related services. GME stands for Graduate Medical Expense and is also known as the "covered lives assessment." This is an annual surcharge/tax on every person who has insurance coverage in the state. Certain administrative expenses are reclassified as medical costs when calculating the MLR. Such costs include activities that improve health care; for example, wellness programs.

Some of the key administrative expenses are:

- Taxes and fees not associated with medical costs such as the Section 332 assessment and premium tax;
- maintenance and upgrading of systems to comply with legal requirements (e.g., HIPAA, federal health care reform mandates);
- costs for consumer education and decision support tools/processes, promotion of wellness, programs for managing chronic and complex medical conditions, maintaining the provider network as well as measuring quality and efficiency of providers, and operating costs of consumer, employer, broker and provider web portals; and
- employee costs for items such as processing requests for services, claims, correspondence and appeals, conducting medical reviews, and providing customer service.

Additionally, there are fees and assessments associated with the Patient Protection and Affordable Care Act (PPACA). These include the Insurer's Fee and Reinsurance Assessment. The Insurer's Fee is a permanent fee that applies to fully insured coverage. The Reinsurance Assessment is a temporary fee that applies to all commercial groups (both fully insured and self-funded) from 2014 to 2016.

Current Rate Increase Components

When deciding whether to seek a premium increase or decrease, we review claims data and expenses to determine what the expected costs and expenses will be for a future period.

Following this review process, we are requesting premium increases related to medical cost trends for the health benefits products that appear in Chart 1. If approved, the increases will be added to the 2012 premium. Chart 1 shows the requested increases by product. The new premiums will apply to all groups that renew or enroll during the first quarter of 2013. Below Chart 1 is an overview of the reasons for the increase.

CHART 1: Impact of Premium Request

Product	Renewal Date	Number of Impacted Subscribers	Requested Estimated Medical Increase Over 2012 Medical Premium (%)	Requested Estimated Pharmacy Increase Over 2012 Pharmacy Premium (%)	Estimated Total Trend Increase (Medical and Pharmacy) Over 2012 Premium (%)
HMO	January 2013 - March 2013	32,989	16.5%	16.5%	16.5%

- The rate filing we have made is seeking an increase mainly related to rising medical costs. As previously mentioned, medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs. Some of the key health care cost trends that have affected this year’s rate actions include:
 - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. We estimate that this component increases costs by approximately 5.6% per year.
 - **Increased Utilization** – The number of office visits and other services continues to grow. We estimate that this component increases costs by approximately 5.5% per year.
 - **Higher Costs from Deductible Leveraging** – Health care costs continue to rise every year, while the pricing for the products is based on deductibles and copayments that generally remain the same. As a result, when groups continue with the same member cost shares, a greater percentage of health care costs need to be covered by health insurance premiums each year. We estimate that this component increases costs by approximately 1.1% per year.
 - **Cost shifting from the public to the private sector** – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals is no longer covering all the cost of care. The cost difference is being shifted to private health plans. Additionally, Medicare and Medicaid rates to hospitals are expected to decline due to the impact of PPACA on Medicare and the affect of the recession on Medicaid. A rate increase paid by Medicaid to hospitals is often below the actual

cost increase hospitals will experience. The cost impact for this component is included in the estimate for increasing cost of medical services shown above.

- **Impact of New Technology** - Improvements to medical technology and clinical practice require use of more expensive services, leading to increased health care spending and utilization. The cost impact for this component is included in the estimates for increasing cost of medical services and increased utilization shown above.
- The medical cost component may also be impacted by changes to the population covered under the product.
 - **Migration Between Oxford Products** – At times, groups and members move between products. This movement has an impact on the costs in both the old and new products. We estimate that this component increases costs by approximately 0.8% per year.
 - **Regulation 146** - A part of the medical costs include a pooling technique established under New York Insurance Regulation 146, which attempts to equalize risk within the New York small group and individual markets. This requires carriers with fewer high-cost claimants to pay into the pool, while carriers with more high-cost claimants receive funds from the pool. We are projecting a slight change in our Regulation 146 amount for Oxford Health Plans (NY), Inc.'s small group products in 2013 due to a projected increase in high cost claimants for the individuals covered under this entity, relative to estimated industry averages.
- As noted above, there are also fees and assessment related to PPACA. These amounts apply to all business starting January 1, 2014. The requested premium increases for 2013 include portions of these full amounts depending upon the number of contract months extending into 2014. These fees and assessments account for 0.3% of the overall requested rate increase.
- The table below summarizes the drivers of the requested rate increase.

CHART 2: Drivers of Requested Rate Increase

Type of Cost:	Percentage Assumed in Current (2012) Rate	Per Member Per Month Increase	Portion of Increase	Percentage Assumed in Renewal (2013) Rate
Medical Services* - Cost of providing healthcare services to policyholders	90.4%	\$29.42	43.7%	83.8%
Administrative Expenses - Marketing, claims processing, taxes, assessments, and other costs to the company	13.0%	\$2.83	4.2%	11.8%
Pre-Tax Underwriting Gain/Loss - Amount the company keeps after paying claims and administrative expenses**	-3.4%	\$35.09	52.1%	4.4%
Total	100.0%	\$67.34	100.0%	100.0%

* 43.6% of the Medical Services cost increases are due to how many people use the services and how often they use them and 56.4% is due to the cost per service (unit cost).

** The driver of the change in Pre-Tax Underwriting Gain/Loss of the requested rate increase is a result of the modifications made by DFS to our requested rates for effective dates in 2012 (current rates). As shown in Chart 2 (above), the rates for 2012 effective dates result in a policy period loss based upon our cost projections.

Additional Benefit Changes for 2013 Plans

We have also submitted benefit change filings to the New York State DFS associated with state mandated autism coverage and federal reform changes to women's preventive coverage. Premium increases approved by DFS for these items will impact your final premium, in addition to the requested premium increases listed in Chart 1. In the event that additional benefit changes (e.g., benefit mandate or change) are made to our HMO product prior to your 2013 renewal, those changes may also impact your final premium.

Final Rate Increase

Please be aware that your group's final renewal premium increase for 2013 may be different than the percentages listed in Chart 1. The Superintendent of Financial Services may approve (as requested), modify or deny the proposed rate adjustment. Your final premium will account for the rate adjustment approved by the New York State DFS, as well as any changes resulting from the benefit plan design chosen and your group's census upon renewal. If you are a subscriber of a group plan, please contact your employer for information about how this information affects your premium contribution.

Oxford Health Plans (NY), Inc.
New York Small Group HMO Plans
Narrative Summary of Requested Rate Changes – Effective 2nd quarter 2013

We have prepared this Narrative Summary as further explanation of the letter you recently received from us outlining our annual proposed premium rate adjustment filing(s) with the New York State Department of Financial Services (DFS). This Narrative Summary will remain posted here, on our website, for a minimum of 30 calendar days from the date of our letter to you, our policyholder, or subscriber. Please review this information carefully and contact us or DFS, as indicated in our letter, with questions within 30 days.

Rate Component Overview

The main components of an insurer's annual premium are the medical costs and administrative expenses we incur for providing health care benefits coverage. A small percentage of the premium is also projected to be profit, which helps us to sustain and grow our business. Medical costs are the main portion of the premium and are accounted for in the minimum loss ratio (MLR)—the percentage of the premiums paid toward medical costs. Under New York state law, the MLR must be at least 82% of the premium charged for the product during the calendar year. This means that at least 82 cents of each premium dollar is to be paid toward medical costs.

Medical costs include items that are typically thought of as medical costs, such as physician office visits, inpatient and outpatient care, covered prescription drugs and new mandated benefits. Medical costs also include taxes and assessments associated with medical services. These items are sometimes referred to as "HCRA" or "GME." HCRA stands for the Health Care Reform Act and is a surcharge on hospital-related services. GME stands for Graduate Medical Expense and is also known as the "covered lives assessment." This is an annual surcharge/tax on every person who has insurance coverage in the state. Certain administrative expenses are reclassified as medical costs when calculating the MLR. Such costs include activities that improve health care; for example, wellness programs.

Some of the key administrative expenses are:

- Taxes and fees not associated with medical costs such as the Section 332 assessment and premium tax;
- maintenance and upgrading of systems to comply with legal requirements (e.g., HIPAA, federal health care reform mandates);
- costs for consumer education and decision support tools/processes, promotion of wellness, programs for managing chronic and complex medical conditions, maintaining the provider network as well as measuring quality and efficiency of providers, and operating costs of consumer, employer, broker and provider web portals; and
- employee costs for items such as processing requests for services, claims, correspondence and appeals, conducting medical reviews, and providing customer service.

Additionally, there are fees and assessments associated with the Patient Protection and Affordable Care Act (PPACA). These include the Insurer's Fee and Reinsurance Assessment. The Insurer's Fee is a permanent fee that applies to fully insured coverage. The Reinsurance Assessment is a temporary fee that applies to all commercial groups (both fully insured and self-funded) from 2014 to 2016.

Current Rate Increase Components

When deciding whether to seek a premium increase or decrease, we review claims data and expenses to determine what the expected costs and expenses will be for a future period.

Following this review process, we are requesting premium increases related to medical cost trends for the health benefits products that appear in Chart 1. If approved, the increases will be added to the 2012 premium. Chart 1 shows the requested increases by product. The new premiums will apply to all groups that renew or enroll during the second quarter of 2013. Below Chart 1 is an overview of the reasons for the increase.

CHART 1: Impact of Premium Request

Product	Renewal Date	Number of Impacted Subscribers	Requested Estimated Medical Increase Over 2012 Medical Premium (%)	Requested Estimated Pharmacy Increase Over 2012 Pharmacy Premium (%)	Estimated Total Trend Increase (Medical and Pharmacy) Over 2012 Premium (%)
HMO	April 2013 – June 2013	27,417	16.9%	16.9%	16.9%

- The rate filing we have made is seeking an increase mainly related to rising medical costs. As previously mentioned, medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs. Some of the key health care cost trends that have affected this year’s rate actions include:
 - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. We estimate that this component increases costs by approximately 5.6% per year.
 - **Increased Utilization** – The number of office visits and other services continues to grow. We estimate that this component increases costs by approximately 5.5% per year.
 - **Higher Costs from Deductible Leveraging** – Health care costs continue to rise every year, while the pricing for the products is based on deductibles and copayments that generally remain the same. As a result, when groups continue with the same member cost shares, a greater percentage of health care costs need to be covered by health insurance premiums each year. We estimate that this component increases costs by approximately 1.1% per year.
 - **Cost shifting from the public to the private sector** – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals is no longer covering all the cost of care. The cost difference is being shifted to private health plans. Additionally, Medicare and Medicaid rates to hospitals are expected to decline due to the impact of PPACA on Medicare and the affect of the recession on Medicaid. A rate increase paid by Medicaid to hospitals is often below the actual

cost increase hospitals will experience. The cost impact for this component is included in the estimate for increasing cost of medical services shown above.

- **Impact of New Technology** - Improvements to medical technology and clinical practice require use of more expensive services, leading to increased health care spending and utilization. The cost impact for this component is included in the estimates for increasing cost of medical services and increased utilization shown above.
- The medical cost component may also be impacted by changes to the population covered under the product.
 - **Migration Between Oxford Products** – At times, groups and members move between products. This movement has an impact on the costs in both the old and new products. We estimate that this component increases costs by approximately 0.8% per year.
 - **Regulation 146** - A part of the medical costs include a pooling technique established under New York Insurance Regulation 146, which attempts to equalize risk within the New York small group and individual markets. This requires carriers with fewer high-cost claimants to pay into the pool, while carriers with more high-cost claimants receive funds from the pool. We are projecting a slight change in our Regulation 146 amount for Oxford Health Plans (NY), Inc.'s small group products in 2013 due to a projected increase in high cost claimants for the individuals covered under this entity, relative to estimated industry averages.
- As noted above, there are also fees and assessment related to PPACA. These amounts apply to all business starting January 1, 2014. The requested premium increases for 2013 include portions of these full amounts depending upon the number of contract months extending into 2014. These fees and assessments account for 1.1% of the overall requested rate increase.
- The table below summarizes the drivers of the requested rate increase.

CHART 2: Drivers of Requested Rate Increase

Type of Cost:	Percentage Assumed in Current (2012) Rate	Per Member Per Month Increase	Portion of Increase	Percentage Assumed in Renewal (2013) Rate
Medical Services* - Cost of providing healthcare services to policyholders	90.4%	\$28.46	40.0%	83.1%
Administrative Expenses - Marketing, claims processing, taxes, assessments, and other costs to the company	13.0%	\$6.85	9.6%	12.5%
Pre-Tax Underwriting Gain/Loss - Amount the company keeps after paying claims and administrative expenses**	-3.4%	\$35.91	50.4%	4.3%
Total	100.0%	\$71.22	100.0%	100.0%

* 43.6% of the Medical Services cost increases are due to how many people use the services and how often they use them and 56.4% is due to the cost per service (unit cost).

** The driver of the change in Pre-Tax Underwriting Gain/Loss of the requested rate increase is a result of the modifications made by DFS to our requested rates for effective dates in 2012 (current rates). As shown in Chart 2 (above), the rates for 2012 effective dates result in a policy period loss based upon our cost projections.

Additional Benefit Changes for 2013 Plans

We have also submitted benefit change filings to the New York State DFS associated with state mandated autism coverage and federal reform changes to women's preventive coverage. Premium increases approved by DFS for these items will impact your final premium, in addition to the requested premium increases listed in Chart 1. In the event that additional benefit changes (e.g., benefit mandate or change) are made to our HMO product prior to your 2013 renewal, those changes may also impact your final premium.

Final Rate Increase

Please be aware that your group's final renewal premium increase for 2013 may be different than the percentages listed in Chart 1. The Superintendent of Financial Services may approve (as requested), modify or deny the proposed rate adjustment. Your final premium will account for the rate adjustment approved by the New York State DFS, as well as any changes resulting from the benefit plan design chosen and your group's census upon renewal. If you are a subscriber of a group plan, please contact your employer for information about how this information affects your premium contribution.

Oxford Health Plans (NY), Inc.
New York Small Group HMO Plans
Narrative Summary of Requested Rate Changes – Effective 3rd quarter 2013

We have prepared this Narrative Summary as further explanation of the letter you recently received from us outlining our annual proposed premium rate adjustment filing(s) with the New York State Department of Financial Services (DFS). This Narrative Summary will remain posted here, on our website, for a minimum of 30 calendar days from the date of our letter to you, our policyholder, or subscriber. Please review this information carefully and contact us or DFS, as indicated in our letter, with questions within 30 days.

Rate Component Overview

The main components of an insurer's annual premium are the medical costs and administrative expenses we incur for providing health care benefits coverage. A small percentage of the premium is also projected to be profit, which helps us to sustain and grow our business. Medical costs are the main portion of the premium and are accounted for in the minimum loss ratio (MLR)—the percentage of the premiums paid toward medical costs. Under New York state law, the MLR must be at least 82% of the premium charged for the product during the calendar year. This means that at least 82 cents of each premium dollar is to be paid toward medical costs.

Medical costs include items that are typically thought of as medical costs, such as physician office visits, inpatient and outpatient care, covered prescription drugs and new mandated benefits. Medical costs also include taxes and assessments associated with medical services. These items are sometimes referred to as "HCRA" or "GME." HCRA stands for the Health Care Reform Act and is a surcharge on hospital-related services. GME stands for Graduate Medical Expense and is also known as the "covered lives assessment." This is an annual surcharge/tax on every person who has insurance coverage in the state. Certain administrative expenses are reclassified as medical costs when calculating the MLR. Such costs include activities that improve health care; for example, wellness programs.

Some of the key administrative expenses are:

- Taxes and fees not associated with medical costs such as the Section 332 assessment and premium tax;
- maintenance and upgrading of systems to comply with legal requirements (e.g., HIPAA, federal health care reform mandates);
- costs for consumer education and decision support tools/processes, promotion of wellness, programs for managing chronic and complex medical conditions, maintaining the provider network as well as measuring quality and efficiency of providers, and operating costs of consumer, employer, broker and provider web portals; and
- employee costs for items such as processing requests for services, claims, correspondence and appeals, conducting medical reviews, and providing customer service.

Additionally, there are fees and assessments associated with the Patient Protection and Affordable Care Act (PPACA). These include the Insurer's Fee and Reinsurance Assessment. The Insurer's Fee is a permanent fee that applies to fully insured coverage. The Reinsurance Assessment is a temporary fee that applies to all commercial groups (both fully insured and self-funded) from 2014 to 2016.

Current Rate Increase Components

When deciding whether to seek a premium increase or decrease, we review claims data and expenses to determine what the expected costs and expenses will be for a future period.

Following this review process, we are requesting premium increases related to medical cost trends for the health benefits products that appear in Chart 1. If approved, the increases will be added to the 2012 premium. Chart 1 shows the requested increases by product. The new premiums will apply to all groups that renew or enroll during the third quarter of 2013. Below Chart 1 is an overview of the reasons for the increase.

CHART 1: Impact of Premium Request

Product	Renewal Date	Number of Impacted Subscribers	Requested Estimated Medical Increase Over 2012 Medical Premium (%)	Requested Estimated Pharmacy Increase Over 2012 Pharmacy Premium (%)	Estimated Total Trend Increase (Medical and Pharmacy) Over 2012 Premium (%)
HMO	July 2013 – September 2013	20,828	17.4%	17.4%	17.4%

- The rate filing we have made is seeking an increase mainly related to rising medical costs. As previously mentioned, medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs. Some of the key health care cost trends that have affected this year’s rate actions include:
 - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. We estimate that this component increases costs by approximately 5.6% per year.
 - **Increased Utilization** – The number of office visits and other services continues to grow. We estimate that this component increases costs by approximately 5.5% per year.
 - **Higher Costs from Deductible Leveraging** – Health care costs continue to rise every year, while the pricing for the products is based on deductibles and copayments that generally remain the same. As a result, when groups continue with the same member cost shares, a greater percentage of health care costs need to be covered by health insurance premiums each year. We estimate that this component increases costs by approximately 1.1% per year.
 - **Cost shifting from the public to the private sector** – Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals is no longer covering all the cost of care. The cost difference is being shifted to private health plans. Additionally, Medicare and Medicaid rates to hospitals are expected to decline due to the impact of PPACA on Medicare and the affect of the recession on Medicaid. A rate increase paid by Medicaid to hospitals is often below the actual

cost increase hospitals will experience. The cost impact for this component is included in the estimate for increasing cost of medical services shown above.

- **Impact of New Technology** - Improvements to medical technology and clinical practice require use of more expensive services, leading to increased health care spending and utilization. The cost impact for this component is included in the estimates for increasing cost of medical services and increased utilization shown above.
- The medical cost component may also be impacted by changes to the population covered under the product.
 - **Migration Between Oxford Products** – At times, groups and members move between products. This movement has an impact on the costs in both the old and new products. We estimate that this component increases costs by approximately 0.8% per year.
 - **Regulation 146** - A part of the medical costs include a pooling technique established under New York Insurance Regulation 146, which attempts to equalize risk within the New York small group and individual markets. This requires carriers with fewer high-cost claimants to pay into the pool, while carriers with more high-cost claimants receive funds from the pool. We are projecting a slight change in our Regulation 146 amount for Oxford Health Plans (NY), Inc.'s small group products in 2013 due to a projected increase in high cost claimants for the individuals covered under this entity, relative to estimated industry averages.
- As noted above, there are also fees and assessment related to PPACA. These amounts apply to all business starting January 1, 2014. The requested premium increases for 2013 include portions of these full amounts depending upon the number of contract months extending into 2014. These fees and assessments account for 2.0% of the overall requested rate increase.
- The table below summarizes the drivers of the requested rate increase.

CHART 2: Drivers of Requested Rate Increase

Type of Cost:	Percentage Assumed in Current (2012) Rate	Per Member Per Month Increase	Portion of Increase	Percentage Assumed in Renewal (2013) Rate
Medical Services* - Cost of providing healthcare services to policyholders	90.4%	\$27.41	36.2%	82.4%
Administrative Expenses - Marketing, claims processing, taxes, assessments, and other costs to the company	13.0%	\$11.72	15.5%	13.4%
Pre-Tax Underwriting Gain/Loss - Amount the company keeps after paying claims and administrative expenses**	-3.4%	\$36.63	48.3%	4.2%
Total	100.0%	\$75.77	100.0%	100.0%

* 43.6% of the Medical Services cost increases are due to how many people use the services and how often they use them and 56.4% is due to the cost per service (unit cost).

** The driver of the change in Pre-Tax Underwriting Gain/Loss of the requested rate increase is a result of the modifications made by DFS to our requested rates for effective dates in 2012 (current rates). As shown in Chart 2 (above), the rates for 2012 effective dates result in a policy period loss based upon our cost projections.

Additional Benefit Changes for 2013 Plans

We have also submitted benefit change filings to the New York State DFS associated with state mandated autism coverage and federal reform changes to women's preventive coverage. Premium increases approved by DFS for these items will impact your final premium, in addition to the requested premium increases listed in Chart 1. In the event that additional benefit changes (e.g., benefit mandate or change) are made to our HMO product prior to your 2013 renewal, those changes may also impact your final premium.

Final Rate Increase

Please be aware that your group's final renewal premium increase for 2013 may be different than the percentages listed in Chart 1. The Superintendent of Financial Services may approve (as requested), modify or deny the proposed rate adjustment. Your final premium will account for the rate adjustment approved by the New York State DFS, as well as any changes resulting from the benefit plan design chosen and your group's census upon renewal. If you are a subscriber of a group plan, please contact your employer for information about how this information affects your premium contribution.

Oxford Health Plans (NY), Inc.
New York Small Group HMO Plans
Narrative Summary of Requested Rate Changes – Effective 4th quarter 2013

We have prepared this Narrative Summary as further explanation of the letter you recently received from us outlining our annual proposed premium rate adjustment filing(s) with the New York State Department of Financial Services (DFS). This Narrative Summary will remain posted here, on our website, for a minimum of 30 calendar days from the date of our letter to you, our policyholder, or subscriber. Please review this information carefully and contact us or DFS, as indicated in our letter, with questions within 30 days.

Rate Component Overview

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Medical costs include items that are typically thought of as medical costs, such as physician office visits, inpatient and outpatient care, covered prescription drugs and new mandated benefits. Medical costs also include taxes and assessments associated with medical services. These items are sometimes referred to as "HCRA" or "GME." HCRA stands for the Health Care Reform Act and is a surcharge on hospital-related services. GME stands for Graduate Medical Expense and is also known as the "covered lives assessment." This is an annual surcharge/tax on every person who has insurance coverage in the state. Certain administrative expenses are reclassified as medical costs when calculating the MLR. Such costs include activities that improve health care; for example, wellness programs.

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Additionally, there are fees and assessments associated with the Patient Protection and Affordable Care Act (PPACA). These include the Insurer's Fee and Reinsurance Assessment. The Insurer's Fee is a permanent fee that applies to fully insured coverage. The Reinsurance Assessment is a temporary fee that applies to all commercial groups (both fully insured and self-funded) from 2014 to 2016.

Current Rate Increase Components

When deciding whether to seek a premium increase or decrease, we review claims data and expenses to determine what the expected costs and expenses will be for a future period.

Following this review process, we are requesting premium increases related to medical cost trends for the health benefits products that appear in Chart 1. If approved, the increases will be added to the 2012 premium. Chart 1 shows the requested increases by product. The new premiums will apply to all groups that renew or enroll during the fourth quarter of 2013. Below Chart 1 is an overview of the reasons for the increase.

CHART 1: Impact of Premium Request

Product	Renewal Date	Number of Impacted Subscribers	Requested Estimated Medical Increase Over 2012 Medical Premium (%)	Requested Estimated Pharmacy Increase Over 2012 Pharmacy Premium (%)	Estimated Total Trend Increase (Medical and Pharmacy) Over 2012 Premium (%)
HMO	October 2013 – December 2013	19,019	17.7%	17.7%	17.7%

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cost increase hospitals will experience. The cost impact for this component is included in the estimate for increasing cost of medical services shown above.

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- As noted above, there are also fees and assessment related to PPACA. These amounts apply to all business starting January 1, 2014. The requested premium increases for 2013 include portions of these full amounts depending upon the number of contract months extending into 2014. These fees and assessments account for 2.8% of the overall requested rate increase.
- The table below summarizes the drivers of the requested rate increase.

CHART 2: Drivers of Requested Rate Increase

Type of Cost:	Percentage Assumed in Current (2012) Rate	Per Member Per Month Increase	Portion of Increase	Percentage Assumed in Renewal (2013) Rate
Medical Services* - Cost of providing healthcare services to policyholders	90.4%	\$26.27	32.8%	81.7%
Administrative Expenses - Marketing, claims processing, taxes, assessments, and other costs to the company	13.0%	\$16.39	20.5%	14.2%
Pre-Tax Underwriting Gain/Loss - Amount the company keeps after paying claims and administrative expenses**	-3.4%	\$37.35	46.7%	4.1%
Total	100.0%	\$80.00	100.0%	100.0%

* 43.6% of the Medical Services cost increases are due to how many people use the services and how often they use them and 56.4% is due to the cost per service (unit cost).

** The driver of the change in Pre-Tax Underwriting Gain/Loss of the requested rate increase is a result of the modifications made by DFS to our requested rates for effective dates in 2012 (current rates). As shown in Chart 2 (above), the rates for 2012 effective dates result in a policy period loss based upon our cost projections.

Additional Benefit Changes for 2013 Plans

We have also submitted benefit change filings to the New York State DFS associated with state mandated autism coverage and federal reform changes to women's preventive coverage. Premium increases approved by DFS for these items will impact your final premium, in addition to the requested premium increases listed in Chart 1. In the event that additional benefit changes (e.g., benefit mandate or change) are made to our HMO product prior to your 2013 renewal, those changes may also impact your final premium.

Final Rate Increase

Please be aware that your group's final renewal premium increase for 2013 may be different than the percentages listed in Chart 1. The Superintendent of Financial Services may approve (as requested), modify or deny the proposed rate adjustment. Your final premium will account for the rate adjustment approved by the New York State DFS, as well as any changes resulting from the benefit plan design chosen and your group's census upon renewal. If you are a subscriber of a group plan, please contact your employer for information about how this information affects your premium contribution.