

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Filing at a Glance

Company: Oxford Health Plans (NY), Inc.

Product Name: Oxford Small HMO: CY2013

TOI: H15G Group Health -

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.003 Small Group Only

Filing Type: Rate Adjustment pursuant to
Section 4308(c)

SERFF Tr Num: XFRD-128362721 State: New York

SERFF Status: Draft

State Tr Num:

Co Tr Num:

State Status:

Co Status:

Reviewer(s):

Authors: [REDACTED]

Disposition Date:

Date Submitted:

Disposition Status:

Implementation Date Requested: 01/01/2013

Implementation Date:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 05/15/2012

State Status Changed:

Created By: [REDACTED]

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

This rate filing addresses the development of the New York Small Group Liberty HMO rates for the effective dates from January 2013 to December 2013.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Overall Rate Impact: 17%

Company Status Changed:

Deemer Date:

Submitted By:

Company and Contact

Filing Contact Information

[REDACTED]

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48 Monroe Turnpike
 Trumbull, CT 06611

Filing Company Information

Oxford Health Plans (NY), Inc.	CoCode: 95479	State of Domicile: New York
48 Monroe Turnpike	Group Code: 1182	Company Type:
Trumbull, CT 06614	Group Name:	State ID Number: 06-1181200
(203) 459-6000 ext. [Phone]	FEIN Number: 06-1181200	

Filing Fees

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

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.): No
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, 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.): Yes - 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

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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
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes, State Tr Num: 2012060038, SERFF Tr Num: XFRD-128432519

SERFF Tracking Number: XFRD-128362721 State: New York
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 Product Name: Oxford Small HMO: CY2013
 Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 3.500%
Effective Date of Last Rate Revision: 10/01/2012
Filing Method of Last Filing: Prior Approval

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):
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Oxford Health Plans (NY), Inc.	Increase	5.100%	17.000%	\$102,437,753	26,392	\$601,363,015	5.100%	3.800%
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Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	171,603	0	0	0	0	0	0	0
Policy Holders:	26,392	0	0	0	0	0	0	0

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Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Rate Review Details

COMPANY:

Company Name: Oxford Health Plans (NY), Inc.
HHS Issuer Id: 26420
Product Names: Oxford HMO
Trend Factors: We are requesting that the medical and pharmacy rates for 1st quarter 2013 effective dates be increased by 5.1% over the rates for the 4th quarter of 2012 effective dates. We are requesting quarterly medical and pharmacy rate increases of 3.8%, 3.9%, and 3.8% in the 2nd, 3rd, and 4th quarters of 2013, respectively.

FORMS:

New Policy Forms:
Affected Forms:
Other Affected Forms: OHPNY SB HMO S 309, OHPNY GA HMO S 309

REQUESTED RATE CHANGE

INFORMATION:

Change Period: Quarterly
Member Months: 1,477,246
Benefit Change: None
Percent Change Requested: Min: 16.5 Max: 17.7 Avg: 17.0

PRIOR RATE:

Total Earned Premium: 601,363,015.00
Total Incurred Claims: 543,632,165.00
Annual \$: Min: 375.93 Max: 519.01 Avg: 407.08

REQUESTED RATE:

Projected Earned Premium: 707,968,977.00

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Product Name: Oxford Small HMO: CY2013
Project Name/Number: /
Projected Incurred Claims: 587,095,082.00
Annual \$: Min: 438.12 Max: 611.01 Avg: 479.25

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Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Actuarial Memorandum/Actuarial Certification</p> <p>Comments:</p> <p>Attachments: SG HMO Actuarial Memorandum 2013.pdf Certification 2013.pdf</p>		
<p>Satisfied - Item: Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)</p> <p>Comments:</p> <p>Attachment: NY SG HMO 2013 Checklist.pdf</p>		
<p>Bypassed - Item: Consumer Disclosure Form</p> <p>Bypass Reason: Must bypass this Requirement at initial submission since the required documentation is not yet available on HIOS/HHS.</p> <p>Comments:</p>		
<p>Satisfied - Item: Final Notice of Proposed Rate Adjustment</p> <p>Comments:</p> <p>Attachments: 2013 Oxford NY SG Final Notification Letter Group.pdf 2013 Oxford NY SG Final Notification Letter Subscriber.pdf</p>		

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Item Status: **Status Date:**

Satisfied - Item: Initial Notice of Proposed Rate Adjustment

Comments:

Attachment:

2013_Oxford_NY_Small_HMO_Initial_Notices.pdf

Item Status: **Status Date:**

Satisfied - Item: Rate Summary Worksheet

Comments:

Attachments:

Oxford SG HMO 2013 HHS Part I.xls

Oxford SG HMO 2013 HHS Part I.pdf

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 1 - General Information

Comments:

Attachments:

2013 Oxford NYSG HMO Standard Exhibit 1.pdf

2013 Oxford NYSG HMO Standard Exhibit 1.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 2 - Summary of Average Claim Trend and Administrative Expenses

Comments:

Attachments:

2013 Oxford NYSG HMO Standard Exhibit 2.pdf

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 Expense
 Product Name: Oxford Small HMO: CY2013
 Project Name/Number: /
 2013 Oxford NYSG HMO Standard Exhibit 2.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 3 - Narrative Summary

Comments:

Final DFS-Approved Narrative Summaries

Attachments:

2013 Oxford NY SG HMO Narrative Summaries.pdf
 2013 Oxford NYSG HMO Standard Exhibit 3.pdf

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 4 - Summary of Proposed Percentage Rate Changes

Comments:

Attachments:

2013 Oxford NYSG HMO Standard Exhibit 4A.pdf
 2013 Oxford NYSG HMO Standard Exhibit 4A.xls
 2013 Oxford NYSG HMO Standard Exhibit 4B.pdf
 2013 Oxford NYSG HMO Standard Exhibit 4B.xls
 2013 Oxford NYSG HMO Standard Exhibit 4C.pdf
 2013 Oxford NYSG HMO Standard Exhibit 4C.xls
 2013 Oxford NYSG HMO Standard Exhibit 4D.pdf
 2013 Oxford NYSG HMO Standard Exhibit 4D.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 5 - Distribution of Contracts Affected by Proposed Rate Adjustments

Comments:

Attachments:

SERFF Tracking Number: XFRD-128362721 State: New York
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- 2013 Oxford NYSG HMO Standard Exhibit 5A.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 5A.xls
- 2013 Oxford NYSG HMO Standard Exhibit 5B.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 5B.xls

Item Status: **Status Date:**

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

Comments:

Attachments:

- 2013 Oxford NYSG HMO Standard Exhibit 6.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 6.xls

Item Status: **Status Date:**

Satisfied - Item: Standard Exhibit 7 - Historical Data

Comments:

Attachments:

- 2013 Oxford NYSG HMO Standard Exhibit 7.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 7.xls

Item Status: **Status Date:**

Satisfied - Item: Redacted Documents for Web Posting

Comments:

Attachments:

- Cover letter HMO 2013_REDACTED.pdf
- Certification 2013_REDACTED.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 1 REDACTED.pdf
- 2013 Oxford NYSG HMO Standard Exhibit 1 REDACTED.xls

Item Status: **Status**

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Expense
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Project Name/Number: /

Date:

Satisfied - Item: Cover Letter

Comments:

Attachment:

Cover letter HMO 2013.pdf

Item Status:

Status

Date:

Satisfied - Item: Section I - Supporting Exhibits I - III

Comments:

As noted in the Cover Letter.

Attachments:

Exhibit I - HMO Rate Development.pdf

Exhibit II - HMO Migration Analysis.pdf

Exhibit III - HMO Standardized Premium.pdf

Item Status:

Status

Date:

Satisfied - Item: Section II - Rate Manual

Comments:

As noted in the Cover Letter.

Attachment:

NYSG_HMO_2013_rate_manual.pdf



Oxford Health Plans (NY), Inc.
New York Small Group HMO Product
Rates Effective January 2013 – December 2013

ACTUARIAL MEMORANDUM

I. Introduction

This rate filing addresses development of the rates effective from January 1, 2013 through December 31, 2013 for the New York Small Group HMO product written by Oxford Health Plans (NY), Inc. (“OHP”). This rate filing is being submitted pursuant to Prior Approval. Rates effective January 1, 2012 through December 31, 2012 were filed with the New York State Department of Financial Services (“DFS”) on June 15, 2011 and modified by DFS on September 3, 2011.

II. Requested Rate Adjustments

We are requesting that the medical and pharmacy rates for 1st quarter 2013 effective dates be increased by 5.1% over the rates for the 4th quarter of 2012 effective dates. This requested quarterly increase results in an annual increase of 16.5% for both medical and pharmacy plans.

We are requesting quarterly medical and pharmacy rate increases of 3.8% for 2nd quarter 2013 effective dates, 3.9% for 3rd quarter 2013 effective dates, and 3.8% for 4th quarter 2013 effective dates. These proposed quarterly increases result in average annual increases of 16.9% for 2nd quarter 2013, 17.4% for 3rd quarter 2013, and 17.7% for 4th quarter 2013 for medical, pharmacy, and on a combined basis.

The requested rate increases above include the applicable impacts of the fees and assessments associated with the Patient Protection and Affordable Care Act (“PPACA”). This is described in greater detail in Section VI of this Memorandum.

In addition to this premium rate adjustment filing, we separately submitted benefit change filings associated with state mandated autism coverage and federally mandated changes to women's preventive coverage. The requested rate impact for these coverage changes is approximately 1.8%. This is not included in the requested rate increases listed above. More detailed information about these filings can be found in DFS Supplemental Exhibit 6.

III. Source Data

We projected future claims for the HMO product by using claims incurred between January 1, 2011 and December 31, 2011 paid through March 31, 2012. Completion factors were applied by incurred month in order to calculate the fully incurred claims.

As required by the DFS filing checklist, we used the filed large group credibility formula for

Oxford Health Insurance, Inc. to test the credibility of this block of business. The formula is as follows:

$$A = \text{Number of Contracts Factor} = (\text{Contracts}/500)^{1/2}, \text{ never to exceed } 141.42\%$$

The resulting credibility of this block of business and experience period exceeds 100% based upon this formula.

IV. Trend

We develop forward-looking medical expense estimates based on a number of considerations. As a general matter, we review our own recent/emerging claims experience at the state level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Forward looking utilization levels are developed based on emerging state level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

The projected annual trend factor is 12.5%. This breaks down into the following components: 5.6% unit cost, 5.5% utilization, and 1.1% trend leveraging. Please note that this trend factor excludes any risk margin.

V. Rate Development

The key assumptions used in the development of the required rate change are as follows:

- **Trend:** The rate development assumes projected annual trend of 12.5% (5.6% unit cost, 5.5% utilization, and 1.1% trend leveraging).
- **Regulation 146:** We are projecting a payment of \$5.18 PMPM for Regulation 146 for calendar year 2013; the calendar year 2011 experience period reflects the actual payment amount of \$5.51 PMPM.
- **Benefit Change Adjustment:** The claim projection includes a +0.3% adjustment to reflect the expected average increase in benefits for the changes to the HMO product that were separately filed by OHP and approved by DFS effective January 1, 2011. Note that the projected standardized premium projection also includes an adjustment for the corresponding premium impact of these changes.
- **Migration:** The rate development includes a 1.5% adjustment to the experience period claims to account for the fact that migration between products increases expected claim costs by more than is considered by the trend projection factor. This was calculated by squaring the annual migration factor calculated in Exhibit II to reflect the two years between the experience and rating periods. We observe the majority of migration into the HMO product from the EPO product and the majority of migration out of the HMO product into the EPO product. In aggregate, the members migrating out of the HMO product are more costly than the remaining members thereby decreasing costs in the HMO product. This result is due to the fact that the HMO product is at the bottom of the pricing spectrum. In aggregate, the members migrating into the HMO product are more costly than the existing members. This increases costs in the HMO product by more than

is considered by trend. The estimated combined impact of these member migrations is a 0.8% annual increase to projected claims in addition to the trend factor described above.

- **Target Loss Ratio:** The rate development assumes an 84% target loss ratio before the addition of PPACA fees and assessments.

Please see Exhibit I for a detailed development of the requested rate change. We have used claims incurred between January 1, 2011 and December 31, 2011 paid through March 31, 2012 as our base experience period for the projection. The calendar year loss ratio for this experience period is 82.7%.

As shown in Exhibit I, the following adjustments are made to the experience period claims as part of the claims projection:

1. **Trend:** A trend factor of 1.266 is applied reflecting a 12.5% annual trend and 24 months between the endpoint of the experience period (December 31, 2011) and the endpoint of the rating period (December 31, 2013). Note that the Regulation 146 amounts from the experience period are removed before the claims are trended and prior to any of the following adjustments being made.
2. **Benefit Adjustment:** A benefit adjustment factor of 1.003 is applied to account for the average impact of the benefit changes filed effective January 1, 2011. This filing was approved by the New York State Insurance Department.
3. **Migration Adjustment:** An adjustment factor of 1.015 is applied to reflect the migration between Oxford products and its projected impact on HMO medical claims.

As aforementioned, the projected Regulation 146 amount for the rating period is a payment of \$5.18 PMPM. This amount is added to the trended and adjusted claims in order to calculate the total projected claims for the rating period.

For the premium projection shown in Exhibit III, we calculated the standardized premiums by bringing the earned premiums from the experience period to the 4th quarter 2012 rate level. Please see Exhibit III for this calculation.

The projected loss ratio of 88.1% for the rating period is calculated by dividing the projected claims by the standardized premium. The required 1st quarter 2013 rate increase over approved 4th quarter 2012 rates is 4.8% to target an 84% loss ratio. The addition of the PPACA fees and assessments described in Section VI increases the requested rate adjustment to 5.1%. For each of the 2nd, 3rd, and 4th quarters of 2013, we are proposing a trend increase of 3.0% prior to the additional increases for the PPACA fees and assessments. This percentage is calculated by taking the projected annual pricing trend of 12.5% to the ¼ power. The addition of the PPACA fees and assessments described in Section VI increases the requested quarterly rate adjustments to 3.8%, 3.9%, and 3.8% for 2nd through 4th quarters 2013, respectively.

VI. Insurer and Reinsurance Fees

The Patient Protection and Affordable Care Act (PPACA) includes several new taxes and fees which will increase health insurance costs and need to be reflected in premium. The two largest cost impacts both take effect with calendar year 2014 earned premiums:

1. **Insurer Fee:** This is a permanent fee that applies to fully insured coverage. This fee will fund tax credits for insurance coverage purchased on the exchanges. The total fee

increases from \$8B in 2014 to \$14.3B in 2018 (indexed to premium for subsequent years.) Each insurance carrier's assessment will be based on earned health insurance premiums with certain exclusions. We estimate 2014 premium will need to be increased by 2.2% to cover this fee.

2. **Reinsurance Fee:** This is a temporary fee that applies to all commercial groups (both fully insured and self-funded) from 2014 to 2016 for the purpose of funding the reinsurance pool for high cost claimants in the individual market during this three year transitional period. The total baseline amounts to be collected to fund this pool are \$12B in 2014, \$8B in 2015, and \$5B in 2016, and individual states can add to this baseline. Each insurance carrier will be assessed on a per capita basis. We estimate 2014 premium will need to be increased by \$5.85 per member per month to cover just the baseline amount mentioned above.

Because these fees apply to all earned premiums starting in calendar year 2014, they impact only 1 month of premium associated with February 2013 rate effective dates, 2 months of premium for March, 2013 rate effective dates, ... and 11 months of premium associated with December 2013 rate effective dates. As a result, the full 2014 impacts outlined above have been reduced for the 2013 rate effective dates in this filing to reflect just the amount of the policy period premium that falls into 2014. We have calculated the aggregate impacts by quarter in order to continue to maintain the same rates for all effective dates within each quarter.

VII. Expected Loss Ratio

The requested rate increase reflects an 84% target loss ratio before the addition of PPACA fees and assessments.

VIII. Commissions

Broker commissions are 3.5% of premium for business new and renewing in calendar year 2013.

IX. Projected Expense Components

Please see DFS Supplemental Exhibit 2 with the projected expense components for 2013. Please note that we have included the average impact the PPACA fees and assessment on line 6.5 because they vary by quarter as described in Section VI.



Oxford Health Plans (NY), Inc.

New York Small Group HMO Product
Rates Effective January 2013 – December 2013

ACTUARIAL CERTIFICATION

I, [REDACTED], am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The filing is in compliance with all applicable laws and regulations of the State of New York.
- (b) The filing is in compliance with Actuarial Standard of Practice No. 8.
- (c) The expected loss ratio meets the minimum requirement of the State of New York.
- (d) The benefits are reasonable in relation to the premiums charged.
- (e) The rates are not unfairly discriminatory.

[REDACTED]

June 15, 2012

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

As of 5/18/2012

Use this Checklist for all rate adjustment filings submitted pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law. One of the following two SERFF filing type codes must be used to properly denote such a filing. A rate submission with the wrong filing type code will be rejected and will need to be resubmitted with the correct filing type code.

Rate Adjustment Pursuant to Section 3231(e)(1): This filing type is used for Article 42 insurers that are submitting a rate adjustment only filing for a hospital and/or medical coverage (including Medicare Supplemental insurance) for small groups and individuals under the Section 3231(e)(1) prior approval process. This filing type cannot be used for form filings, initial rate filings, or by Article 43 Corporations or Health Maintenance Organizations (HMOs).

Rate Adjustment Pursuant to Section 4308(c): This filing type is used for Article 43 Corporations and HMOs that are submitting a rate adjustment only filing for any policy form that uses a community rating structure. This includes hospital and/or medical policy forms, or separate stand-alone dental policy forms, that are not required to be community rated but for which the corporation voluntarily community rates. "Community rating" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. This also includes the HMO portion of large group Point of Service business where an approved experience rating formula is not used. This filing code cannot be used for form filings, initial rate filings, or by commercial insurers.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) can include an expansion of an existing rate table to include new benefit options (such as rates for additional copays or deductibles) provided that: (a) the already approved contract language includes the new benefit options being added, (b) the actuarial memorandum clearly identifies the new benefit options being added and provides appropriate actuarial support for the new rates, and (c) approved contract language pages and the Department's approval letter are included with the rate filing documenting that the benefit options being added are included in the already approved contract language. No Section 3231(e)(1) or Section 4308(c) rate adjustment filing can include rates that require contract language approval where such approval has not already been received.

A change to existing rating region differentials is a rate adjustment filing pursuant to Section 3231(e)(1) or Section 4308(c). A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot reflect an expansion to a new service area. A service area expansion, and the rate applicable to that new service area, must be submitted as a separate rate filing using the "Normal Pre-Approval" SERFF filing type code. A Section 3231(e)(1) or Section 4308(c) filing cannot be used to withdraw from a service area.

If a company wishes to eliminate some of its approved benefit options included in the current rate manual, this cannot be done pursuant to a Section 3231(e)(1) or Section 4308(c) rate adjustment application. Such elimination is to be implemented by submitting a form and rate filing using the "Normal Pre-Approval" SERFF filing type code and the filing is to include a revised statement of variables for the benefit options that are available along with revised rate manual pages reflecting the revised benefit options.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot 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. Once a new rate has been approved (for a new policy form or for a revision to an existing policy form), such new rate can be incorporated into the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing.

The "Normal Pre-Approval" SERFF filing type code triggers the traditional Department review (generally by the Albany Health Bureau unit) and would be used for all form and rate filings, form only filings, experience rating formula filings, or commercial insurer rate only filings other than filings submitted pursuant to Section

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

3231(e)(1), or Article 43 Corporation and HMO rate only filings other than filings submitted pursuant to Section 4308(c). The “Normal Pre-Approval” SERFF filing type code would also be used for old individual medical policy forms that are not community rated. Rate revisions for products subject to Section 3231(e)(1) or 4308(c) incorporated into a form and rate filing that adjusts an existing policy form for a change in benefit language can only reflect rate changes due to the benefit revision and can not reflect any adjustment for experience or trend. A “Normal Pre-Approval” SERFF type filing for a product subject to Section 3231(e)(1) or 4308(c) can not include rolling rate tables that extend beyond the period included in the most recently approved or pending Section 3231(e)(1) or Section 4308(c) rate adjustment submission (for example, the last rate adjustment submission included quarterly rolling rate tables for each calendar quarter of 2012; a benefit revision is submitted January 2012 to be effective July 1, 2012; this form and rate filing can include rolling rate tables for third and fourth quarter 2012, but not beyond fourth quarter 2012).

New or revised commission schedules or broker fee schedules must first be placed on file using a rate filing with a “Normal Pre-Approval” SERFF filing type code. Once the new or revised schedule has been placed on file, any rate impact can be included with the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing and the change and its impact on the premium rates is to be discussed in the actuarial memorandum.

It is recommended that a Section 3231(e)(1) or Section 4308(c) rate filing application be submitted at least 150 days before the proposed effective date, however, in determining how far in advance to submit such a rate filing, the company should consider: the time needed to load final rates into its computer system; produce the final rate notice, which is to be sent at least 60 days before the scheduled rate change effective date of the renewal cohort; the 60 days the Department has to review the material; and the time the clock may be stopped while the company responds to issues raised by the Department about the rate filing.

It is recommended that a rate adjustment submission not be submitted more than 180 days prior to the proposed rate effective date. It is recommended that a rate adjustment submission not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing. If a company can not send the required final notice at least 60 days in advance of the rate change date for a particular renewal cohort, then the rate change implementation date for such renewal cohort will need to be deferred. Contract terms will dictate whether the rate change can be deferred to a later implementation date for that renewal cohort (e.g., for the July 2012 renewal cohort, deferring the rate change to August 2012, while retaining the next rate change date as July 2013), or deferring implementation of the newly approved rates to a later renewal cohort (e.g., assuming quarterly rolling rates are used: renewing the July 2012 renewal cohort using the previously approved second quarter 2012 rate tables, and implementing the newly approved rates with the August 2012 renewal cohort).

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2003, Microsoft Excel 2003, or Adobe Acrobat 9.

When an attachment is submitted via SERFF as other than an Adobe Acrobat PDF file, another copy of that attachment is to also be included in Adobe Acrobat PDF file format. This can occur when one of the standard exhibits is required to be submitted as an Excel workbook, or when an appendix/attachment to the actuarial memorandum is submitted in other than PDF format. Failure to include a PDF version of each attachment will result in an objection letter being sent for the missing material and the rate submission will be tolled while waiting for the missing material to be submitted.

The rate manual and the year over year exhibit (if distinct versions are used) are to be attached to the Rate Schedule tab of an initial SERFF filing. All other attachments are to be attached to the Supporting Documentation tab of the initial SERFF filing.

An “amendment” to a SERFF filing, as described beginning on page 183 of the SERFF Industry Manual (available online via SERFF), is used when the amendment is not in response to an objection letter. For example: the filer has decided to add a schedule item; the filer has noticed an error in one of the originally submitted schedule items and is submitting a correction before the error is raised in an objection letter. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, year over year exhibit, etc.) needs to be amended, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be corrected.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

A revision to a previously submitted schedule item made in response to an objection letter is to use the “Revising Schedule Items” process described beginning page 170 of the SERFF Industry Manual. This is the method that is to be used when any schedule item needs to be revised in response to an objection letter, including a revised rate manual to be submitted in response to the Department’s decision. If a schedule item (e.g., actuarial memorandum, standard exhibit, rate manual, year over year exhibit, etc.) needs to be revised in response to an objection letter, the entire schedule item attachment is to be resubmitted using this process and not just the pages that need to be revised.

NOTE: A new section, Public Disclosure of the Rate Application, has been added at the end of the checklist. If the applicant chooses to submit a redacted version of the rate application for posting on the Department’s website, see the guidance there.

NOTE: Parts I and II of the HHS Preliminary Justification are now required for all market segments and for all section 3231(e)(1) or 4308(c) rate submissions. See the section “HHS Preliminary Justification Parts I and II” below for guidance.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
DEFINITIONS		<ul style="list-style-type: none"> a. Company refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing. b. A company’s commercial book of business includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus. c. Loss ratio refers to incurred claims divided by earned premiums for a given period of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including “quality improvement expenses” or “community benefit expenses”. Earned premiums <u>do not include</u> any adjustment for assessments or taxes. d. Market segment refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc. Small group is as defined in New York Insurance Law and Regulation. e. Product street name refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department. f. Rate applicability period refers to the length of time in which the rates in a rate table are assumed to remain in effect. <ul style="list-style-type: none"> (i) Example 1: A non-rolling rate table is developed to be effective January 1, 2012 and is expected to be revised January 1, 2013. The rate applicability 	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>period for this table is January 1, 2012 through December 31, 2012.</p> <p>(ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2012 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2012 (mid renewal date) through February 14, 2013. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2012 through January 31, 2013.</p> <p>g. 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, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 7 or in the rate development analysis.</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarters 2012 and 1st and 2nd quarters 2013. The 2nd quarter 2012 rates have already been approved. Therefore, the 2nd quarter 2012 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 2012 rate level. If the 2nd quarter 2012 rate table included a 2% increase due to the addition of a new benefit that is being added to all policyholders at renewal, the standardization for periods prior to April 1, 2012 would not reflect this 2% increase since the incurred claims for this earlier period did not reflect this additional benefit.</p> <p>(ii) Example: An insurance company uses a quarterly rolling rate structure and has been raising rates 4% each quarter as of the beginning of a new quarter. The first quarter 2011 rate for plan design A is \$100, the first quarter 2012 rate is \$116.99, and the second quarter 2012 rate is \$121.67. These increases reflect no revision to the underlying covered benefits. The second quarter 2012 rate table is the standard rate level. Contract X was paying \$100 per month for January-December 2011. At renewal January 1, 2012, the premium was scheduled to increase to \$116.99 but a change to plan design B occurred that reduced the premium by 5% to \$111.14 for January 2012 and later. The second quarter 2012 rate for plan design A is \$121.67 and the second quarter 2012 rate for plan design B is \$115.58 (\$121.67 x 0.95). The earned premium for this contract for each month from January through December 2011 is standardized to the second quarter 2012 level by adjusting by 121.67/100.00, and the</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p align="center">January 2012 earned premium is standardized to the second quarter 2012 level by adjusting by 115.58/111.14.</p>	
<p>ROLLING RATE STRUCTURE</p>		<ul style="list-style-type: none"> a. 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). 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. 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>Rate Manual</p>
<p>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</p>		<ul style="list-style-type: none"> a. Beginning with rate adjustment filings that include rate tables to be effective January 1, 2012 or later, the rate adjustment filing must include all community rated policy forms within a given market segment (such as all small group products) whether or not a premium rate adjustment is requested for a particular product or rider in that market segment. All entities within the same holding company system are to submit filings for a given market segment at the same time; the filings can be submitted under different SERFF filings, but all the applicable filings must be submitted within a total of seven calendar days. b. A company can revise a previously approved non-rolling rate table provided that: <ul style="list-style-type: none"> (i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or (ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing. c. 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 quarterly rate tables, or the first six monthly rate tables, included in the previously approved rate adjustment filing are not revised, and (iii) policyholders in the renewal cohort(s) affected by the change to the previously approved rate tables did not receive a final 60 day notice informing them of the approved rates from the previously approved rate adjustment filing. The revised rate adjustment filing must include a year’s worth of rates as discussed in the “Rolling Rate Structure” section above. (Example: A rolling rate filing was submitted and approved that included quarterly rolling rate tables for 1st, 2nd, 3rd 	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		and 4 th quarter of 2012. The company can not revise the 1 st and 2 nd quarter 2012 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 2012 and 1 st and 2 nd quarter 2013.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened.	
STANDARD EXHIBITS 1 - 7	Introduction	Exhibits 1 through 7 must be submitted as part of each rate adjustment application. All exhibits, except Exhibit 3, must be submitted as a Microsoft Excel file and as an Adobe PDF file. For Exhibits 1-2 and 4-7 the supplied workbook must be used. Only use the first tab of each Excel workbook for data entry.	
Exhibit 1		<p>General information about the rate adjustment submission.</p> <ul style="list-style-type: none"> a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit. b. Indicate the company type using the drop down list: Article 42 Accident and Health company (A&H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&C – 41), and Article 43 Non-Profit Medical and Dental Indemnity or Health and Hospital Service Corporations (Not for Profit – 43). c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list. d. Item D – the “new rate effective date” must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day final rate notice. This date would usually be the first date the proposed rates would affect renewing policyholders. So a 1/1/2013 effective date would imply that the first renewal cohort affected by the rate submission would be January 2013. e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected. f. This exhibit must be submitted as an Excel file and as an Adobe PDF file. 	Standard Exhibit 1
Exhibit 2		<p>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</p> <ul style="list-style-type: none"> a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert more rows as needed. Only use the first tab for data entry. b. Use a separate row to enter information for each combination of market segment/rating pool included in this rate adjustment application. Use the drop down list to enter the market segment. Enter a description of the rating pool in the column indicated; if the rating pools vary by rating region, the rating pool identifier should include a region identifier. All market segments of Healthy New York are usually combined into one rating pool and in that case choose as market 	Standard Exhibit 2

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>segment HNY-IND or HNY-SG based on which subpopulation has the most membership.</p> <p>c. Information is for medical base plans and all associated riders combined.</p> <p>d. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rate applicability period.</p> <p>e. The administrative expense components incorporated into the proposed rates are to be entered as a percentage of gross premium and as a per member per month amount.</p> <p>f. Enter the data for the rate period included in this rate adjustment filing. This refers to the various non-claim expense components included in the proposed rates and the average annualized claim trend assumed.</p> <p>g. Enter the data for the rate period included in the immediately prior rate adjustment filing (i.e., a section 3231(e)(1) or 4308(c) rate adjustment filing). This refers to the various non-claim expense components included in the proposed rates submitted with this prior filing and the average annualized claim trend assumed in this prior filing. If there is no immediately prior rate adjustment filing, enter the data assumed in the initial or prior form and rate filing.</p>	
<p>Exhibit 3</p>		<p>Narrative Summary.</p> <p>a. The format of the exhibit is illustrative, but must include the required material. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. If submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>b. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</p> <p>c. The narrative summary will be a public document.</p> <p>d. It is suggested that once reviewed by the Department, the company post the narrative summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for entering a user ID and password. Links should be provided on key pages of the company’s website so that the information may be easily located. Any change(s) to the narrative summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified. Narrative summaries should remain on the company’s website for at least 12 months past the proposed effective date of the rate submission.</p> <p>e. The narrative summary should include, but not be limited to, the following</p>	<p>Standard Exhibit 3</p>

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>information:</p> <ul style="list-style-type: none"> (i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application. (ii) A summary of the proposed rate adjustments. (iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the “street name” of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy). (iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples: <ul style="list-style-type: none"> (a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy. (b) A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy. (v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission. (vi) An explanation, in plain language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type. <p>Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	
<p>Exhibit 4</p>		<p>Summary of Proposed Percentage Rate Change to Existing Rate.</p> <ul style="list-style-type: none"> a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing. <ul style="list-style-type: none"> (i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used. (ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used. (iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used. (iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used. b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment filing. Use the drop down list to enter the market segment. c. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for 	<p>Standard Exhibit 4</p>

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>data entry.</p> <p>d. This exhibit is to summarize the proposed percentage rate changes. The percentage rate change is the percentage change from the rate the subscriber is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which are not being revised by the current rate application) to the proposed rate that this subscriber would be paying at the subscriber’s next rate change date according to the new rate application.</p> <p>Example 1: the rate structure is quarterly rolling rates, has a 12 month rate guarantee period, and the rate adjustment application is for second quarter 2013 issues and renewals. The rate change would be the percentage change from the second quarter 2012 rates to proposed second quarter 2013 rates.</p> <p>Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2013. The prior rate application included quarterly rolling rates for each quarter of 2012. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2012 before all the third and fourth quarter 2012 renewals have taken place. The proposed percentage change for fourth quarter 2013 would be the change from the fourth quarter 2012 rates to the proposed fourth quarter 2013 rates.</p> <p>e. If the subscriber will need to change to a different plan design at renewal (i.e., a required change from the current plan design whether mandated by a government entity or not, but not due to the discontinuation of the current policy form or discontinuation of a particular plan design), a supplement to Exhibit 4 is to be included. The supplemental exhibit is to indicate (i) a high level summary of the difference in covered benefits and cost sharing between the current and replacement plan, and (ii) the estimated pricing percentage change due solely to the difference in the plan designs between the replacement plan and the existing plan. This supplemental exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file; if submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>f. The weighted averages may be based on membership or contract as used in Standard Exhibit 5 instead of premium volume.</p> <p>g. The values entered should follow the organization of the rate manual. If the drug rate is included with the rates in the medical rate table, the combined result is entered in Part A and/or Part B. If the drug rate is a separate rate table associated with a drug rider, then the medical changes are shown in Part A and/or Part B and the drug rider changes are shown in Part C and/or Part D.</p> <p>h. Parts A and B summarize the proposed changes for the base medical rate tables and excludes the impact of all optional riders. The lowest and highest values indicate for a given market segment, region, policy form, product combination the</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>lowest percentage change that applies to a renewing subscriber/contract holder and the highest percentage change that applies to a renewing subscriber/contract holder. This difference could be due to different percentage changes proposed by rating tier or by plan design within a particular product.</p> <p>Example: The rate adjustment application is only for small group PPO and within this product there are only two product designs. The proposed rate changes for design A are: employee only = 10%, employee+child(ren) = 8%, employee+spouse = 13% and employee+family = 11%. The proposed rate change for design B are: employee only = 9%, employee+child(ren) = 7%, employee+spouse = 12% and employee+family = 10%. The lowest change proposed is 7% and the highest change proposed is 13%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</p> <p>i. Parts C and D summarize the proposed changes just for the traditional drug riders. <u>Exclude</u> minor drug related riders such as a rider to include oral contraceptives. All the drug riders available with a given base medical product can be aggregated into one row.</p> <p>Example 1: Drug riders D1 to D99 are available with the PPO product. The proposed changes on the drug riders vary from 10% to 16%. There would be one row for the PPO policy form/product. The lowest change proposed is 10% and the highest change proposed is 16%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</p> <p>Example 2: As in Example 1, but drug riders HD1-HD19 are available with the HSA high deductible PPO product. There would be another row for the high deductible PPO policy form/product indicating the lowest, highest, and weighted average changes among the HD1-HD19 drug riders.</p> <p>j. A separate row should be completed for each market segment. If the percentage rate change for sole proprietor is different from small group, then a separate market segment of sole proprietor is to be reported.</p> <p>k. Where rate changes differ by rating region within a market segment, separate rows are to be used by market segment/rating region combination.</p> <p>l. Separate information should be submitted for each rolling rate table of a rolling rate structure. For example: if a calendar quarterly rolling rate structure is used and the rate adjustment filing includes proposed rate tables for first, second, third and fourth quarters 2013, separate information should be entered in Parts B and D for the impact of the first quarter 2013 rate changes, the impact of the second quarter 2013 rate changes, the impact of the third quarter 2013 rate changes, and the impact of the fourth quarter 2013 rate changes.</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

<p>Exhibit 5</p>		<p>Distribution of Contracts Affected by the Proposed Rate Adjustments.</p> <ol style="list-style-type: none"> a. There are two different versions of this exhibit as indicated below. Not all versions may be required for a given rate submission. <ol style="list-style-type: none"> (i) Part A – for use with <u>Non-Rolling</u> Rate Structures. (ii) Part B – for use with <u>Rolling</u> Rate Structures. b. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for data entry. c. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. Use the drop down list to enter the market segment. d. This exhibit indicates the distribution of the proposed rate changes for each market segment, rating region and product, as well as the weighted average rate change impact for that segment/region/product combination. If the same percentage rate change applies to each rating region, then a separate break out by rating region is not necessary and the results can be shown for all rating regions combined. e. The distribution basis can be by number of contracts or by number of members – fill in the applicable column. The same basis is to be used for all products within a given rate adjustment submission. Enter the applicable counts in the appropriate column (members column or contracts column), and replace the “mm/dd/yyyy” placeholder with the applicable “as of” date for the counts entered. The Weighted Average % should be developed based on the distribution of contracts or members for that market segment/rating region/product. At the end of each market segment enter a Market Segment Total row indicating the member/contract counts in total and by rate change column and the Weighted Average % for all rating regions/products in that market segment combined. f. The percentage rate change reflects the expected change in premium rate that would apply to that subscriber/contract holder on that subscriber/contract holder’s next rate change date according to the new rate application. This would reflect the percentage rate change from the rate the contract holder is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application) to the proposed rate that this contract holder would be paying at the contract holder’s next rate change date according to the new rate application The rate change reflects the impact of the base medical plans and all riders applicable to that contract. g. Enter in Part A the information for the various products that use a <u>non-rolling</u> rate structure. h. Enter in Part B the information for the various products that use a <u>rolling</u> rate structure. Separate rows are to be used for each rolling rate cohort. For example, if 	<p>Standard Exhibit 5</p>
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2013, then separate rows would be used to enter information for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.</p>	
<p>Standard Exhibit 6</p>		<p>Summary of Policy Form and Product Changes.</p> <p>a. This Standard Exhibit summarizes all rate changes filed pursuant to sections of the New York Insurance Law other than Section 3231(e)(1) or Section 4308(c) that impact the policyholders affected by this rate adjustment filing and which affect the percentage changes shown on Standard Exhibits 4 or 5.</p> <p>b. The format of the Standard Exhibit is fixed. Insert additional rows as needed. Only use the first tab for data entry. Use the drop down list to enter the filing status. Leave the Approval Date column blank for any filing that has not yet been approved. This Standard Exhibit must be submitted as an Excel file and also as an Adobe PDF file.</p> <p>c. List all rate filings that have been approved since the prior Section 3231(e)(1) or Section 4308(c) rate filing that impact the percentage rate change of the policyholders affected by this rate adjustment filing. The actuarial memorandum should include a brief description of such changes, when the changes were implemented, and the impact on the rate changes in Standard Exhibits 4 and 5.</p> <p>d. List all rate filings currently pending with the Department that if approved would impact the percentage rate change of the policyholders affected by this rate adjustment submission. This includes any pending request to discontinue a policy</p>	<p>Standard Standard Exhibit 6</p>
<p>Standard Exhibit 7</p>		<p>Historical Data by Each Policy Form Included in the Rate Adjustment Filing.</p> <p>a. This Standard Exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the Standard Exhibit is fixed; insert additional rows as needed. Only use the first tab for data entry.</p> <p>b. Indicate the company name, the NAIC code number for that entity, and the SERFF filing number for the applicable rate filing in the spaces indicated.</p> <p>c. Use a separate row for each base medical policy form belonging to a rating pool (i.e., a permitted aggregation of base medical policy forms). Data is to be shown for each base medical policy form included in the rate adjustment filing even if no rate adjustment is proposed for that base medical policy form. Then add another row for the rating pool total and indicate an appropriate rating pool identifier in the first column. Skip a line and then enter similar data for the next rating pool.</p> <p>d. Indicate the form number for each base medical policy form, the product name as in the rate manual, the street product name, and the rating pool identifier (the rating</p>	<p>Standard Standard Exhibit 7</p>

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar policy forms for small group policy forms and for individual policy forms.</p> <p>e. Indicate for each base medical policy form if the policy form aggregation has changed from the previous rate filing. If yes, the actuarial memorandum must include an explanation of 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>f. 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 earliest rolling rate period of a rolling rate structure.</p> <p>g. 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.)</p> <p>h. The weighted average rate change percentage proposed (from the rate currently charged the policyholder [or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application] to the proposed rate to be charged to that same cohort of policyholders) for the indicated base medical policy form, including all associated riders. The weighting should be consistent with how the average changes were calculated in Standard Standard Exhibit 5 (i.e., based on members or contracts). 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 the 1st, 2nd, 3rd, and 4th quarters of 2013. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2012 rate tables to the 1st quarter 2013 rate tables.)</p> <p>i. For the number of policyholders affected and the number of covered lives affected by this rate filing, indicate the effect 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). For group business, “policyholders” is referring to the number of groups, not the number of subscribers or contracts.</p> <p>j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and 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,</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>period of the rolling rate structure.</p> <p>k. The experience entered for the three 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 cannot 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, 2013. The recent experience period cannot have an ending date earlier than June 30, 2012, i.e., 12 months prior to July 1, 2013.).</p> <p>(iii) The first prior period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior period.</p> <p>(iv) The incurred claims for each of the three experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims.</p> <p>(v) Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.</p> <p>l. Enter the average annual composite medical trend assumption used in the proposed rate development 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, as well as any other component such as for case mix or intensity (identify and discuss and justify any such other component in the actuarial memorandum along with the utilization component and unit cost component).</p> <p>m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting Standard Exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods.</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>this rate filing, separate rows are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined, and the rating pool identifier is to include a rating region identifier.</p>	
ACTUARIAL MEMORANDUM	11NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> 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. 	Actuarial Memorandum
Justification of Rates	<p>§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p>	<ul style="list-style-type: none"> a. Description of proposed changes in rates, including the following: <ul style="list-style-type: none"> (i) The member (or contract) weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to that policy form (or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application). This is to be shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. (The percentage change is comparable to the percentage change developed for Standard Standard Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months. (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 rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2013. The change from each of the 2nd quarter 2013 rolling rate tables to the corresponding 3rd quarter 2013 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated. (iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment filing, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive 	Rate Manual, Actuarial Memorandum, & Exhibit I – Rate Development

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>quarterly rate tables).</p> <p>(iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio.</p> <p>(v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vi) 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, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an Standard Exhibit showing how this variance and the percentage impact of this variance were developed.</p> <p>(viii) 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. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition.</p> <p>b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department’s approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table.</p> <p>c. Include the following (year over year Standard Exhibit):</p> <p>(i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>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 submission.</p> <p>(ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, 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 submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2013 and first and second quarter 2014. Rates are for 12 month periods. Show the rates for the third quarter 2012, the proposed rates for the third quarter 2013, and the dollar and percentage change from third quarter 2012 to the proposed third quarter 2013 rates. Show a similar table for the proposed fourth quarter 2013, and first and second quarter 2014 rates as well.)</p> <p>d. Discuss the standard premium development used in Standard Standard Exhibit 7. See discussion above on Standard Standard Exhibit 7.</p> <p>e. Discuss the source data used to develop the projected incurred claims for the renewal rate applicability period.</p> <p>(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.</p> <p>(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.</p> <p>(iii) Discuss the credibility of such source data.</p> <p>(iv) Include an Standard Exhibit showing the source data and indicate all adjustments made</p> <p>to this source data to develop the projected incurred 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) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment.</p> <p>f. Indicate the assumed annualized claim trend projection factors used to project the 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) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <p>(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</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<ul style="list-style-type: none"> (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic 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>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</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 2013 rate table to the proposed 3rd quarter 2013 rate table was developed for each rating element in the proposed rate table.) This demonstration must clearly show how the proposed rate change was developed from the projected source data, current rate level, and expected loss ratio. Provide justification for the percentage change proposed. (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 2013 rate table to the 4th quarter 2013 rate table). Provide justification for these changes between the rolling rate tables. (iii) Clearly show how the proposed rate development, as applicable, reflects recoveries from the standard direct pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327), and discuss how the recovery amounts used were developed. (iv) Clearly show how the proposed rate development, as applicable, reflects payments to, or receipts from, the Department Regulation 146 (11 NYCRR 361) and New York Insurance Law Section 3233 marketing stabilization pool. Clearly discuss how the corporation has been complying with 11 NYCRR 361 (Regulation 146), Section 361.6(g), and include in the rate application any new plan pursuant to Section 361.6(g)(2)(i). Such discussion should include an Standard Exhibit showing how all monies received from the Regulation 146 pool from calendar years 2007 to date have been used to benefit consumers pursuant to the requirements of Section 361.6(g). (v) Discuss if the source data includes any very large claims on an individual, how such large claims have been handled, and any internal mechanism to pool large claims across more than the rating pool that contained the large claim. Clearly 	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>for pooling large claims.</p> <p>h. 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 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 cannot be based on differences due to age, sex, health status or industry among the members selecting the different benefit options.</p> <p>i. 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 cannot 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>j. 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>k. Discuss any significant change in the non claim expense components indicated on Standard Standard Exhibit 2 between the prior rate adjustment filing and this rate adjustment filing, including any item where the \$pmpm value exceeds \$1 and where the \$pmpm value changed by more than 10% between the prior filing and the current filing. Discuss the source for the non-claim expense components indicated on Standard Standard Exhibit 2 for the current rate filing and, for the percentage of gross premium values, how the proposed rate change was reflected in the</p>	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		percentage of premium should decrease for an expense that is not directly tied to premium). Discuss any revision to the expense allocation basis that has occurred since the last rate adjustment filing.	
Minimum Loss Ratio Requirements	§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)	<ul style="list-style-type: none"> a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010. b. The minimum loss ratio for the official Medicare Supplemental products is: <ul style="list-style-type: none"> (i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance Law, as amended by Chapter 107 of the Laws of 2010; and (ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52). 	Actuarial Memorandum
Actuarial Certification	11NYCRR 52.40(a)(1)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio incorporated into the proposed rate tables 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 incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. 	Actuarial Certification
REVISED RATE MANUAL PAGES	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	<p>Rate Manual.</p> <ul style="list-style-type: none"> a. Table of contents. b. Rate pages, including a page indicating the composition of each rating region. c. Insurer/corporation name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts, as applicable. g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual, to the extent applicable. j. Expected loss ratio(s). 	Rate Manual

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

<p>NOTICES TO POLICYHOLDERS Initial & Final</p>	<p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p>	<p>a. As indicated in Circular Letter No. 12 (2011), a draft of the initial notice should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval Prefiling” filing type code. (It is strongly recommended that the company also include a draft of the Narrative Summary in this prefiling submission.)</p> <p>b. Include with the rate adjustment filing a sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Department of Financial Services.</p> <p>(i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Department.</p> <p>(ii) If different notices are used for different products or different rating regions, submit a sample for each such product and/or each such rating region.</p> <p>c. Include with the rate adjustment filing a sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.</p>	<p>Initial Notification Letters, Second Notification Letters</p>
<p>HHS PRELIMINARY JUSTIFICATION PARTS I AND II</p>	<p>PPACA §1003</p>	<p>a. For every rate submission pursuant to section 3231(e)(1) or section 4308(c) of the New York Insurance Law, the insurer is to submit Parts I and II of the U.S. Department of Health and Human Services (HHS) Preliminary Justification, whether or not such justification material is required to be submitted to HHS.</p> <p>b. This requirement applies to large group community rated products as well as to small group and individual products, and to non-grandfathered and grandfathered products, but this requirement does not apply to a product type that would never require such justification material to be submitted to HHS (for example: Medicare Supplemental products, stand-alone dental products).</p> <p>c. The justification material is to be prepared using the template and instructions provided by HHS.</p>	<p>2013 HHS Part I, 2013 HHS Part II</p>
<p>PUBLIC DISCLOSURE OF THE RATE APPLICATION</p>		<p>Posting a Redacted Version of the Rate Adjustment Application to the Department’s Website.</p> <p>a. A redacted version of this rate application will be posted to the Department’s website to aid consumers’ understanding of the reason(s) for the requested rate change(s).</p> <p>b. The Department will accept redaction of only the following information in the rate application:</p> <p>(i) personally identifiable information, including names and contact information of actuaries or other individuals, including those who work for the health plan, a consulting firm, or the Department, that are contained in the application; and</p> <p>(ii) information that identifies in reasonably precise terms specific provider</p>	<p>Cover Letter REDACTED, Certification REDACTED, Standard Exhibit 1 REDACTED</p>

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law

		<p>reimbursement rates contained in contracts between the health plan and a particular provider or formally affiliated provider group. Information that discloses trend, even specific trend, will <i>not</i> qualify for redaction. For example, if an insurer has a single pharmacy benefit manager (PBM), information about generic, brand and specialty drug costs per member will be disclosed. However, information about per unit dispensing fees paid to the PBM, or the level of rebates received, may be redacted.</p> <p>c. In order to expedite the posting of the redacted application to the Department’s website, the company is to attach within SERFF as a PDF file the redacted version of each document submitted with the application, including the completed checklist, all of the standard Standard Exhibits, the actuarial memorandum plus any attachments or appendices, the rate manuals and year over year Standard Exhibits, as well as any other documentation submitted. A redacted attachment/file should be clearly labeled as a redacted version.</p> <p>d. The redacted version of the application that will be posted to the Department’s website will be constructed by the Department and will not be submitted to the insurer for prior review. <i>Where a document is attached to SERFF without a clearly labeled redacted version in PDF format, it will be assumed that no redactions are requested and the unredacted version of the document will be posted to the website as filed.</i></p>	
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<Date>

<BA Name>
 <Group Name>
 <Address>
 <City>, <State> <ZIP>

RE: Renewal Information for: <Group Name>, Group #: <Group # >; <CSP Code>

Dear <BA Name>,

Your company's policy is scheduled to renew on <effective date>. The information below shows key benefits for your existing Oxford¹ plan now and upon renewal, with corresponding rates. These renewal rates will remain in effect for twelve months beginning on your policy's anniversary date.²

We are committed to offering comprehensive benefits at affordable prices and providing your employees access to quality care with the support they need to stay healthy. We look forward to working together in the upcoming year to provide you and your employees with better information to make better decisions that lead to better health outcomes.

PLAN INFORMATION

PLAN DESIGN	EXISTING	RENEWAL
Network	<Data>	<Data>
Out-of-Network Coinsurance	<Data>	<Data>
Out-of-Network Deductible	<Data>	<Data>
Office Copayment	<Data>	<Data>
Prescription	<Data>	<Data>
UCR or Out-of-Network Reimbursement ³ Amount (where available)	<Data>	<Data>
Riders	<Data>	<Data>

MONTHLY PREMIUMS

TIERS	EXISTING RATES		RENEWAL RATES	
	Employee #	Rate	Employee #	Rate
Single	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Couple	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Parent/Children	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Family	<# of EEs>	<\$0.00>	<# of EEs>	<\$0.00>
Premium Total	<Total # of EEs>	<Total \$0.00>	<Total # of EEs>	<Total \$0.00>

IMPORTANT INFORMATION

Full details tied to your renewal can be reviewed and submitted on our online renewal tool, **Idea Management SystemSM (IDEA)**. Simply log on to the My Account section of oxfordhealth.com within 60 days of your renewal date and click the Idea Management System (IDEA) link. We have many options to help meet your company's particular health insurance needs. All changes, however, must be made fifteen (15) days prior to your effective date to process your renewal.

RENEWAL REQUIREMENTS

You must submit documents to confirm that your group meets participation requirements (does not apply to HMO and POS products) and is eligible for small group coverage. Please review the enclosed *New York Small Group (2-50) Underwriting Requirements* document for details.

The following documents must be completed and submitted within the next fifteen (15) days to process your renewal:

- An updated *New York Small Group Annual Certification Form*, which is included in this renewal package and available through oxfordhealth.com.
- Tax documentation: Examples of acceptable documents include a *Quarterly Combined Withholding, Wage Reporting and Unemployment Insurance Return Form (NYS-45)*, a *W-4* for each new eligible employee not represented on the *NYS-45, Form 11-20S* and *K1 Schedule C*. If you filed a consolidated tax return as an affiliated group, please provide your most recent IRS form 851. See enclosed *Instruction Sheet* for details.

Required documents can be uploaded to the Renewal Manager tool on IDEA or sent via mail to: Oxford Enrollment Department, 14 Central Park Drive, Hooksett, NH 03106. If you complete the renewal through IDEA, renewals can be submitted up to the last day of the month prior to your renewal date. All other plan design and administrative changes not submitted online must be received by the 15th of the month prior to the renewal date.

As part of our audit process, additional documentation, including eligible waivers, may be required.

If you do not provide the documents listed above or requested as part of an audit within the timeframe outlined, your group will receive a notice of non-renewal (termination).

NOTE: Our lock box administrator automatically cashes all premium checks upon receipt. Because we must verify your group's eligibility and compliance with our participation guidelines, your cashed check does not obligate Oxford to renew your coverage. Further, if you submit payment that exceeds any outstanding balance, and your group is not renewed, Oxford will refund the additional amount.

Thank you for your continued business. If you have any questions regarding your renewal, or if you would like more information, please contact your broker or General Agent, or call Client Services at 1-888-201-4216. We look forward to a continued and long-lasting relationship, serving you and your employees.

Sincerely,
Client Services

Enclosures
cc: Broker

¹ Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

² Please be advised that rates for community-rated products are subject to state regulatory approval. The rates reflected above have been approved by the state Department of Financial Services. Rates or your total premium may change if benefits are required to be added to your plan during the plan year or if your census changes.

³ Our HMO and EPO products do not have out-of-network benefits. These plans include reimbursement for out-of-network emergency services received outside of the Oxford service area using 70th percentile FairHealth data. All NY plans with out-of-network benefits use a Medicare based reimbursement methodology called the Out-of-Network Reimbursement Amount to reimburse out-of-network claims.



<Date>

<Subscriber First Name> <Subscriber Last Name>
<Address 1>
<Address 2>
<City>, <State> <Zip>

Notice of Premium Rate Adjustment Decision
<Group Name>, <Group # >; <CSP Code>
THIS IS NOT A BILL

Dear <Subscriber First Name> <Subscriber Last Name> ,

In <<Month YYYY>>, we wrote to you to tell groups and their employees about a rate application we were filing with the New York State Department of Financial Services (DFS). Your group’s Oxford¹ plan is scheduled to renew on <effective date>. The information below shows your group’s current rates and approved renewal rates. These renewal rates reflect the total premiums your group must pay. Your individual contribution will be established by your employer.

Renewal rates are effective for twelve months beginning on <Effective Date>. The rates listed below could change if (1) your group makes benefit changes, (2) benefits are required to be added during the plan year and/or (3) your group becomes a large group before renewal (has 50 or more eligible employees).

MONTHLY PREMIUMS FOR <<PLAN DESIGN NAME>>

TIERS	CURRENT RATES	RENEWAL RATES
	Rate	Rate
Single	<\$0.00>	<\$0.00>
Couple	<\$0.00>	<\$0.00>
Parent/Children	<\$0.00>	<\$0.00>
Family	<\$0.00>	<\$0.00>

Please contact your employer for information about your contribution or for more information about the upcoming renewal.

Sincerely,

Howard C. Margolies
Vice President
Small Business, New York

¹ Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

Initial Notice of Proposed Rate Adjustment

Oxford NY Small HMO

Table of Contents

Q1-13 Oxford NY Small HMO Group - Initial Notice	NY-12-580-a
Q2-13 Oxford NY Small HMO Group - Initial Notice	NY-12-580-b
Q3-13 Oxford NY Small HMO Group - Initial Notice	NY-12-580-c
Q4-13 Oxford NY Small HMO Group - Initial Notice	NY-12-580-d
Q1-13 Oxford NY Small HMO Association - Initial Notice	NY-12-581-a
Q2-13 Oxford NY Small HMO Association - Initial Notice	NY-12-581-b
Q3-13 Oxford NY Small HMO Association - Initial Notice	NY-12-581-c
Q4-13 Oxford NY Small HMO Association - Initial Notice	NY-12-581-d
Q1-13 Oxford NY Small HMO Subscriber - Initial Notice	NY-12-582-a
Q2-13 Oxford NY Small HMO Subscriber - Initial Notice	NY-12-582-b
Q3-13 Oxford NY Small HMO Subscriber - Initial Notice	NY-12-582-c
Q4-13 Oxford NY Small HMO Subscriber - Initial Notice	NY-12-582-d



Date

<<Name>>
<<Company Name, Group Code: xxxxxx>>
<<Company Street Address>>
<<City,>> <<State>> <<ZIP Code>>

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The chart below shows the percentage increases we are requesting for medical and pharmacy premiums.

Renewal Date	Estimated Increase Over 2012 Medical Premium (%)	Estimated Increase Over 2012 Pharmacy Premium (%)	Estimated Increase Over 2012 Total Premium (Medical and Pharmacy) (%)
1/1/2013 – 3/31/2013	16.5%	16.5%	16.5%

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<Date>

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Vice President Small Business, New York

² In addition to the premium rate adjustment filing, we separately submitted benefit change filings associated with state mandated autism coverage and federally mandated changes to women's preventive coverage. Until these filings are approved we will not know the rate impact but the requested rate impact is approximately 1.8 %. The rates ultimately approved by DFS for these benefits will impact your final rate. In the event that other benefit changes (e.g., benefit mandate) are made prior to your renewal, those changes may impact your final premium rate as well.



<Date>

<BA First Name> <BA Last Name>
<Association Name>, <Group Code>
<Address 1>
<Address 2>
<City>, <State> <Zip>

**Notice of Premium Rate Adjustment Filing
THIS IS NOT A BILL**

Dear _____:

Thank you for allowing UnitedHealthcare to serve your health benefit plan needs with our Oxford products.

In New York, proposed premium rates for small group plans are filed with the New York State Department of Financial Services (DFS) annually.¹ Our annual proposed premium rate adjustment filings are typically filed in June for the next year’s renewal rates.

We're writing to let you know that Oxford Health Plans (NY), Inc. is filing a premium rate adjustment request for the Oxford small group HMO product on June 15, 2012. We are sending this notice to you and employees who are certificate holders to inform you of our rate adjustment request and give you the opportunity to provide comments to DFS or ask us or DFS for additional information. Requests for information and comments must be submitted within 30 days from the date of our rate filing. Because we do not have contact information for the employers that are members of your association or trust, we are asking that you provide a copy of this letter to impacted employers so they are aware of the rate filing and the notice we are sending to their employees.

What we are requesting

The chart below shows the percentage increases we are requesting for medical and pharmacy premiums.

Renewal Date	Estimated Increase Over 2012 Medical Premium (%)	Estimated Increase Over 2012 Pharmacy Premium (%)	Estimated Increase Over 2012 Total Premium (Medical and Pharmacy) (%)
10/1/2013 – 12/31/2013	17.7%	17.7%	17.7%

What you need to know

An approved rate change will affect 2013 renewal rates. **Your group does not need to take any action or change payments at this time.**

You will receive a second notice about your 2013 renewal rates after the Superintendent of Financial Services makes a decision on our rate adjustment request. The second notice will be sent at least 60 days before the rate change effective date.

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Please be aware that your group's final renewal rate increase for 2013 *may be different* than the percentages listed above. The Superintendent of Financial Services may approve (as requested), modify or deny the proposed rate adjustment. The group's final rate will be based on 1) the rates approved by DFS, 2) adjustments to the rate (increases or decreases) due to benefit changes, 3) the plan design chosen by the group and 4) the group's census at renewal.²

Where to find more information or make a comment

Rising medical expenses are the main reason for the requested increase. A number of factors contribute to these rising costs, including increases in the cost of medical services, increases in the amount of services used, and changes to the population enrolled in the product. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

You may contact us or DFS to request additional information or submit written comments to DFS. Requests for information and comments must be made **within 30 days from the date of our rate filing. This time period starts on June 15 and ends on July 15, 2012.** If you are making comments, you must note that your inquiry is regarding Oxford Health Plans (NY), Inc. and the Oxford small group HMO product. DFS will post your written comments on its website with personal identifying information removed.

Requests for information or comments to DFS must be submitted to:

Health Bureau – Premium Rate Adjustments
New York State Department of Financial Services
25 Beaver Street
New York, NY 10004
<http://www.dfs.ny.gov>
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As noted above, information will be available on **oxfordhealth.com**. You may go to the *Employer Messages* section to view and print this information. This information may also be obtained by writing to us at:

Oxford
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
888-201-4216

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Date

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What we are requesting

The chart below shows the percentage increases we are requesting for medical and pharmacy premiums.

Renewal Date	Estimated Increase Over 2012 Medical Premium (%)	Estimated Increase Over 2012 Pharmacy Premium (%)	Estimated Increase Over 2012 Total Premium (Medical and Pharmacy) (%)
1/1/2013 – 3/31/2013	16.5%	16.5%	16.5%

What you need to know

An approved rate change will affect 2013 renewal rates. **Your group does not need to take any action or change payments at this time.**

You will receive a second notice about your 2013 renewal rates after the Superintendent of Financial Services makes a decision on our rate adjustment request. The second notice will be sent at least 60 days before the rate change effective date.

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The chart below shows the percentage increases we are requesting for medical and pharmacy premiums.

Renewal Date	Estimated Increase Over 2012 Medical Premium (%)	Estimated Increase Over 2012 Pharmacy Premium (%)	Estimated Increase Over 2012 Total Premium (Medical and Pharmacy) (%)
4/1/2013 – 6/30/2013	16.9%	16.9%	16.9%

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Renewal Date	Estimated Increase Over 2012 Medical Premium (%)	Estimated Increase Over 2012 Pharmacy Premium (%)	Estimated Increase Over 2012 Total Premium (Medical and Pharmacy) (%)
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SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "Oxford SG HMO 2013 HHS Part I.xls" is not a PDF document and cannot be reproduced here.

Rate Summary Worksheet

Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

OMB-0938-1141

A. Base Period Data

Start Period: 01/01/2011 End Period: 12/31/2011

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	1,477,246	\$ 122,421,662.41	\$ 116,561,113.34	\$ 5,860,549.06	\$ 3.97	\$ 78.90	\$ 82.87
Outpatient	1,477,246	\$ 79,844,477.37	\$ 74,836,386.64	\$ 5,008,090.74	\$ 3.39	\$ 50.66	\$ 54.05
Professional	1,477,246	\$ 183,961,697.38	\$ 159,519,986.26	\$ 24,441,711.11	\$ 16.55	\$ 107.98	\$ 124.53
Prescription Drugs	1,477,246	\$ 73,111,875.98	\$ 44,671,290.64	\$ 28,440,585.35	\$ 19.25	\$ 30.24	\$ 49.49
Other	1,477,246	\$ 26,370,171.42	\$ 26,146,643.69	\$ 223,527.73	\$ 0.15	\$ 17.70	\$ 17.85
Capitation	1,477,246	\$ 35,801,342.66	\$ 35,801,342.66	\$ 0.00	\$ 0.00	\$ 24.24	\$ 24.24
Total	1,477,246	\$ 521,511,227.22	\$ 457,536,763.23	\$ 63,974,463.99	\$ 43.31	\$ 309.72	\$ 353.03

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2012 End Period: 12/31/2012

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.1328	\$ 93.87	\$ 89.38	0.0479
Outpatient	1.1207	\$ 60.57	\$ 57.39	0.0526
Professional	1.1207	\$ 139.56	\$ 122.32	0.1235
Prescription Drugs	1.1207	\$ 55.46	\$ 34.25	0.3824
Other	1.1328	\$ 20.22	\$ 20.05	0.0085
Capitation	1.1328	\$ 27.45	\$ 27.45	0.0000
Total		\$ 397.14	\$ 350.84	0.12

B2. Claims Projection for Future Rate

Start Period: 01/01/2013 End Period: 12/31/2013

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.1328	\$ 106.34	\$ 101.25	0.0479
Outpatient	1.1210	\$ 67.90	\$ 65.00	0.0427
Professional	1.1210	\$ 156.44	\$ 138.56	0.1143
Prescription Drugs	1.1210	\$ 62.18	\$ 38.80	0.3759
Other	1.1328	\$ 22.91	\$ 22.71	0.0085
Capitation	1.1328	\$ 31.10	\$ 31.10	0.0000
Total		\$ 446.86	\$ 397.43	0.11

B3. Medical Trend Breakout

Factor	Impact
Utilization	43.6%
Unit Cost	56.4%
Other Factors	0.0%

C. Components of Current and Future Rates

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 397.4254	82.93%	\$ 368.00	90.40%	\$ 29.42	40.77%
2. Administrative Costs	\$ 61.15	12.76%	\$ 53.11	13.05%	\$ 8.04	11.14%
3. Underwriting Gain/Loss	\$ 20.68	4.31%	\$ (14.03)	-3.45%	\$ 34.70	48.09%
4. Total Rate	\$ 479.25	100.00%	\$ 407.08	100.00%	\$ 72.17	100.00%
5. Overall Rate Increase		17.73%				

D. Components of Rate Increase

	Impact on Rate	Percent
Claims Components		
1. Inpatient	\$ 11.87	40.33%
2. Outpatient	\$ 6.94	23.60%
3. Professional	\$ 14.80	50.31%
4. Prescription Drugs	\$ 4.14	14.09%
5. Other	\$ 2.66	9.05%
6. Capitation	\$ 3.64	12.39%
7. Cost Share	\$ 2.52	8.56%
8. Correction of Prior Net Claims Estimate	\$ (17.16)	-58.32%
9. Total	\$ 29.42	100.00%
Claims Restatement for Current Rate Period		
8.a. Prior Net Claims Estimate for Current Rate Period	\$ 368.00	
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 350.84	

E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	New Form	Requested	Implemented
2012	N	22.6260%	11.2700%
2011	N	19.0366%	9.0068%
2010	N	22.5286%	22.5286%

F. Range and Scope of Proposed Increase

Number of Covered Individuals	123,104	Threshold Rate Increase	17.1195%
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	Range of Rate Increase
Minimum % Increase	16.5422%
Maximum % Increase	17.7243%

Last Updated: 4/23/12 12:03 PM

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Oxford Health Plans (NY), Inc.</u> Company submitting the rate adjustment request 48 Monroe Turnpike, Trumbull, CT 06611 Company mailing address	<u>HMO - 44</u> Company Type	<u>For Profit</u> Org. Type	<u>95479</u> Company NAIC Code
B.	Contact Person: [REDACTED] Rate filing contact person name, title	[REDACTED] Contact phone number	[REDACTED] Contact Email address	
C.	Actuarial Contact (If different from above): Actuary name, title	Actuary phone number	Actuary Email address	
D.	New Rate Information (See Note #1): <u>February 15, 2013 through November 14, 2014</u> New rate applicability period	New rate effective date <u>1/1/2013</u>	<u>XFRD-128362721</u> SERFF Tracking Number	
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): <u>Small Group</u>			
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?	Yes, please see Exhibit 6 for filings that would affect the rate tables included in this rate filing.		
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, small group HMO policyholders and contract holders with renewal dates in 1st, 2nd, 3rd, and 4th quarters of 2013		
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, all the required exhibits have been submitted with this rate application		
5.	Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	Yes. XFRD-128432519		

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. It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date. It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.
- (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.

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 1.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 2: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT AND PRIOR RATE ADJUSTMENT FILINGS

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

A. Complete a separate ROW for each market segment/rating pool combination included in the current rate adjustment filing:

- Information should be for medical base plans and associated riders combined.

- Indicate the market segment the rating pool belongs to by using the drop down list. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group.

- Enter a description of the rating pool within the indicated market segment. If the rating pools vary by rating region, the rating pool description should include a region identifier (eg., SG HMO Downstate, SG HMO Upstate).

- Use a separate row for each market segment/rating pool combination included in the current rate adjustment filing.

- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components included in the proposed rates and the average annual claim trend assumed.

D. Enter the corresponding information requested for the immediately prior rate adjustment filing. This refers to the various expense components included in the proposed rates submitted with the immediately prior rate adjustment filing and the average claim trend assumed. If there is no immediately prior rate adjustment filing, enter the data from the initial form and rate filing.

E. This form must be submitted as an Excel file and as a PDF file.

		Data Item for Specified Rating Pool																												
		For the period included in this rate adjustment filing																												
1. Market Segment	2. Description of rating pool within the market segment	3. Period assumed - beginning date (MM/DD/YYYY)	4. Period assumed - ending date (MM/DD/YYYY)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
SG	Small Group HMO	XX 1/1/2013	12/31/2013	12.5%	0.80%	0.00%	3.50%	2.05%	1.32%	5.09%	12.76%	2.79%	0.01%	0.34%	0.98%	35.00%	0.00%	16.53%	3.78	0.00	16.52	9.68	6.23	24.02	60.23	13.17	0.04	4.61	0.00	78.06
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EXHIBIT 2: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES INCLUDED IN CURRENT AND PRIOR RATE ADJUSTMENT FILINGS

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

A. Complete a separate ROW for each market segment/rating pool combination included in the current rate adjustment filing:

- Information should be for medical base plans and associated riders combined.

- Indicate the market segment the rating pool belongs to by using the drop down list. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group.

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- Use a separate row for each market segment/rating pool combination included in the current rate adjustment filing.

- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

B. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components included in the proposed rates and the average annual claim trend assumed.

D. Enter the corresponding information requested for the immediately prior rate adjustment filing. This refers to the various expense components included in the proposed rates submitted with the immediately prior rate adjustment filing and the average claim trend assumed. If there is no immediately prior rate adjustment filing, enter the data from the initial form and rate filing.

E. This form must be submitted as an Excel file and as a PDF file.

		Data Item for Specified Rating Pool																												
		For the rate period included in the immediately prior rate adjustment filing (or initial form & rate filing)																												
1. Market Segment	2. Description of rating pool within the market segment	18. Period assumed - beginning date (MM/DD/YYYY)	19. Period assumed - ending date (MM/DD/YYYY)	20. Average annual claim trend assumed	21.1 Regulatory authority licenses and fees, including New York State 332 assessment	21.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	21.3 Commissions and broker fees - as a % of gross premium	21.4 Premium Taxes - as a % of gross premium	21.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	21.6 Other administrative expenses - as a % of gross premium	21.7 Subtotal columns 21.1 through 21.6	22. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	23. State income tax component - as a % of gross premium	23.1 State income tax rate assumed (eg 3%)	24. Federal income tax component - as a % of gross premium	24.1 Federal income tax rate assumed (eg 30%)	25. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	26. Subtotal lines 21.7 + 22 + 23 + 24 + 25	27.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	27.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	27.3 Commissions and broker fees - as \$mpm	27.4 Premium Taxes - as \$mpm	27.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as \$mpm	27.6 Other administrative expenses as \$mpm	27.7 Subtotal lines 27.1 through 27.6	28. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	29. State income tax component - as \$mpm	30. Federal income tax component - as \$mpm	31. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	32. Subtotal columns 27.7 through 31
SG	Small Group HMO	1/1/2012	12/31/2012	15.2%	0.80%	0.00%	3.50%	2.00%	0.00%	6.75%	13.05%	2.95%	0.21%	7.10%	1.00%	34.00%	0.00%	17.21%	3.17	0.00	13.88	7.93	0.00	26.76	51.75	11.72	0.83	3.98	0.00	68.29
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SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

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Narrative Summaries

Oxford NY Small HMO

Table of Contents

	<u>Page(s)</u>
Q1-13 Oxford NY SG HMO Narrative Summary	1 - 5
Q2-13 Oxford NY SG HMO Narrative Summary	6 - 10
Q3-13 Oxford NY SG HMO Narrative Summary	11 - 15
Q4-13 Oxford NY SG HMO Narrative Summary	16 - 20

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

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 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%

- 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 2.8% 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.

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: Oxford Health Plans (NY), Inc.
NAIC Code: 95479
SERFF Tracking #: XFRD-128362721

Submit a Narrative Summary explaining the reason(s) for the proposed rate adjustment. The purpose of this Narrative Summary is to provide a written explanation to the company's policyholders to help them to understand the reason(s) why a rate increase is needed.

- The Narrative Summary will be a public document and will be posted on the Department's website and furnished by the Department to the public upon request.

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It is strongly encouraged that the company submit the Narrative Summary to the Department ten (10) days before submitting a rate adjustment application. It is recommended that the company include a draft of the narrative summary with a draft of the initial notice in a "Prior Approval Prefiling" submitted to the Department through SERFF.

- It is suggested that once reviewed by the Department, the company post the Narrative Summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for a user ID and password. Links should be provided on key pages of the company's website so that the information may be easily located.

Any change(s) made to the Narrative Summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified.

- The Narrative Summary should include, but not be limited to, the following information:
 - 1) The name of the company submitting the rate adjustment request.
 - 2) A summary of the proposed rate adjustments.
 - 3) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect certain policyholders in a market segment (e.g., Small Group), or with certain products (indicate the "street name" of the products affected), or only a certain renewal cohort (e.g., policyholders renewing mm/dd/yyyy – mm/dd/yyyy).
 - 4) 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).
 - 5) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders.
For example:
 - (a) For a non-guaranteed rate structure: All policyholders will receive the rate adjustment on mm/dd/yyyy.
 - (b) For a rate structure with a 12 month rate guarantee: A policyholder will receive the rate adjustment on the policyholder's next anniversary on or after mm/dd/yyyy.
 - 6) The number of policyholders/members affected by the proposed rate adjustment(s); aggregated across all market segments and products affected by the rate adjustments submission.
 - 7) An explanation, in plain-language, as to why it is necessary to request such rate changes. As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type.
- Each page of the Narrative Summary should be numbered (i.e., [page] of [pages]).

EXHIBIT 4 - PART A: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

-- for Base Medical Plan with NON ROLLING Rate Structure

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

95479
Company NAIC Code

XFRD-128362721
SERFF tracking number

- => Use this Exhibit for the base medical plan type policy forms/products with NON ROLLING rate structure that are included in the rate adjustment submission.
- => This form must be submitted as an Excel file and as a PDF file.
- => The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => 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).
- => Provide a list of proposed rate changes for each base medical plan type, by product name/street name. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => 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.

Base Medical Plan Non Rolling Rate Products

SERFF# XFRD-128362721

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Proposed Percentage Rate Change		
						Lowest	Highest	Weighted Avg

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 4A.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 4 - PART B: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

-- for Base Medical Plan with ROLLING Rate Structure

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

95479
Company NAIC Code

XFRD-128362721
SERFF tracking number

- => Use this Exhibit for the base medical plan type policy forms/products with ROLLING rate structure that are included in the rate adjustment submission.
- => This form must be submitted as an Excel file and as a PDF file.
- => The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => 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 effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure.)
- => 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).
- => Provide a list of proposed rate changes for each base medical plan type, by product name/street name. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => 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.

Base Medical Plan Rolling Rate Products

SERFF# XFRD-128362721

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
OHPNY SB HMO S 309	Small Group	All	Small Group HMO	Small Group HMO	1/1/2013	Q1 2013	16.5%	16.5%	16.5%
OHPNY GA HMO S 309									
OHPNY SB HMO S 309	Small Group	All	Small Group HMO	Small Group HMO	4/1/2013	Q2 2013	16.9%	16.9%	16.9%
OHPNY GA HMO S 309									
OHPNY SB HMO S 309	Small Group	All	Small Group HMO	Small Group HMO	7/1/2013	Q3 2013	17.4%	17.4%	17.4%
OHPNY GA HMO S 309									
OHPNY SB HMO S 309	Small Group	All	Small Group HMO	Small Group HMO	10/1/2013	Q4 2013	17.7%	17.7%	17.7%
OHPNY GA HMO S 309									

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 4B.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 4 - PART C: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

- for Drug Riders Available with Base Medical Products (NON ROLLING Rate Structure)

Oxford Health Plans (NY), Inc.

 Company submitting the rate adjustment request

95479

 Company NAIC Code

XFRD-128362721

 SERFF tracking number

- => Use this Exhibit for the Drug Riders that are available for the base medical plan type policy forms/products with a NON ROLLING rate structure included in the rate adjustment submission.
- => The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
- => This form must be submitted as an Excel file and as a PDF file.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => 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).
- => Provide a list of proposed rate changes for drug riders available with non rolling rate base medical products. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed percentage rate change" is just for the drug riders available with the indicated base medical product and excludes the impact of the base medical plan rates and non-drug riders.
 The lowest, highest, and weighted average are just among the drug riders available to the indicated base medical product.
- => This is for the traditional drug riders, but not for minor drug related riders such as the inclusion of oral contraceptives.

Drug Riders Available With Non Rolling Rate Base Medical Products

SERFF#: XFRD-128362721

Base Medical Policy Form #	Market Segment	Rating Region	Drug Rider	Base Medical Product Name	Effective Date of New Rate	Proposed Percentage Rate Change		
						Lowest	Highest	Weighted Avg

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 4C.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 4 - PART D: SUMMARY OF PROPOSED PERCENTAGE RATE CHANGE TO EXISTING RATE

- for Drug Riders Available with Base Medical Products (ROLLING Rate Structure)

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

95479
Company NAIC Code

XFRD-128362721
SERFF tracking number

- => Use this Exhibit for the Drug Riders that are available for the base medical plan type policy forms/products with a ROLLING rate structure included in the rate adjustment submission.
- => The format of this exhibit is discussed below. Add more rows as needed. Only use the first tab for data entry.
- => This form must be submitted as an Excel file and as a PDF file.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => 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 effective date is the earliest date that proposed rate change will become effective. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure).
- => 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).
- => Provide a list of proposed rate changes for drug riders available with rolling rate base medical products. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed percentage rate change" is just for the drug riders available with the indicated base medical product and excludes the impact of the base medical plan rates and non-drug riders.
The lowest, highest, and weighted average are just among the drug riders available to the indicated base medical product.
- => This is for the traditional drug riders, but not for minor drug related riders such as the inclusion of oral contraceptives.

Drug Riders Available With Rolling Rate Base Medical Products

SERFF:

XFRD-128362721

Base Medical Policy Form #	Market Segment	Rating Region	Drug Rider	Base Medical Product Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group	All	All	Small Group HMO	1/1/2013	Q1 2013	16.5%	16.5%	16.5%
OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group	All	All	Small Group HMO	4/1/2013	Q2 2013	16.9%	16.9%	16.9%
OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group	All	All	Small Group HMO	7/1/2013	Q3 2013	17.4%	17.4%	17.4%
OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group	All	All	Small Group HMO	10/1/2013	Q4 2013	17.7%	17.7%	17.7%

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 4D.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 5 - PART A: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS for NON ROLLING Rate Structured Products

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Tracking #: XFRD-128362721

Instructions:

- 1) The percentage rate change reflects 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 members or number of contracts . The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
- 3) The Weighted Average Percentage should be developed based on the distribution of contracts or members for that market segment/product and for the market segment in total.
- 4) Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- 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) Provide the distribution of contracts or members affected by proposed rate change for all non-rolling rate contracts by effective date/market segment/product.
- 7) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
- 8) After each market segment there should be a market segment total row. Enter Total in the "Product" column, the sum of the counts in the various columns, and the market segment weighted avg %.
- 9) This exhibit must be submitted as an Excel file and a PDF file.

FOR NON-ROLLING RATE STRUCTURE PRODUCTS -- Distribution of Non Rolling Rate Contracts by Proposed Rate Adjustment SERFF#: XFRD-128362721

Effective Date	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of	Total # of Contracts as of	Number of Members with Proposed Percentage Rate Change at Renewal										
							4/30/2012	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%
Market Segment Total:																	

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 5A.xls" is not a PDF document and cannot be reproduced here.

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 5B.xls" is not a PDF document and cannot be reproduced here.

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: Oxford Health Plans (NY), Inc.

NAIC Code: 95479

SERFF Number: XFRD-128362721

Instructions:

- This Exhibit summarizes all benefit/rate changes filed under sections other than §3231(e)(1)/4308(c) that impact the rate tables in this filing.
- 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).
- Enter filing status (approved or pending) using the drop down list. For pending files leave the approval date blank.
- Extend the worksheet to add more rows as needed. Only use the first tab for data entry.

List of rate filings that have been approved since the prior §3231(e)(1) or §4308(c) rate filing or are currently pending with the Department, which impact the rate tables in this filing.

Filing Status	SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
Pending	XFRD-128316143	2012050075	5/3/2012	OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group HMO	State mandated Autism coverage	
Pending	XFRD-128332065	2012060086	6/12/2012	OHPNY SB HMO S 309 OHPNY GA HMO S 309	Small Group HMO	Federally mandated women's preventive coverage	

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

- A. Complete a separate ROW for each base medical policy form included in the rate adjustment filing, even if no rate adjustment is proposed for that base medical policy form.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
 - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- E. 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). Include a region identifier in this column if needed.
- F. Note that many cells include a drop down list. Use the drop down list for entries.
- G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

		Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)																				
1a. Base medical policy form number	1b. Product Name as in Rate Manual	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	14.11 Earned premiums for experience period (\$mpm)	14.12 Standardized premiums for experience period (\$mpm)	14.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	14.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	14.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	14.18 Ratio: Col 14.7/ Col 14.4 (Incurred Claims / Earned Premiums)	14.19 Ratio: Col 14.7/ Col 14.5 (Incurred Claims / Standardized Earned Premiums)	14.20 Ratio: Col 14.10/ Col 14.4 (Administration Expense / Earned Premiums)	14.21 Ratio: (Col 14.7 + Col 14.8 + Col 14.9 + Col 14.10) / Col 14.4
OHPNY SB HMO S 309	HMO	XX 01/01/2011	12/31/2011	1,477,246	553,499,557	666,741,924	410,838,276	449,394,790	0	8,141,974	79,714,487	374.68	451.34	278.11	304.21	0.00	5.51	53.96	0.812	0.674	0.144	0.971
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

- A. Complete a separate ROW for each base medical policy form included in the rate adjustment filing, even if no rate adjustment is proposed for that base medical policy form.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
 - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- E. 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). Include a region identifier in this column if needed.
- F. Note that many cells include a drop down list. Use the drop down list for entries.
- G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

		First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																					
1a. Base medical policy form number	1b. Product Name as in Rate Manual	15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	15.11 Earned premiums for experience period (\$mpm)	15.12 Standardized premiums for experience period (\$mpm)	15.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	15.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	15.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	15.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	15.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	15.18 Ratio: Col 15.7/ Col 15.4 (Incurred Claims / Earned Premiums)	15.19 Ratio: Col 15.5/ Col 15.4 (Incurred Claims / Earned Premiums)	15.20 Ratio: Col 15.10/ Col 15.4 (Administrative Expenses / Earned Premiums)	15.21 Ratio: Col 15.7 + Col 15.8 + Col 15.9 / Col 15.4	
OHPNY SB HMO S 309	HMO	XX	01/01/2010	12/31/2010	751,333	251,736,914	298,036,802	165,213,627	192,931,322	0	3,450,698	34,935,388	335.05	396.68	219.89	256.79	0.00	4.59	46.50	0.766	0.647	0.139	0.919
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

- A. Complete a separate ROW for each base medical policy form included in the rate adjustment filing, even if no rate adjustment is proposed for that base medical policy form.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
 - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- E. 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). Include a region identifier in this column if needed.
- F. Note that many cells include a drop down list. Use the drop down list for entries.
- G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

		Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																					
1a. Base medical policy form number	1b. Product Name as in Rate Manual	16.1 Beginning date of the experience period (MM/DD/YYYY)	16.2 Ending Date of the experience period (MM/DD/YY)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.11 Earned premiums for experience period (\$pmpm)	16.12 Standardized premiums for experience period (\$pmpm)	16.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$pmpm)	16.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$pmpm)	16.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$pmpm)	16.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$pmpm)	16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$pmpm)	16.18 Ratio: Col 16.7/ Col 16.4 (Incurred Claims / Earned Premiums)	16.19 Ratio: Col 16.7/ Col 16.5 (Incurred Claims / Standardized Earned Premiums)	16.20 Ratio: Col 16.10/ Col 16.4 (Administration / Earned Premiums)	16.21 Ratio: (Col 16.7 + Col 16.8 + Col 16.10) / Col 16.4	
OHPNY SB HMO S 309	HMO	XX	1/1/2009	12/31/2009	58,938	17,381,952	25,779,851	7,407,086	12,132,100	0	(1,608,433)	2,269,965	294.92	437.41	125.68	205.85	0.00	(27.29)	38.51	0.698	0.471	0.131	0.736
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000

EXHIBIT 7: HISTORICAL DATA BY EACH POLICY FORM INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: XFRD-128362721

- A. Complete a separate ROW for each base medical policy form included in the rate adjustment filing, even if no rate adjustment is proposed for that base medical policy form.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
 - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- E. 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). Include a region identifier in this column if needed.
- F. Note that many cells include a drop down list. Use the drop down list for entries.
- G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

1a. Base medical policy form number	1b. Product Name as in Rate Manual	Annualized Medical Trend Factors Assumed in Rate Development (%)				Ratios: Most Recent Experience Period to First Prior Period						Ratios: First Prior Period to Second Prior Period						Ratio: Standard Premium to Earned Premium		
		17.1 All benefits combined, composite	17.2 Due to utilization	17.3 Due to unit cost	17.4 Due to case mix/intensity/other	18.1 Member months	18.2 Earned premiums (\$mpm)	18.3 Standardized premiums (\$mpm)	18.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	18.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	18.6 Administrative expenses (including commissions and premium taxes), but excluding federal and state income taxes (\$mpm)	19.1 Member months	19.2 Earned premiums (\$mpm)	19.3 Standardized premiums (\$mpm)	19.4 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	19.5 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	19.6 Administrative expenses (including commissions and premium taxes), but excluding federal and state income taxes (\$mpm)	20.1 Most Recent Experience Period	20.2 First Prior Experience Period	20.3 Second Prior Experience Period
OHPNY SB HMO S 309	HMO	XX 12.50%	XX 5.50%	XX 5.60%	XX 1.10%	XX 1.966	1.118	1.138	1.265	1.185	1.161	XX 12.748	1.136	0.907	1.750	1.247	1.207	XX 1.205	1.184	1.483
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000
		XX				XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000	0.000	0.000	0.000	XX 0.000	0.000	0.000



June 15, 2012

Mr. Michel Laverdiere, FSA, MAAA
Deputy Chief Actuary
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: Oxford Health Plans (NY), Inc.
NY Small Group HMO
Form #'s OHPNY SB HMO S 309, OHPNY GA HMO S 309.
Rate Filing for January 2013 – December 2013 Rate Effective Dates

Dear Mr. Laverdiere,

This rate filing addresses the development of the New York Small Group Liberty HMO rates for the effective dates from January 2013 to December 2013.

Included in this filing are

- Actuarial Certification
- Actuarial Memorandum
- Section I – Supporting Exhibits I – III
- Section II - Rate Manual Including Comparison to Current Rates
- Section III – Sample Notices

Should you have any questions or need any additional information, please contact me at [REDACTED]

Sincerely,

[REDACTED]



Oxford Health Plans (NY), Inc.

New York Small Group HMO Product
Rates Effective January 2013 – December 2013

ACTUARIAL CERTIFICATION

I, [REDACTED], am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The filing is in compliance with all applicable laws and regulations of the State of New York.
- (b) The filing is in compliance with Actuarial Standard of Practice No. 8.
- (c) The expected loss ratio meets the minimum requirement of the State of New York.
- (d) The benefits are reasonable in relation to the premiums charged.
- (e) The rates are not unfairly discriminatory.

[REDACTED]

June 15, 2012

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A.	Insurer Information: <u>Oxford Health Plans (NY), Inc.</u> <small>Company submitting the rate adjustment request</small> 48 Monroe Turnpike, Trumbull, CT 06611 <small>Company mailing address</small>	<u>HMO - 44</u> <small>Company Type</small>	<u>For Profit</u> <small>Org. Type</small>	<u>95479</u> <small>Company NAIC Code</small>
B.	Contact Person: <u>REDACTED</u> <small>Rate filing contact person name, title</small>	<u>REDACTED</u> <small>Contact phone number</small>	<u>REDACTED</u> <small>Contact Email address</small>	
C.	Actuarial Contact (If different from above): _____ <small>Actuary name, title</small>	_____ <small>Actuary phone number</small>	_____ <small>Actuary Email address</small>	
D.	New Rate Information (See Note #1): <u>February 15, 2013 through November 14, 2014</u> <small>New rate applicability period</small>	_____ <small>New rate effective date</small>	<u>1/1/2013</u>	<u>XFRD-128362721</u> <small>SERFF Tracking Number</small>
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): <u>Small Group</u>			
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?	Yes, please see Exhibit 6 for filings that would affect the rate tables included in this rate filing.		
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, small group HMO policyholders and contract holders with renewal dates in 1st, 2nd, 3rd, and 4th quarters of 2013		
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, all the required exhibits have been submitted with this rate application		
5.	Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	Yes. XFRD-128432519		

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. It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date. It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.
- (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.

SERFF Tracking Number: XFRD-128362721 State: New York
Filing Company: Oxford Health Plans (NY), Inc. State Tracking Number:
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Oxford Small HMO: CY2013
Project Name/Number: /

Attachment "2013 Oxford NYSG HMO Standard Exhibit 1 REDACTED.xls" is not a PDF document and cannot be reproduced here.



June 15, 2012

Mr. Michel Laverdiere, FSA, MAAA
Deputy Chief Actuary
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: Oxford Health Plans (NY), Inc.
NY Small Group HMO
Form #'s OHPNY SB HMO S 309, OHPNY GA HMO S 309.
Rate Filing for January 2013 – December 2013 Rate Effective Dates

Dear Mr. Laverdiere,

This rate filing addresses the development of the New York Small Group Liberty HMO rates for the effective dates from January 2013 to December 2013.

Included in this filing are

- Actuarial Certification
- Actuarial Memorandum
- Section I – Supporting Exhibits I – III
- Section II - Rate Manual Including Comparison to Current Rates
- Section III – Sample Notices

Should you have any questions or need any additional information, please contact me at [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Oxford Health Plans (NY), Inc.
New York Small Group HMO
Development of Required Q1-13 Rate Increase

Exhibit I

Experience Period: Incurred 1/2011 - 12/2011 Paid Through 3/2012

HMO

Member Months

(a)	Member Months	1,477,246
(b) = (a) / 12	Average Members	123,104

Experience Period Claims

		<u>Dollars</u>	<u>PMPM</u>
(c)	Total Medical/Rx Claims	\$ 437,446,149	\$ 296.12
(d)	Regulation 146	\$ 8,141,974	\$ 5.51
(e)	<u>GME</u>	<u>\$ 11,948,640</u>	<u>\$ 8.09</u>
(f) = sum(c):(e)	Total Incurred Claims	\$ 457,536,763	\$ 309.72

Experience Period Premiums

(g)	Earned Premiums	\$ 553,499,557	\$ 374.68
(h)	<u>Timothy's Law \$ Received</u>	<u>\$ -</u>	<u>\$ -</u>
(i) = (g) + (h)	Total Premium	\$ 553,499,557	\$ 374.68

Experience Period Loss Ratios

(j) = (f) / (i)	Experience Period Loss Ratio	82.7%	82.7%
(k) = (f) / (g)	Experience Period Loss Ratio Net of TL	82.7%	82.7%

Claim Projection

(l) = (f) - (d)	Incurred Claims Net of Reg 146	\$ 449,394,790	\$ 304.21
(m)	Annualized Trend	12.5%	12.5%
(n)	Months of Trend	24	24
(o) = [1+(m)] ^[(n)/12]	Trend Factor	1.266	1.266
(p)	Impact of Sweeps Benefit Changes	1.003	1.003
(q)	Impact of Migrating Business	1.015	1.015
(r) = (l) * (o) * (p) * (q)	Projected Claims Net of Reg 146	\$ 579,441,128	\$ 392.24
(s)	Projected Reg 146 for Rating Period	\$ 7,653,952	\$ 5.18
(t) = (r) + (s)	Projected Claims Including Reg 146	\$ 587,095,080	\$ 397.43

Premium & Loss Ratio Projection

(u)	Standardized Premiums *	\$ 666,741,924	\$ 451.34
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**Oxford Health Plans (NY), Inc.
New York Small Group HMO
Development of Required Q1-13 Rate Increase**

Experience Period: Incurred 1/2011 - 12/2011 Paid Through 3/2012

		HMO	
(v) = (t) / (u)	Projected Loss Ratio *	88.1%	88.1%
(w)	Target Loss Ratio	84.0%	84.0%
(x) = (v)/(w)-1	Required Q1-13 / Q4-12 Rate Change	4.8%	4.8%
(y)	Resulting Q1-13 / Q1-12 Rate Change	16.2%	16.2%
(z)	Requested Quarterly Trend	3.0%	3.0%
(aa)	Resulting Q2-13 / Q2-12 Rate Change	15.6%	15.6%
(ab)	Resulting Q3-13 / Q3-12 Rate Change	15.1%	15.1%
(ac)	Resulting Q4-13 / Q4-12 Rate Change	14.5%	14.5%
<u>PPACA Insurer Fee and Reinsurance Assessment **</u>			
(ad)	Additional Q1-13 / Q1-12 Rate Change	0.3%	0.3%
(ae)	Additional Q2-13 / Q2-12 Rate Change	1.1%	1.1%
(af)	Additional Q3-13 / Q3-12 Rate Change	2.0%	2.0%
(ag)	Additional Q4-13 / Q4-12 Rate Change	2.8%	2.8%
(ah)	Requesting Q1-13 / Q1-12 Rate Change	16.5%	16.5%
(ai)	Requesting Q2-13 / Q2-12 Rate Change	16.9%	16.9%
(aj)	Requesting Q3-13 / Q3-12 Rate Change	17.4%	17.4%
(ak)	Requesting Q4-13 / Q4-12 Rate Change	17.7%	17.7%

* At Q4-12 rate level & developed using earned premiums excluding Timothy's Law receivables

** Full Projected impacts are 2.2% and \$5.85 PMPM for Insurer Fee and Reinsurance Assessment, respectively. 2013 impacts are based upon number of months in CY 2014

**Oxford Health Plans (NY), Inc.
Oxford Health Insurance, Inc.
New York Small Group
2013 Rates - Migration Factor Development**

Member Months		Member Months for Pre-Renewal Period				
		To				
		HMO	POS	EPO	Direct	Metro
From	HMO		0	1,222	12	12
	POS	2,561		88,924	128,154	249,103
	EPO	207,677	2,886		16,706	10,360
	Direct	17,065	2,456	214,506		8,612
	Metro	17,695	5,586	485,627	319,696	

Member Months		Member Months for Post-Renewal Period				
		To				
		HMO	POS	EPO	Direct	Metro
From	HMO		0	1,229	12	12
	POS	2,547		88,332	127,772	247,778
	EPO	205,219	2,880		16,636	10,469
	Direct	16,925	2,438	212,979		8,561
	Metro	17,350	5,595	482,950	318,474	

Percentage		Average Allowed Claim Cost Relative for Pre-Renewal Period				
		To				
		HMO	POS	EPO	Direct	Metro
From	HMO		0.0%	23.1%	130.0%	-46.9%
	POS	-38.6%		-27.9%	-27.2%	-25.8%
	EPO	-24.9%	158.2%		17.3%	63.1%
	Direct	-21.5%	83.6%	-19.3%		19.6%
	Metro	-39.0%	145.1%	-24.4%	-11.4%	

Percentage		Average Allowed Claim Cost Relative for Post-Renewal Period				
		To				
		HMO	POS	EPO	Direct	Metro
From	HMO		0.0%	-50.8%	-95.1%	146.6%
	POS	16.6%		19.9%	13.7%	4.9%
	EPO	9.2%	153.7%		31.7%	67.1%
	Direct	27.2%	46.0%	-7.7%		5.6%
	Metro	6.2%	70.0%	-0.3%	3.1%	

HMO		% of HMO Business	Actual Average Allowed Claim Difference
to	POS	0.0%	0.0%
	EPO	1.8%	23.1%
	Direct	0.1%	130.0%
	Metro	0.1%	-46.9%
	Total	2.0%	-0.5%
from	POS	0.1%	16.6%
	EPO	10.9%	9.2%
	Direct	0.9%	27.2%
	Metro	0.7%	6.2%
	Total	12.6%	1.3%
Aggregate Impact			0.8%

**Oxford Health Plans (NY), Inc.
New York Small Group HMO**

Standardized Premium Calculation

Effective Month Year	Effective Quarter Year	Time Period for Premium Data in column (A)	Earned Premium 1/2009 - 12/2009 A	Filed Rate Increase to 4Q- 12 Level * B	1/2009 - 12/2009 Standardized Premium C = A x (1+B)
February 2008	1Q2008	1/2009	\$ -	NA	NA
March 2008	1Q2008	1/2009 - 2/2009	\$ -	NA	NA
April 2008	2Q2008	1/2009 - 3/2009	\$ -	NA	NA
May 2008	2Q2008	1/2009 - 4/2009	\$ -	NA	NA
June 2008	2Q2008	1/2009 - 5/2009	\$ -	NA	NA
July 2008	3Q2008	1/2009 - 6/2009	\$ -	NA	NA
August 2008	3Q2008	1/2009 - 7/2009	\$ -	NA	NA
September 2008	3Q2008	1/2009 - 8/2009	\$ -	NA	NA
October 2008	4Q2008	1/2009 - 9/2009	\$ -	NA	NA
November 2008	4Q2008	1/2009 - 10/2009	\$ -	NA	NA
December 2008	4Q2008	1/2009 - 11/2009	\$ -	NA	NA
January 2009	1Q2009	1/2009 - 12/2009	\$ -	NA	NA
February 2009	1Q2009	2/2009 - 12/2009	\$ -	NA	NA
March 2009	1Q2009	3/2009 - 12/2009	\$ -	NA	NA
April 2009	2Q2009	4/2009 - 12/2009	\$ -	NA	NA
May 2009	2Q2009	5/2009 - 12/2009	\$ -	NA	NA
June 2009	2Q2009	6/2009 - 12/2009	\$ -	NA	NA
July 2009	3Q2009	7/2009 - 12/2009	\$ 2,135,105	50.2%	\$ 3,207,119
August 2009	3Q2009	8/2009 - 12/2009	\$ 3,748,993	50.2%	\$ 5,631,322
September 2009	3Q2009	9/2009 - 12/2009	\$ 5,053,239	50.2%	\$ 7,590,415
October 2009	4Q2009	10/2009 - 12/2009	\$ 2,685,946	45.1%	\$ 3,897,249
November 2009	4Q2009	11/2009 - 12/2009	\$ 2,177,992	45.1%	\$ 3,160,218
December 2009	4Q2009	12/2009	\$ 1,580,677	45.1%	\$ 2,293,528

1/1/2009 - 12/31/2009 Total \$ 17,381,952

\$ 25,779,851

Ratio to Convert Earned Premium to Standardized Premium

1.48

**Oxford Health Plans (NY), Inc.
New York Small Group HMO**

Standardized Premium Calculation

Effective Month Year	Effective Quarter Year	Time Period for Premium Data in column (A)	Earned Premium 1/2010 - 12/2010 A	Filed Rate Increase to 4Q- 12 Level * B	1/2010 - 12/2010 Standardized Premium C = A x (1+B)
February 2009	1Q2009	1/2010	\$ -	-	\$ -
March 2009	1Q2009	1/2010 - 2/2010	\$ -	-	\$ -
April 2009	2Q2009	1/2010 - 3/2010	\$ -	-	\$ -
May 2009	2Q2009	1/2010 - 4/2010	\$ -	-	\$ -
June 2009	2Q2009	1/2010 - 5/2010	\$ -	-	\$ -
July 2009	3Q2009	1/2010 - 6/2010	\$ 2,129,737	50.2%	\$ 3,199,054
August 2009	3Q2009	1/2010 - 7/2010	\$ 5,159,928	50.2%	\$ 7,750,672
September 2009	3Q2009	1/2010 - 8/2010	\$ 10,391,179	50.2%	\$ 15,608,476
October 2009	4Q2009	1/2010 - 9/2010	\$ 8,577,851	45.1%	\$ 12,446,275
November 2009	4Q2009	1/2010 - 10/2010	\$ 11,322,969	45.1%	\$ 16,429,381
December 2009	4Q2009	1/2010 - 11/2010	\$ 18,826,995	45.1%	\$ 27,317,559
January 2010	1Q2010	1/2010 - 12/2010	\$ 25,432,722	38.0%	\$ 35,093,782
February 2010	1Q2010	2/2010 - 12/2010	\$ 17,782,187	38.0%	\$ 24,537,058
March 2010	1Q2010	3/2010 - 12/2010	\$ 21,546,633	38.0%	\$ 29,731,495
April 2010	2Q2010	4/2010 - 12/2010	\$ 26,079,927	33.4%	\$ 34,778,899
May 2010	2Q2010	5/2010 - 12/2010	\$ 23,033,586	33.4%	\$ 30,716,449
June 2010	2Q2010	6/2010 - 12/2010	\$ 29,225,220	33.4%	\$ 38,973,306
July 2010	3Q2010	7/2010 - 12/2010	\$ 14,455,621	23.1%	\$ 17,796,621
August 2010	3Q2010	8/2010 - 12/2010	\$ 11,506,971	23.1%	\$ 14,166,476
September 2010	3Q2010	9/2010 - 12/2010	\$ 12,497,355	23.1%	\$ 15,385,759
October 2010	4Q2010	10/2010 - 12/2010	\$ 6,593,727	18.0%	\$ 7,779,368
November 2010	4Q2010	11/2010 - 12/2010	\$ 5,502,242	18.0%	\$ 6,491,619
December 2010	4Q2010	12/2010	\$ 4,243,855	18.0%	\$ 5,006,957
1/1/2010 - 12/31/2010 Total			\$ 254,308,702		\$ 343,209,204

Ratio to Convert Earned Premium to Standardized Premium

1.35

**Oxford Health Plans (NY), Inc.
New York Small Group HMO**

Standardized Premium Calculation

Effective Month Year	Effective Quarter Year	Time Period for Premium Data in column (A)	Earned Premium 1/2011 - 12/2011 A	Filed Rate Increase to 4Q- 12 Level * B	1/2011 - 12/2011 Standardized Premium C = A x (1+B)
February 2010	1Q2010	1/2011	\$ 1,682,805	38.0%	\$ 2,322,048
March 2010	1Q2010	1/2011 - 2/2011	\$ 4,356,552	38.0%	\$ 6,011,464
April 2010	2Q2010	1/2011 - 3/2011	\$ 8,672,932	33.4%	\$ 11,565,792
May 2010	2Q2010	1/2011 - 4/2011	\$ 11,167,777	33.4%	\$ 14,892,794
June 2010	2Q2010	1/2011 - 5/2011	\$ 20,189,701	33.4%	\$ 26,923,984
July 2010	3Q2010	1/2011 - 6/2011	\$ 14,113,187	23.1%	\$ 17,375,043
August 2010	3Q2010	1/2011 - 7/2011	\$ 15,107,981	23.1%	\$ 18,599,755
September 2010	3Q2010	1/2011 - 8/2011	\$ 24,074,565	23.1%	\$ 29,638,707
October 2010	4Q2010	1/2011 - 9/2011	\$ 18,884,592	18.0%	\$ 22,280,296
November 2010	4Q2010	1/2011 - 10/2011	\$ 25,719,813	18.0%	\$ 30,344,582
December 2010	4Q2010	1/2011 - 11/2011	\$ 43,450,939	18.0%	\$ 51,264,002
January 2011	1Q2011	1/2011 - 12/2011	\$ 65,350,494	21.6%	\$ 79,434,841
February 2011	1Q2011	2/2011 - 12/2011	\$ 40,040,460	21.6%	\$ 48,669,986
March 2011	1Q2011	3/2011 - 12/2011	\$ 45,972,143	21.6%	\$ 55,880,065
April 2011	2Q2011	4/2011 - 12/2011	\$ 41,614,108	17.5%	\$ 48,900,605
May 2011	2Q2011	5/2011 - 12/2011	\$ 36,444,769	17.5%	\$ 42,826,132
June 2011	2Q2011	6/2011 - 12/2011	\$ 46,842,962	17.5%	\$ 55,045,016
July 2011	3Q2011	7/2011 - 12/2011	\$ 25,572,208	17.5%	\$ 30,049,820
August 2011	3Q2011	8/2011 - 12/2011	\$ 19,374,906	17.5%	\$ 22,767,391
September 2011	3Q2011	9/2011 - 12/2011	\$ 22,279,415	17.5%	\$ 26,180,469
October 2011	4Q2011	10/2011 - 12/2011	\$ 9,372,972	14.1%	\$ 10,693,349
November 2011	4Q2011	11/2011 - 12/2011	\$ 7,014,107	14.1%	\$ 8,002,189
December 2011	4Q2011	12/2011	\$ 6,200,171	14.1%	\$ 7,073,593
1/1/2011 - 12/31/2011 Total			\$ 553,499,557		\$ 666,741,924

Ratio to Convert Earned Premium to Standardized Premium

1.20

Oxford Health Plans Inc.

***NY Small Group Gated HMO Plan
Section I - Rate Manual***

For Groups with 2-50 Employees

Rates Effective 2013

OXFORD HEALTH PLANS

***NY Small Group Gated HMO Plan
Rate Manual***

Table of Contents

	<u>PAGE(S)</u>
HMO Medical, Pharmacy, and Rider Rates	1 - 2
Rate Change Summary	3
Form Numbers	4
Benefit Descriptions	5
Medical Base Rates and Rating Factors	6
Pharmacy Base Rates and Rating Factors	7
Rate Calculation Example	8
Base Rate Adjustment Table	9

Oxford Health Plans, Inc.
New York Small Group - Gated HMO Plan
Effective 2013

**Manhattan, Richmond, Kings, Queens, Bronx, Rockland, Nassau, Suffolk,
 Westchester, Dutchess, Orange, Putnam, Ulster, & Sullivan Counties.**

January 2013 to March 2013

April 2013 to June 2013

Medical:

\$30 PCP/ \$50 Specialist Office Visit Copay, \$150
 ER Copay, \$150 Ambulatory Surgery, \$500 per day
 up to \$1000 max per continuous confinement.

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$375.93	\$438.12	\$62.19	16.5%		\$389.09	\$454.86	\$65.77	16.9%
Parent/Child(ren)	\$695.47	\$810.52	\$115.05	16.5%		\$719.82	\$841.49	\$121.67	16.9%
Couple	\$827.05	\$963.86	\$136.81	16.5%		\$856.00	\$1,000.69	\$144.69	16.9%
Family	\$1,165.38	\$1,358.17	\$192.79	16.5%		\$1,206.18	\$1,410.07	\$203.89	16.9%

Pharmacy:

\$15/\$35/\$75C with a \$100 Deductible

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$92.18	\$107.44	\$15.26	16.6%		\$95.41	\$111.55	\$16.14	16.9%
Parent/Child(ren)	\$170.53	\$198.76	\$28.23	16.6%		\$176.51	\$206.37	\$29.86	16.9%
Couple	\$202.80	\$236.37	\$33.57	16.6%		\$209.90	\$245.41	\$35.51	16.9%
Family	\$285.76	\$333.06	\$47.30	16.6%		\$295.77	\$345.81	\$50.04	16.9%

Bio-Based Mental Health Rider

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$3.23	\$3.76	\$0.53	16.4%		\$3.34	\$3.90	\$0.56	16.8%
Parent/Child(ren)	\$5.98	\$6.96	\$0.98	16.4%		\$6.18	\$7.22	\$1.04	16.8%
Couple	\$7.11	\$8.27	\$1.16	16.3%		\$7.35	\$8.58	\$1.23	16.7%
Family	\$10.01	\$11.66	\$1.65	16.5%		\$10.35	\$12.09	\$1.74	16.8%

Mental Health Parity Rider

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$10.15	\$11.83	\$1.68	16.6%		\$10.51	\$12.28	\$1.77	16.8%
Parent/Child(ren)	\$18.78	\$21.89	\$3.11	16.6%		\$19.44	\$22.72	\$3.28	16.9%
Couple	\$22.33	\$26.03	\$3.70	16.6%		\$23.12	\$27.02	\$3.90	16.9%
Family	\$31.47	\$36.67	\$5.20	16.5%		\$32.58	\$38.07	\$5.49	16.9%

Dependent to Age 26 (default)

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Parent/Child(ren)	\$3.57	\$4.15	\$0.58	16.2%		\$3.69	\$4.31	\$0.62	16.8%
Couple	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Family	\$5.99	\$6.98	\$0.99	16.5%		\$6.20	\$7.25	\$1.05	16.9%

Dependent to Age 29

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Parent/Child(ren)	\$48.31	\$56.30	\$7.99	16.5%		\$50.00	\$58.45	\$8.45	16.9%
Couple	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Family	\$51.30	\$59.79	\$8.49	16.5%		\$53.10	\$62.07	\$8.97	16.9%

Vision

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$4.64	\$4.64	\$0.00	0.0%		\$4.64	\$4.64	\$0.00	0.0%
Parent/Child(ren)	\$8.58	\$8.58	\$0.00	0.0%		\$8.58	\$8.58	\$0.00	0.0%
Couple	\$10.21	\$10.21	\$0.00	0.0%		\$10.21	\$10.21	\$0.00	0.0%
Family	\$14.38	\$14.38	\$0.00	0.0%		\$14.38	\$14.38	\$0.00	0.0%

Oxford Health Plans, Inc.
New York Small Group - Gated HMO Plan
Effective 2013

**Manhattan, Richmond, Kings, Queens, Bronx, Rockland, Nassau, Suffolk,
Westchester, Dutchess, Orange, Putnam, Ulster, & Sullivan Counties.**

July 2013 to September 2013

October 2013 to December 2013

Medical:

\$30 PCP/ \$50 Specialist Office Visit Copay, \$150
ER Copay, \$150 Ambulatory Surgery, \$500 per day
up to \$1000 max per continuous confinement.

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$402.71	\$472.68	\$69.97	17.4%		\$416.80	\$490.68	\$73.88	17.7%
Parent/Child(ren)	\$745.01	\$874.46	\$129.45	17.4%		\$771.08	\$907.76	\$136.68	17.7%
Couple	\$885.96	\$1,039.90	\$153.94	17.4%		\$916.96	\$1,079.50	\$162.54	17.7%
Family	\$1,248.40	\$1,465.31	\$216.91	17.4%		\$1,292.08	\$1,521.11	\$229.03	17.7%

Pharmacy:

\$15/\$35/\$75C with a \$100 Deductible

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$98.75	\$115.92	\$17.17	17.4%		\$102.21	\$120.33	\$18.12	17.7%
Parent/Child(ren)	\$182.69	\$214.45	\$31.76	17.4%		\$189.09	\$222.61	\$33.52	17.7%
Couple	\$217.25	\$255.02	\$37.77	17.4%		\$224.86	\$264.73	\$39.87	17.7%
Family	\$306.13	\$359.35	\$53.22	17.4%		\$316.85	\$373.02	\$56.17	17.7%

Bio-Based Mental Health Rider

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$3.46	\$4.05	\$0.59	17.1%		\$3.58	\$4.20	\$0.62	17.3%
Parent/Child(ren)	\$6.40	\$7.49	\$1.09	17.0%		\$6.62	\$7.77	\$1.15	17.4%
Couple	\$7.61	\$8.91	\$1.30	17.1%		\$7.88	\$9.24	\$1.36	17.3%
Family	\$10.73	\$12.56	\$1.83	17.1%		\$11.10	\$13.02	\$1.92	17.3%

Mental Health Parity Rider

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$10.88	\$12.76	\$1.88	17.3%		\$11.26	\$13.25	\$1.99	17.7%
Parent/Child(ren)	\$20.13	\$23.61	\$3.48	17.3%		\$20.83	\$24.51	\$3.68	17.7%
Couple	\$23.94	\$28.07	\$4.13	17.3%		\$24.77	\$29.15	\$4.38	17.7%
Family	\$33.73	\$39.56	\$5.83	17.3%		\$34.91	\$41.08	\$6.17	17.7%

Dependent to Age 26 (default)

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Parent/Child(ren)	\$3.82	\$4.48	\$0.66	17.3%		\$3.95	\$4.65	\$0.70	17.7%
Couple	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Family	\$6.42	\$7.53	\$1.11	17.3%		\$6.64	\$7.82	\$1.18	17.8%

Dependent to Age 29

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Parent/Child(ren)	\$51.75	\$60.74	\$8.99	17.4%		\$53.56	\$63.05	\$9.49	17.7%
Couple	\$0.00	\$0.00	\$0.00	n/a		\$0.00	\$0.00	\$0.00	n/a
Family	\$54.96	\$64.50	\$9.54	17.4%		\$56.88	\$66.96	\$10.08	17.7%

Vision

	<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>		<u>2012</u>	<u>2013</u>	<u>\$ Adj</u>	<u>% Adj</u>
Four-Tier A									
Single	\$4.64	\$4.64	\$0.00	0.0%		\$4.64	\$4.64	\$0.00	0.0%
Parent/Child(ren)	\$8.58	\$8.58	\$0.00	0.0%		\$8.58	\$8.58	\$0.00	0.0%
Couple	\$10.21	\$10.21	\$0.00	0.0%		\$10.21	\$10.21	\$0.00	0.0%
Family	\$14.38	\$14.38	\$0.00	0.0%		\$14.38	\$14.38	\$0.00	0.0%

Oxford Health Plans, Inc.
New York Small Group - Gated HMO Plan

	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013
Medical				
<i>Minimum rate change</i>	16.5%	16.9%	17.4%	17.7%
<i>Maximum rate change</i>	16.5%	16.9%	17.4%	17.7%
<i>Member weighted average rate change</i>	16.5%	16.9%	17.4%	17.7%
Pharmacy				
<i>Minimum rate change</i>	16.6%	16.9%	17.4%	17.7%
<i>Maximum rate change</i>	16.6%	16.9%	17.4%	17.7%
<i>Member weighted average rate change</i>	16.6%	16.9%	17.4%	17.7%

**Oxford Health Plans Inc.
New York Small Group HMO
Rate Manual - Forms**

Form # OHPNY SB HMO S 309

Form # OHPNY GA HMO S 309

New York Small Group HMO Plan

Benefit	Plan
Network	Liberty
Out-of-Area Access	Emergency only
Gatekeeper	Gated only
Out-of-network Benefit	None
Office Visit Copay PCP	\$30
Office Visit Copay Specialist	\$50
Preventive Care	100%
Outpatient Copay	\$150
Inpatient Copay	\$500 (2 days)
ER Copay	\$150
Radiology (MRI, CT, PT)	20% coinsurance to \$100, \$500 Max per year
Pediatric Dental	N/A
Gym Benefit	\$200 every 6 months
DME	
PT	Included
Optional Rx:	
Deductible	\$100 (brand only)
Generic	\$15
Preferred Brand	\$35
Brand	\$75
Annual Max	None
Optional Riders:	
Vision	\$50 per exam reimbursement every 12 month, \$70 per appliance reimbursement every 24 mos
Dependent to Age 29	
Bio-Based Mental Health	
Federal Mental Health Parity	



**Oxford Health Plans Inc.
New York Small Group HMO**

Rate Manual - Medical Base Rate & Rating Factors

1. Single Base Rate		249.30
2. Forward Trends	<u><i>Date</i></u>	<u><i>Adjustment</i></u>
	7/1/2009 through 9/30/2009	1.000
	10/1/2009 through 12/31/2009	1.036
	1/1/2010 through 3/31/2010	1.073
	4/1/2010 through 6/30/2010	1.111
	7/1/2010 through 9/30/2010	1.242
	10/1/2010 through 12/31/2010	1.299
	1/1/2011 through 3/31/2011	1.231
	4/1/2011 through 6/30/2011	1.274
	7/1/2011 through 9/30/2011	1.274
	10/1/2011 through 12/31/2011	1.313
	1/1/2012 through 3/31/2012	1.489
	4/1/2012 through 6/30/2012	1.541
	7/1/2012 through 9/30/2012	1.595
	10/1/2012 through 12/31/2012	1.650
	1/1/2013 through 3/31/2013	1.735
	4/1/2013 through 6/30/2013	1.824
	7/1/2013 through 9/30/2013	1.917
	10/1/2013 through 12/31/2013	2.015
3. Region	<u><i>County</i></u>	<u><i>Adjustment</i></u>
	Manhattan/ Richmond/ Bronx	1.000
	Kings/Queens	1.000
	Rockland	1.000
	Nassau	1.000
	Suffolk	1.000
	Westchester	1.000
	Dutchess/ Orange/ Putnam	1.000
	Ulster/ Sullivan	1.000
4. Tier Relativities	<u><i>Tier</i></u>	<u><i>Adjustment</i></u>
	Single rate	1.000
	Parent / Child(ren) rate	1.850
	Husband / Wife rate	2.200
	Family rate	3.100

**Oxford Health Plans Inc.
New York Small Group HMO**

Rate Manual - Pharmacy Base Rate & Rating Factors

1. Single Base Rate		63.08
2. Forward Trends	<u>Date</u>	<u>Adjustment</u>
	7/1/2009 through 9/30/2009	1.000
	10/1/2009 through 12/31/2009	1.032
	1/1/2010 through 3/31/2010	1.065
	4/1/2010 through 6/30/2010	1.099
	7/1/2010 through 9/30/2010	1.134
	10/1/2010 through 12/31/2010	1.170
	1/1/2011 through 3/31/2011	1.198
	4/1/2011 through 6/30/2011	1.236
	7/1/2011 through 9/30/2011	1.236
	10/1/2011 through 12/31/2011	1.274
	1/1/2012 through 3/31/2012	1.444
	4/1/2012 through 6/30/2012	1.495
	7/1/2012 through 9/30/2012	1.547
	10/1/2012 through 12/31/2012	1.601
	1/1/2013 through 3/31/2013	1.683
	4/1/2013 through 6/30/2013	1.769
	7/1/2013 through 9/30/2013	1.860
	10/1/2013 through 12/31/2013	1.955
3. Region	<u>County</u>	<u>Adjustment</u>
	Manhattan/ Richmond/ Bronx	1.000
	Kings/Queens	1.000
	Rockland	1.000
	Nassau	1.000
	Suffolk	1.000
	Westchester	1.000
	Duchess/ Orange/ Putnam	1.000
	Ulster/ Sullivan	1.000
4. Tier Relativities	<u>Tier</u>	<u>Adjustment</u>
	Single rate	1.000
	Parent / Child(ren) rate	1.850
	Husband / Wife rate	2.200
	Family rate	3.100

**Oxford Health Plans Inc.
New York Small Group HMO**

Rate Calculation Example

Medical Plan: Gated HMO Plan
Pharmacy Plan: \$15/\$35/\$75C with a \$100 Deductible
Effective Date: 1/1/2013
Region: Manhattan/ Richmond/ Bronx

	Medical	Pharmacy	Dependent Age 26 (default)	Total
1. Single Base Rate	\$ 249.30	\$ 63.08		
2. x Base Rate Adjustment	1.013	1.012		
3. x Forward Trend	1.735	1.683		
4. x Region Adjustment	1.000	1.000		
5. x Tier Relativities				
<i>Single</i>	1.00	\$ 438.12	\$ -	\$ 545.56
<i>Parent / Child(ren)</i>	1.85	\$ 810.52	\$ 4.15	\$1,013.44
<i>Husband / Wife</i>	2.20	\$ 963.86	\$ -	\$1,200.23
<i>Family</i>	3.10	\$ 1,358.17	\$ 6.98	\$1,698.22

BASE RATE ADJUSTMENT TABLE

<u>Adjustment Reason</u>	<u>Adjustment Effective Date</u>	<u>Base Medical</u>	<u>Base Non-Rx Riders</u>	<u>Base Rx Riders</u>
100% Preventive Coverage	Jan-11	1.0030	1.0000	1.0000
Medical Sweeps	Jan-11	1.0100	1.0000	1.0000
Rx Sweeps	Jan-11	1.0000	1.0000	1.0120
Cumulative Adjustment				
January 1, 2011 to Date		1.0130	1.0000	1.0120