

SERFF Tracking Number: GRPH-127320298 State: New York  
Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
Company Tracking Number:  
TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.004F Small Group Only - HMO  
Maintenance (HMO)  
Product Name: Healthy New York HMO  
Project Name/Number: 2012 Rate Increase/

## Filing at a Glance

Company: GHI HMO Select, Inc.

Product Name: Healthy New York HMO

TOI: HOrg02G Group Health Organizations -  
Health Maintenance (HMO)

Sub-TOI: HOrg02G.004F Small Group Only -  
HMO

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

SERFF Tr Num: GRPH-127320298 State: New York

SERFF Status: Closed-APPR  
Approved

Co Tr Num:

State Tr Num: 2011070136

State Status:

Reviewer(s): [REDACTED]

Disposition Date: 10/20/2011

Authors: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Date Submitted: 07/19/2011

Disposition Status: APPR Approved

Implementation Date: 01/01/2012

Implementation Date Requested: 01/01/2012

State Filing Description:

## General Information

Project Name: 2012 Rate Increase

Project Number:

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: GHI HMO Select,  
Inc. is licensed to write health insurance in New  
York State.

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 10/27/2011

State Status Changed:

Created By: [REDACTED]

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Market Type: Group

Group Market Size: Small

Overall Rate Impact: 19.8%

Deemer Date:

Submitted By: [REDACTED]

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PPACA Notes: null

Filing Description:

This submission contains the 2012 GHI HMO Select, Inc. Healthy New York HMO rate increase application.

## Company and Contact

### Filing Contact Information

[REDACTED]  
EmblemHealth  
55 Water Street  
New York, NY 10041

[REDACTED]  
[REDACTED]  
[REDACTED]

### Filing Company Information

GHI HMO Select, Inc.  
789 Grant Avenue  
Lake Katrine, NY 12449  
[REDACTED]

CoCode: 95835  
Group Code: -99  
Group Name:  
FEIN Number: 13-4061844

State of Domicile: New York  
Company Type:  
State ID Number:

## 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.): Group Remittance
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, "File and Use" Rate Adjustment, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare

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

SERFF Tracking Number: GRPH-127320298 State: New York  
 Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
 Company Tracking Number:  
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO) Sub-TOI: HOrg02G.004F Small Group Only - HMO  
 Product Name: Healthy New York HMO  
 Project Name/Number: 2012 Rate Increase/

## Rate Information

Rate data applies to filing.

**Filing Method:** Review and Approval  
**Rate Change Type:** Increase  
**Overall Percentage of Last Rate Revision:** 0.000%  
**Effective Date of Last Rate Revision:** 10/01/2010  
**Filing Method of Last Filing:** Transitional Guidelines

## 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):
GHI HMO Select, Inc.	Increase	19.800%	19.800%	\$828,947	580	\$4,186,601	19.800%	19.800%
<b>Product Type:</b>	<b>HMO</b>	<b>PPO</b>	<b>EPO</b>	<b>POS</b>	<b>HSA</b>	<b>HDHP</b>	<b>FFS</b>	<b>Other</b>
<b>Covered Lives:</b>	951							
<b>Policy Holders:</b>	580							

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(HMO)  
Product Name: Healthy New York HMO  
Project Name/Number: 2012 Rate Increase/

## Rate Review Details

### COMPANY:

Company Name: GHI HMO Select, Inc.  
HHS Issuer Id: 48342  
Product Names: Healthy New York HMO  
Trend Factors:

### FORMS:

New Policy Forms: N/A  
Affected Forms: N/A  
Other Affected Forms: GHI HMO HNY-GRI-2001

### REQUESTED RATE CHANGE

#### INFORMATION:

Change Period: Annual  
Member Months: 14,376  
Benefit Change: None  
Percent Change Requested: Min: 19.8 Max: 19.8 Avg: 19.8

#### PRIOR RATE:

Total Earned Premium: 4,274,551.00  
Total Incurred Claims: 4,126,561.00  
Annual \$: Min: 218.01 Max: 338.46 Avg: 295.23

#### REQUESTED RATE:

Projected Earned Premium: 5,084,514.00  
Projected Incurred Claims: 5,002,146.00

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Annual \$: Min: 261.18 Max: 405.48 Avg: 353.68

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## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
	Rate Manual / Changes	GHI HMO HNY- GRI-2001	New		2012 GHI HMO HNY Rate Change.pdf 2012 GHI HMO HNY Rate Manual.pdf

GHI HMO SELECT, INC.  
2011 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
\$ Change  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
% Change  
HEALTHY NEW YORK

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2011 - December 31, 2011</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	353.94	n/a	n/a	n/a	672.46	787.27	1,030.91		
With Drugs \$750K Max	406.15	n/a	n/a	n/a	771.67	903.42	1,183.01		
HDHP Without Drugs	264.42	n/a	n/a	n/a	502.40	588.18	770.20		
HDHP With Drugs \$750K Max	306.08	n/a	n/a	n/a	581.52	680.81	891.51		
	<b>Grandfathered Group</b>								
Without Drugs	351.89	n/a	n/a	n/a	668.57	782.71	1,024.95		
With Drugs \$750K max	403.83	n/a	n/a	n/a	767.25	898.25	1,176.24		
HDHP Without Drugs	262.89	n/a	n/a	n/a	499.49	584.77	765.74		
HDHP With Drugs \$750K Max	304.33	n/a	n/a	n/a	578.20	676.92	886.41		
	<b>Grandfathered Individual</b>								
Without Drugs	350.18	n/a	n/a	n/a	665.33	778.92	1,019.98		
With Drugs \$3K max	397.25	n/a	n/a	n/a	754.75	883.61	1,157.07		
HDHP Without Drugs	261.62	n/a	n/a	n/a	497.07	581.94	762.03		
HDHP With Drugs \$3K max	299.37	n/a	n/a	n/a	568.77	665.88	871.97		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2012 - December 31, 2012</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	424.02	n/a	n/a	n/a	805.61	943.15	1,235.03		
With Drugs \$750K Max	486.57	n/a	n/a	n/a	924.46	1,082.30	1,417.25		
HDHP Without Drugs	316.78	n/a	n/a	n/a	601.88	704.64	922.70		
HDHP With Drugs \$750K Max	366.68	n/a	n/a	n/a	696.66	815.61	1,068.03		
	<b>Grandfathered Group</b>								
Without Drugs	421.56	n/a	n/a	n/a	800.95	937.69	1,227.89		
With Drugs \$750K max	483.79	n/a	n/a	n/a	919.17	1,076.10	1,409.14		
HDHP Without Drugs	314.94	n/a	n/a	n/a	598.39	700.55	917.36		
HDHP With Drugs \$750K Max	364.59	n/a	n/a	n/a	692.68	810.95	1,061.92		
	<b>Grandfathered Individual</b>								
Without Drugs	419.52	n/a	n/a	n/a	797.07	933.15	1,221.94		
With Drugs \$3K max	475.91	n/a	n/a	n/a	904.19	1,058.56	1,386.17		
HDHP Without Drugs	313.42	n/a	n/a	n/a	595.49	697.16	912.91		
HDHP With Drugs \$3K max	358.65	n/a	n/a	n/a	681.39	797.72	1,044.62		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2012 - December 31, 2012</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	70.08	n/a	n/a	n/a	133.15	155.88	204.12		
With Drugs \$750K Max	80.42	n/a	n/a	n/a	152.79	178.88	234.24		
HDHP Without Drugs	52.36	n/a	n/a	n/a	99.48	116.46	152.50		
HDHP With Drugs \$750K Max	60.60	n/a	n/a	n/a	115.14	134.80	176.52		
	<b>Grandfathered Group</b>								
Without Drugs	69.67	n/a	n/a	n/a	132.38	154.98	202.94		
With Drugs \$750K max	79.96	n/a	n/a	n/a	151.92	177.85	232.90		
HDHP Without Drugs	52.05	n/a	n/a	n/a	98.90	115.78	151.62		
HDHP With Drugs \$750K Max	60.26	n/a	n/a	n/a	114.48	134.03	175.51		
	<b>Grandfathered Individual</b>								
Without Drugs	69.34	n/a	n/a	n/a	131.74	154.23	201.96		
With Drugs \$3K max	78.66	n/a	n/a	n/a	149.44	174.95	229.10		
HDHP Without Drugs	51.80	n/a	n/a	n/a	98.42	115.22	150.88		
HDHP With Drugs \$3K max	59.28	n/a	n/a	n/a	112.62	131.84	172.65		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2012 - December 31, 2012</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Group</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Individual</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

GHI HMO SELECT, INC.  
2011 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
\$ Change  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
% Change  
HEALTHY NEW YORK

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		

Effective January 1, 2011 - December 31, 2011

Effective January 1, 2012 - December 31, 2012

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
	<b>Fully PPACA Compliant</b>								
Without Drugs	316.16	n/a	n/a	n/a	600.69	703.25	920.90		
With Drugs \$750K Max	362.81	n/a	n/a	n/a	689.32	807.02	1,056.77		
HDHP Without Drugs	236.21	n/a	n/a	n/a	448.78	525.41	688.01		
HDHP With Drugs \$750K Max	273.41	n/a	n/a	n/a	519.46	608.16	796.37		
	<b>Grandfathered Group</b>								
Without Drugs	314.33	n/a	n/a	n/a	597.22	699.18	915.57		
With Drugs \$750K max	360.73	n/a	n/a	n/a	685.38	802.40	1,050.73		
HDHP Without Drugs	234.84	n/a	n/a	n/a	446.19	522.37	684.03		
HDHP With Drugs \$750K Max	271.85	n/a	n/a	n/a	516.49	604.68	791.81		
	<b>Grandfathered Individual</b>								
Without Drugs	312.81	n/a	n/a	n/a	594.32	695.79	911.13		
With Drugs \$3K max	354.85	n/a	n/a	n/a	674.21	789.32	1,033.60		
HDHP Without Drugs	233.70	n/a	n/a	n/a	444.02	519.83	680.71		
HDHP With Drugs \$3K max	267.42	n/a	n/a	n/a	508.08	594.82	778.91		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
	<b>Fully PPACA Compliant</b>								
Without Drugs	378.76	n/a	n/a	n/a	719.63	842.49	1,103.24		
With Drugs \$750K Max	434.65	n/a	n/a	n/a	825.81	966.81	1,266.01		
HDHP Without Drugs	282.98	n/a	n/a	n/a	537.64	629.44	824.24		
HDHP With Drugs \$750K Max	327.55	n/a	n/a	n/a	622.31	728.58	954.05		
	<b>Grandfathered Group</b>								
Without Drugs	376.57	n/a	n/a	n/a	715.47	837.62	1,096.85		
With Drugs \$750K max	432.15	n/a	n/a	n/a	821.09	961.28	1,258.77		
HDHP Without Drugs	281.34	n/a	n/a	n/a	534.54	625.80	819.47		
HDHP With Drugs \$750K Max	325.68	n/a	n/a	n/a	618.76	724.41	948.59		
	<b>Grandfathered Individual</b>								
Without Drugs	374.75	n/a	n/a	n/a	712.00	833.56	1,091.53		
With Drugs \$3K max	425.11	n/a	n/a	n/a	807.70	945.61	1,238.25		
HDHP Without Drugs	279.97	n/a	n/a	n/a	531.94	622.76	815.49		
HDHP With Drugs \$3K max	320.37	n/a	n/a	n/a	608.68	712.59	933.13		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
	<b>Fully PPACA Compliant</b>								
Without Drugs	62.60	n/a	n/a	n/a	118.94	139.24	182.34		
With Drugs \$750K Max	71.84	n/a	n/a	n/a	136.49	159.79	209.24		
HDHP Without Drugs	46.77	n/a	n/a	n/a	88.86	104.03	136.23		
HDHP With Drugs \$750K Max	54.14	n/a	n/a	n/a	102.85	120.42	157.68		
	<b>Grandfathered Group</b>								
Without Drugs	62.24	n/a	n/a	n/a	118.25	138.44	181.28		
With Drugs \$750K max	71.42	n/a	n/a	n/a	135.71	158.88	208.04		
HDHP Without Drugs	46.50	n/a	n/a	n/a	88.35	103.43	135.44		
HDHP With Drugs \$750K Max	53.83	n/a	n/a	n/a	102.27	119.73	156.78		
	<b>Grandfathered Individual</b>								
Without Drugs	61.94	n/a	n/a	n/a	117.68	137.77	180.40		
With Drugs \$3K max	70.26	n/a	n/a	n/a	133.49	156.29	204.65		
HDHP Without Drugs	46.27	n/a	n/a	n/a	87.92	102.93	134.78		
HDHP With Drugs \$3K max	52.95	n/a	n/a	n/a	100.60	117.77	154.22		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
	<b>Fully PPACA Compliant</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Group</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Individual</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		

Dependent Children [std: covered to 26 end of month]

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Age	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%		

Age	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%		

Age	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%		

Age	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%		

GHI HMO SELECT, INC.  
2011 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK

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HEALTHY NEW YORK

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% Change  
HEALTHY NEW YORK

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2011 - December 31, 2011</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	303.53	n/a	n/a	n/a	576.70	675.16	884.10		
With Drugs \$750K Max	348.30	n/a	n/a	n/a	661.75	774.73	1,014.49		
HDHP Without Drugs	226.77	n/a	n/a	n/a	430.85	504.41	660.52		
HDHP With Drugs \$750K Max	262.48	n/a	n/a	n/a	498.69	583.84	764.52		
	<b>Grandfathered Group</b>								
Without Drugs	301.77	n/a	n/a	n/a	573.36	671.25	878.99		
With Drugs \$750K max	346.31	n/a	n/a	n/a	657.97	770.30	1,008.69		
HDHP Without Drugs	225.46	n/a	n/a	n/a	428.36	501.49	656.70		
HDHP With Drugs \$750K Max	260.98	n/a	n/a	n/a	495.84	580.50	760.15		
	<b>Grandfathered Individual</b>								
Without Drugs	300.31	n/a	n/a	n/a	570.58	668.00	874.73		
With Drugs \$3K max	340.66	n/a	n/a	n/a	647.24	757.74	992.24		
HDHP Without Drugs	224.37	n/a	n/a	n/a	426.28	499.06	653.51		
HDHP With Drugs \$3K max	256.73	n/a	n/a	n/a	487.76	571.04	747.76		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2012 - December 31, 2012</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	363.63	n/a	n/a	n/a	690.89	808.84	1,059.15		
With Drugs \$750K Max	417.26	n/a	n/a	n/a	792.78	928.13	1,215.36		
HDHP Without Drugs	271.67	n/a	n/a	n/a	516.16	604.28	791.30		
HDHP With Drugs \$750K Max	314.45	n/a	n/a	n/a	597.43	699.44	915.89		
	<b>Grandfathered Group</b>								
Without Drugs	361.52	n/a	n/a	n/a	686.89	804.16	1,053.03		
With Drugs \$750K max	414.88	n/a	n/a	n/a	788.25	922.82	1,208.41		
HDHP Without Drugs	270.10	n/a	n/a	n/a	513.18	600.79	786.73		
HDHP With Drugs \$750K Max	312.65	n/a	n/a	n/a	594.02	695.44	910.66		
	<b>Grandfathered Individual</b>								
Without Drugs	359.77	n/a	n/a	n/a	683.55	800.26	1,047.93		
With Drugs \$3K max	408.11	n/a	n/a	n/a	775.39	907.77	1,188.70		
HDHP Without Drugs	268.80	n/a	n/a	n/a	510.68	597.87	782.90		
HDHP With Drugs \$3K max	307.56	n/a	n/a	n/a	584.34	684.11	895.82		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2011 - December 31, 2011</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	60.10	n/a	n/a	n/a	114.19	133.68	175.05		
With Drugs \$750K Max	68.96	n/a	n/a	n/a	131.03	153.40	200.87		
HDHP Without Drugs	44.90	n/a	n/a	n/a	85.31	99.87	130.78		
HDHP With Drugs \$750K Max	51.97	n/a	n/a	n/a	98.74	115.60	151.37		
	<b>Grandfathered Group</b>								
Without Drugs	59.75	n/a	n/a	n/a	113.53	132.91	174.04		
With Drugs \$750K max	68.57	n/a	n/a	n/a	130.28	152.52	199.72		
HDHP Without Drugs	44.64	n/a	n/a	n/a	84.82	99.30	130.03		
HDHP With Drugs \$750K Max	51.67	n/a	n/a	n/a	98.18	114.94	150.51		
	<b>Grandfathered Individual</b>								
Without Drugs	59.46	n/a	n/a	n/a	112.97	132.26	173.20		
With Drugs \$3K max	67.45	n/a	n/a	n/a	128.15	150.03	196.46		
HDHP Without Drugs	44.43	n/a	n/a	n/a	84.40	98.81	129.39		
HDHP With Drugs \$3K max	50.83	n/a	n/a	n/a	96.58	113.07	148.06		

Plan	ALL TIERS		TWO TIER		THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family		
<b>Effective January 1, 2011 - December 31, 2011</b>									
	<b>Fully PPACA Compliant</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Group</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$750K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$750K Max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
	<b>Grandfathered Individual</b>								
Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP Without Drugs	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		
HDHP With Drugs \$3K max	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%		

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

Age	Dependent Children [std: covered to 26 end of month]						
	End of Month						
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

GHI HMO SELECT, INC.  
2011 RATE MANUAL  
HEALTHY NEW YORK

GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK

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GHI HMO SELECT, INC.  
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HEALTHY NEW YORK

Plan	2011 Rates							2012 Rates							% Change													
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family							
<b>Effective January 1, 2011 - December 31, 2011</b>																												
	<b>Fully PPACA Compliant</b>							<b>Fully PPACA Compliant</b>							<b>Fully PPACA Compliant</b>													
Without Drugs	288.29	n/a	n/a	n/a	547.74	641.26	839.71	345.37	n/a	n/a	n/a	656.19	768.23	1,005.97	57.08	n/a	n/a	n/a	108.45	126.97	166.26	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
With Drugs \$750K Max	330.82	n/a	n/a	n/a	628.54	735.85	963.59	396.32	n/a	n/a	n/a	752.99	881.55	1,154.38	65.50	n/a	n/a	n/a	124.45	145.70	190.79	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP Without Drugs	215.38	n/a	n/a	n/a	409.22	479.08	627.35	258.03	n/a	n/a	n/a	490.25	573.94	751.57	42.65	n/a	n/a	n/a	81.03	94.86	124.22	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP With Drugs \$750K Max	249.31	n/a	n/a	n/a	473.68	554.55	726.17	298.67	n/a	n/a	n/a	567.47	664.35	869.95	49.36	n/a	n/a	n/a	93.79	109.80	143.78	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
	<b>Grandfathered Group</b>							<b>Grandfathered Group</b>							<b>Grandfathered Group</b>													
Without Drugs	286.62	n/a	n/a	n/a	544.57	637.55	834.85	343.37	n/a	n/a	n/a	652.39	763.78	1,000.15	56.75	n/a	n/a	n/a	107.82	126.23	165.30	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
With Drugs \$750K max	328.93	n/a	n/a	n/a	624.94	731.64	958.08	394.06	n/a	n/a	n/a	748.68	876.50	1,147.78	65.13	n/a	n/a	n/a	123.74	144.86	189.70	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP Without Drugs	214.14	n/a	n/a	n/a	406.85	476.31	623.72	256.54	n/a	n/a	n/a	487.41	570.62	747.22	42.40	n/a	n/a	n/a	80.56	94.31	123.50	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP With Drugs \$750K Max	247.88	n/a	n/a	n/a	470.97	551.38	722.02	296.96	n/a	n/a	n/a	564.22	660.55	864.98	49.08	n/a	n/a	n/a	93.25	109.17	142.96	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
	<b>Grandfathered Individual</b>							<b>Grandfathered Individual</b>							<b>Grandfathered Individual</b>													
Without Drugs	285.23	n/a	n/a	n/a	541.93	634.46	830.80	341.71	n/a	n/a	n/a	649.23	760.08	995.30	56.48	n/a	n/a	n/a	107.30	125.62	164.50	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
With Drugs \$3K max	323.57	n/a	n/a	n/a	614.76	719.72	942.46	387.64	n/a	n/a	n/a	736.48	862.22	1,129.07	64.07	n/a	n/a	n/a	121.72	142.50	186.61	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP Without Drugs	213.10	n/a	n/a	n/a	404.88	474.00	620.70	255.29	n/a	n/a	n/a	485.05	567.85	743.60	42.19	n/a	n/a	n/a	80.17	93.85	122.90	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
HDHP With Drugs \$3K max	243.84	n/a	n/a	n/a	463.29	542.39	710.25	292.12	n/a	n/a	n/a	555.02	649.78	850.88	48.28	n/a	n/a	n/a	91.73	107.39	140.63	19.8%	n/a	n/a	n/a	19.8%	19.8%	19.8%
	<b>Dependent Children [std: covered to 26 end of month]</b>							<b>Dependent Children [std: covered to 26 end of month]</b>							<b>Dependent Children [std: covered to 26 end of month]</b>													
Age	<b>End of Month</b>																											
30	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

**GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK**

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

**Effective January 1, 2012 - December 31, 2012**

<b>Fully PPACA Compliant</b>								
<b>Without Drugs</b>	424.02	n/a	n/a	n/a	805.61	943.15	1,235.03	
<b>With Drugs \$750K Max</b>	486.57	n/a	n/a	n/a	924.46	1,082.30	1,417.25	
<b>HDHP Without Drugs</b>	316.78	n/a	n/a	n/a	601.88	704.64	922.70	
<b>HDHP With Drugs \$750K Max</b>	366.68	n/a	n/a	n/a	696.66	815.61	1,068.03	
<b>Grandfathered Group</b>								
<b>Without Drugs</b>	421.56	n/a	n/a	n/a	800.95	937.69	1,227.89	
<b>With Drugs \$750K max</b>	483.79	n/a	n/a	n/a	919.17	1,076.10	1,409.14	
<b>HDHP Without Drugs</b>	314.94	n/a	n/a	n/a	598.39	700.55	917.36	
<b>HDHP With Drugs \$750K Max</b>	364.59	n/a	n/a	n/a	692.68	810.95	1,061.92	
<b>Grandfathered Individual</b>								
<b>Without Drugs</b>	419.52	n/a	n/a	n/a	797.07	933.15	1,221.94	
<b>With Drugs \$3K max</b>	475.91	n/a	n/a	n/a	904.19	1,058.56	1,386.17	
<b>HDHP Without Drugs</b>	313.42	n/a	n/a	n/a	595.49	697.16	912.91	
<b>HDHP With Drugs \$3K max</b>	358.65	n/a	n/a	n/a	681.39	797.72	1,044.62	

**Dependent Children [std: covered to 26 end of month]**

<u>Age</u>						<u>End of Month</u>	
<b>30</b>	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

**GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK**

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

**Effective January 1, 2012 - December 31, 2012**

**Fully PPACA Compliant**

<b>Without Drugs</b>	378.76	n/a	n/a	n/a	719.63	842.49	1,103.24
<b>With Drugs \$750K Max</b>	434.65	n/a	n/a	n/a	825.81	966.81	1,266.01
<b>HDHP Without Drugs</b>	282.98	n/a	n/a	n/a	537.64	629.44	824.24
<b>HDHP With Drugs \$750K Max</b>	327.55	n/a	n/a	n/a	622.31	728.58	954.05
<b>Grandfathered Group</b>							
<b>Without Drugs</b>	376.57	n/a	n/a	n/a	715.47	837.62	1,096.85
<b>With Drugs \$750K max</b>	432.15	n/a	n/a	n/a	821.09	961.28	1,258.77
<b>HDHP Without Drugs</b>	281.34	n/a	n/a	n/a	534.54	625.80	819.47
<b>HDHP With Drugs \$750K Max</b>	325.68	n/a	n/a	n/a	618.76	724.41	948.59
<b>Grandfathered Individual</b>							
<b>Without Drugs</b>	374.75	n/a	n/a	n/a	712.00	833.56	1,091.53
<b>With Drugs \$3K max</b>	425.11	n/a	n/a	n/a	807.70	945.61	1,238.25
<b>HDHP Without Drugs</b>	279.97	n/a	n/a	n/a	531.94	622.76	815.49
<b>HDHP With Drugs \$3K max</b>	320.37	n/a	n/a	n/a	608.68	712.59	933.13

**Dependent Children [std: covered to 26 end of month]**

<u>Age</u>						<u>End of Month</u>	
<b>30</b>	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

**GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK**

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

**Effective January 1, 2012 - December 31, 2012**

			Fully PPACA Compliant				
<b>Without Drugs</b>	363.63	n/a	n/a	n/a	690.89	808.84	1,059.15
<b>With Drugs \$750K Max</b>	417.26	n/a	n/a	n/a	792.78	928.13	1,215.36
<b>HDHP Without Drugs</b>	271.67	n/a	n/a	n/a	516.16	604.28	791.30
<b>HDHP With Drugs \$750K Max</b>	314.45	n/a	n/a	n/a	597.43	699.44	915.89
			Grandfathered Group				
<b>Without Drugs</b>	361.52	n/a	n/a	n/a	686.89	804.16	1,053.03
<b>With Drugs \$750K max</b>	414.88	n/a	n/a	n/a	788.25	922.82	1,208.41
<b>HDHP Without Drugs</b>	270.10	n/a	n/a	n/a	513.18	600.79	786.73
<b>HDHP With Drugs \$750K Max</b>	312.65	n/a	n/a	n/a	594.02	695.44	910.66
			Grandfathered Individual				
<b>Without Drugs</b>	359.77	n/a	n/a	n/a	683.55	800.26	1,047.93
<b>With Drugs \$3K max</b>	408.11	n/a	n/a	n/a	775.39	907.77	1,188.70
<b>HDHP Without Drugs</b>	268.80	n/a	n/a	n/a	510.68	597.87	782.90
<b>HDHP With Drugs \$3K max</b>	307.56	n/a	n/a	n/a	584.34	684.11	895.82

**Dependent Children [std: covered to 26 end of month]**

<u>Age</u>						<u>End of Month</u>	
<b>30</b>	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

**GHI HMO SELECT, INC.  
2012 RATE MANUAL  
HEALTHY NEW YORK**

Plan	ALL TIERS	TWO TIER	THREE TIER		FOUR TIER		
	Individual	Family	Two Persons	Family	Employee & Child(ren)	Employee & Spouse	Family

**Effective January 1, 2012 - December 31, 2012**

**Fully PPACA Compliant**

<b>Without Drugs</b>	345.37	n/a	n/a	n/a	656.19	768.23	1,005.97
<b>With Drugs \$750K Max</b>	396.32	n/a	n/a	n/a	752.99	881.55	1,154.38
<b>HDHP Without Drugs</b>	258.03	n/a	n/a	n/a	490.25	573.94	751.57
<b>HDHP With Drugs \$750K Max</b>	298.67	n/a	n/a	n/a	567.47	664.35	869.95
<b>Grandfathered Group</b>							
<b>Without Drugs</b>	343.37	n/a	n/a	n/a	652.39	763.78	1,000.15
<b>With Drugs \$750K max</b>	394.06	n/a	n/a	n/a	748.68	876.50	1,147.78
<b>HDHP Without Drugs</b>	256.54	n/a	n/a	n/a	487.41	570.62	747.22
<b>HDHP With Drugs \$750K Max</b>	296.96	n/a	n/a	n/a	564.22	660.55	864.98
<b>Grandfathered Individual</b>							
<b>Without Drugs</b>	341.71	n/a	n/a	n/a	649.23	760.08	995.30
<b>With Drugs \$3K max</b>	387.64	n/a	n/a	n/a	736.48	862.22	1,129.07
<b>HDHP Without Drugs</b>	255.29	n/a	n/a	n/a	485.05	567.85	743.60
<b>HDHP With Drugs \$3K max</b>	292.12	n/a	n/a	n/a	555.02	649.78	850.88

**Dependent Children [std: covered to 26 end of month]**

<u>Age</u>						<u>End of Month</u>	
<b>30</b>	0.0%	n/a	n/a	n/a	7.0%	0.0%	7.0%

SERFF Tracking Number: GRPH-127320298 State: New York  
 Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
 Company Tracking Number:  
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.004F Small Group Only - HMO  
 Maintenance (HMO)  
 Product Name: Healthy New York HMO  
 Project Name/Number: 2012 Rate Increase/

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)		

**Comments:**  
 The checklist for this submission is included in the file attached below.

**Attachment:**  
 Checklist 2012 GHIHMO HNY.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Actuarial Memorandum/Actuarial Certification		

**Comments:**  
 The actuarial memorandum and certification for this submission are included in the first file attached below. The supporting exhibits are included in the subsequent files.

**Attachments:**  
 GHI HMO Act Memo&Cert HNY.pdf  
 GHI HMO HNY Supporting Exhibits.xls

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Standard Exhibit 1 - General Information		

**Comments:**  
 Exhibit 1 for this submission is included in the file attached below.

**Attachment:**  
 GHI\_HMO\_Ex\_1\_HNY.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Standard Exhibit 2 - FOIL		

SERFF Tracking Number: GRPH-127320298 State: New York  
 Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
 Company Tracking Number:  
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.004F Small Group Only - HMO  
 Maintenance (HMO)  
 Product Name: Healthy New York HMO  
 Project Name/Number: 2012 Rate Increase/  
 Exemption Request

**Comments:**

exhibit 2 for this submission is included in the file attached below.

**Attachment:**

GHI\_HMO\_Ex\_2\_HNY.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Standard Exhibit 3 - Narrative  
Summary

**Comments:**

Exhibit 3 for this submission is included in the file attached below.

**Attachment:**

GHI\_HMO\_Ex\_3\_HNY.pdf

**Item Status:** **Status**  
**Date:**

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

**Comments:**

Exhibit 4 for this submission is included in the file attached below.

**Attachments:**

GHI\_HMO\_Ex\_4\_HNY.pdf

GHI\_HMO\_Ex\_4\_HNY.xls

**Item Status:** **Status**  
**Date:**

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

**Comments:**

Exhibit 5 for this submission is included in the file attached below.

**Attachments:**

GHI\_HMO\_Ex\_5\_HNY.pdf

SERFF Tracking Number: GRPH-127320298 State: New York  
 Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
 Company Tracking Number:  
 TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.004F Small Group Only - HMO  
 Maintenance (HMO)  
 Product Name: Healthy New York HMO  
 Project Name/Number: 2012 Rate Increase/  
 GHI\_HMO\_Ex\_5\_HNY.xls

**Item Status:** **Status Date:**

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

**Comments:**  
 Exhibit 6 for this submission is included in the file attached below.

**Attachment:**  
 GHI\_HMO\_Ex\_6\_HNY.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Standard Exhibit 7 - Historical Data

**Comments:**  
**Attachments:**  
 GHI\_HMO\_Ex\_7\_HNY.pdf  
 GHI\_HMO\_Ex\_7\_HNY.xls

**Item Status:** **Status Date:**

**Satisfied - Item:** Initial Notice of Proposed Rate Adjustment

**Comments:**  
 A sample copy of the initial notice is included in the file attached below.

**Attachment:**  
 GHIHMO HNY Sample Initial Notice.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Final Notice of Proposed Rate Adjustment

**Comments:**  
 A sample copy of the final notice is included in the file attached below.

SERFF Tracking Number: GRPH-127320298 State: New York  
Filing Company: GHI HMO Select, Inc. State Tracking Number: 2011070136  
Company Tracking Number:  
TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.004F Small Group Only - HMO  
Maintenance (HMO)  
Product Name: Healthy New York HMO  
Project Name/Number: 2012 Rate Increase/

**Attachment:**

GHIHMO HNY Sample Final Notice.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Commission Schedule

**Comments:**

The GHI HMO commission schedule is included in the file attached below.

**Attachment:**

GHI HMO Comm Sched.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Underwriting Guidelines

**Comments:**

The underwriting guidelines for these products are included in the file attached below.

**Attachment:**

GHI HMO UW Guidelines 8 11 10.pdf

## NEW YORK INSURANCE DEPARTMENT

### 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 5/24/2011

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 as described in Section 4317(a) of the Insurance Law. 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 as described in Section 4317(a) of the Insurance Law. 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 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

## NEW YORK INSURANCE DEPARTMENT

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

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 recent 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 2011; a benefit revision is submitted January 2011 to be effective July 1, 2011; this form and rate filing can include rolling rate tables for third and fourth quarter 2011, but not beyond fourth quarter 2011).

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.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
<b>DEFINITIONS</b>	a.	<p><b>Company</b> refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing.</p> <p>b. A company’s <b>commercial book of business</b> 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.</p> <p>c. <b>Loss ratio</b> 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</p>	

NEW YORK INSURANCE DEPARTMENT

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>lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses. Earned premiums <u>do not include</u> any adjustment for assessments or taxes.</p> <p>d. <b>Market segment</b> refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc.</p> <p>e. <b>Product street name</b> 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.</p> <p>f. <b>Rate applicability period</b> refers to the length of time in which the rates in a rate table are assumed to remain in effect.</p> <p>(i) Example 1: A non-rolling rate table is developed to be effective January 1, 2012 and is expected to be revised January 1, 2013. The rate applicability 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. <b>Standardized earned premium</b> 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).</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3<sup>rd</sup> and 4<sup>th</sup> quarters 2011 and 1<sup>st</sup> and 2<sup>nd</sup> quarters 2012. The 2<sup>nd</sup> quarter 2011 rates have already been approved. Therefore, the 2<sup>nd</sup> quarter 2011 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2<sup>nd</sup> quarter 2011 rate level. If the 2<sup>nd</sup> quarter 2011 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, 2011 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 2010 rate for plan design A is \$100, the first quarter 2011 rate is \$116.99, and the second quarter 2011 rate is \$121.67. These increases reflect</p>	
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**NEW YORK INSURANCE DEPARTMENT**

**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>no revision to the underlying covered benefits. The second quarter 2011 rate table is the standard rate level. Contract X was paying \$100 per month for January-December 2010. At renewal January 1, 2011, 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 2011 and later. The second quarter 2011 rate for plan design A is \$121.67 and the second quarter 2011 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 2010 is standardized to the second quarter 2011 level by adjusting by 121.67/100.00, and the January 2011 earned premium is standardized to the second quarter 2011 level by adjusting by 115.58/111.14.</p>	
<p><b>ROLLING RATE STRUCTURE</b></p>	<p>a.</p>	<p>Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates).</p> <p>b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period.</p> <p>c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates).</p>	<p>See Rate/Rule Schedule tab in SERFF submission.</p>
<p><b>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</b></p>	<p>a.</p>	<p>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.</p> <p>b. A company can revise a previously approved non-rolling rate table provided that:</p> <p>(i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or</p> <p>(ii) The proposed effective date of the rate table is at least 6 months after the 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.</p> <p>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)</p>	<p>See Rate/Rule Schedule tab in SERFF submission.</p>

**NEW YORK INSURANCE DEPARTMENT**

**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 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 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2011. The company can not revise the 1<sup>st</sup> and 2<sup>nd</sup> quarter 2011 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3<sup>rd</sup> and 4<sup>th</sup> quarter 2011 and 1<sup>st</sup> and 2<sup>nd</sup> quarter 2012.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened.</p>	
<p><b>STANDARD EXHIBITS 1 - 7</b></p>	<p>Introduction</p>	<p>Exhibits 1 through 7 must be submitted as part of each rate adjustment application. For some of the exhibits the format is defined, while for other exhibits the format is illustrative and the company will need to tailor the material included for the specific rate submission.</p>	
<p><b>Exhibit 1</b></p>		<p><b>General information about the rate adjustment submission.</b></p> <ol style="list-style-type: none"> <li>The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit.</li> <li>For Type of Insurer, select from the drop down list (HMO, Article 42, Article 43) or make an entry.</li> <li>For “For Profit” or “Non Profit” click on the applicable box and a check mark will appear.</li> <li>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 1/1/2012 effective date would imply that the first renewal cohort affected by the rate submission would be January 2012.</li> <li>Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected.</li> <li>This exhibit may be submitted as an Adobe PDF file or as an Excel file.</li> </ol>	<p>See Supporting Documentation tab of SERFF submission.</p>
<p><b>Exhibit 2</b></p>		<p><b>FOIL Exemption Request.</b></p> <ol style="list-style-type: none"> <li>A request that the Department exempt from public disclosure any information included in this rate submission, pursuant to New York Public Officers Law Section 87(2)(d) (the “Trade Secret/Competitive Injury Exemption”), must be made by completing this exhibit.</li> <li>A request that the Department apply the Trade Secret/Competitive Injury</li> </ol>	<p>See Supporting Documentation tab of SERFF submission.</p>

**NEW YORK INSURANCE DEPARTMENT**

**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>Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department.</p> <p>c. In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to protect the exempt information. Therefore, the Company should submit to the Department both the original document and a redacted version of the original document, which omits or blocks the information it wishes to exempt from disclosure. The Department will accept the redacted version of the original document within one week after the original rate filing was submitted.</p> <p>d. The exhibit format is illustrative but the company must include the information indicated in sections A, B, C, D and E. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file.</p> <p>e. Enter in section A the insurer information requested.</p> <p>f. Enter in section B the information requested regarding the FOIL contact person at the company.</p> <p>g. Enter in section C the list of documents, exhibits and attachments separately, including the file names of the computer files that are included with the application. Indicate with an asterisk (*) those documents that the company believes contains information subject to the Trade Secret/Competitive Injury Exemption. Any document without an asterisk will be deemed to be a public document.</p> <p>h. Enter in section D the list of all documents, exhibits, and attachments, of which a portion has been redacted, including the file names of computer files that are included with the application. The unredacted portion(s) of the redacted documents may be deemed to be public.</p> <p>i. Enter in section E the statement of necessity. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that:</p> <ul style="list-style-type: none"> <li>(i) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied;</li> <li>(ii) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and</li> <li>(iii) where applicable, indicates where redactions would suffice to protect the exempt information.</li> </ul>	
<b>Exhibit 3</b>		<p><b>Narrative Summary.</b></p> <p>a. The format of the exhibit is illustrative, but must include the required material. The</p>	

**NEW YORK INSURANCE DEPARTMENT**

**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 may be submitted as a Word document file, an Adobe PDF file, or an Excel file.</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 on its website. Any changes to the narrative summary subsequent to the posting are to be submitted to the Department.</p> <p>e. The narrative summary should include, but not be limited to, the following information:</p> <p>(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.</p> <p>(ii) A summary of the proposed rate adjustments. This can be a range as long as the range is consistent with the range(s) stated in the initial notice to policyholders for the various products and rating regions. A range can be no wider than five percentage points.</p> <p>(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).</p> <p>(iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples:</p> <p>(a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy.</p> <p>(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.</p> <p>(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.</p> <p>(vi) An explanation, in plan 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> <p>Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	<p>See Supporting Documentation tab of SERFF submission.</p>
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**NEW YORK INSURANCE DEPARTMENT**

**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><b>Exhibit 4</b></p>		<p><b>Summary of Proposed Percentage Rate Change to Existing Rate.</b></p> <p>a. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission.</p> <p>b. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is essentially fixed, but additional rows can be inserted as needed or additional tabs for several such exhibits can be added to the workbook.</p> <p>c. 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 2012 issues and renewals. The rate change would be the percentage change from the second quarter 2011 rates to proposed second quarter 2012 rates.</p> <p>Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2012. The prior rate application included quarterly rolling rates for each quarter of 2011. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2011 before all the third and fourth quarter 2011 renewals have taken place. The proposed percentage change for fourth quarter 2012 would be the change from the fourth quarter 2011 rates to the proposed fourth quarter 2012 rates.</p> <p>d. 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.</p> <p>e. The weighted averages may be based on membership instead of premium volume.</p> <p>f. The values entered in Sections A and B 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 Section A. If the drug rate is a separate rate table associated with a drug rider, then the medical changes are shown in Section A and</p>	<p>Exhibits 4 and 5:</p> <p>See Supporting Documentation tab of SERFF submission.</p>
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**NEW YORK INSURANCE DEPARTMENT**

**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 drug rider changes are shown in Section B.</p> <p>g. Section A summarizes 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 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.          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>h. Section B summarizes 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.          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.          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>i. A separate exhibit 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>j. Where rate changes differ by rating region within a market segment, separate exhibits are to be submitted by market segment/rating region combination.</p> <p>k. 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 2012, separate information should be submitted for section A and section B for the impact of the first quarter 2012 rate changes, the impact of the second quarter 2012 rate changes, the impact of the third quarter 2012 rate</p>	
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**NEW YORK INSURANCE DEPARTMENT**

**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>changes, and the impact of the fourth quarter 2012 rate changes.</p>	
<p><b>Exhibit 5</b></p>		<p><b>Distribution of Contracts Affected by the Proposed Rate Adjustments.</b></p> <ol style="list-style-type: none"> <li>a. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is essentially fixed, but the company can edit the worksheet to add more rows or tabs as needed.</li> <li>b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission.</li> <li>c. 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.</li> <li>d. The distribution basis can be by number of contracts or by number of members. The same basis is to be used for all products within a given rate adjustment submission. The company should indicate the distribution basis used (number of contracts or number of members). The weighted averages can be calculated using the distribution basis chosen instead of on premium volume.</li> <li>e. 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.</li> <li>f. Enter in section A the information for the various products that do not use a rolling rate structure.</li> <li>g. Enter in section B the information for the various products that use a rolling rate structure. Separate exhibits are to be prepared and submitted for each rolling rate cohort. For example, if the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2012, then separate section B information would be entered for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.</li> </ol>	
<p><b>Exhibit 6</b></p>		<p><b>Summary of Policy Form and Product Changes.</b></p> <ol style="list-style-type: none"> <li>a. This exhibit summarizes all rate changes filed pursuant to sections of the New</li> </ol>	<p>Supp. Documentation tab in SERFF filing.</p>

**NEW YORK INSURANCE DEPARTMENT**

**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>York Insurance Law other than Section 3231(e)(1) or Section 4308(c) that impact the policyholders affected by this rate adjustment submission and which affect the percentage changes shown on Exhibits 4 or 5.</p> <p>b. The format of the exhibit is essentially fixed. Extend the worksheet to add more rows as needed. This exhibit must be submitted as a Word document file or an Excel file, even if it is submitted as an Adobe PDF file.</p> <p>c. In section A, 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 submission. The actuarial memorandum should include a brief description of such changes, when the changes were implemented, and the impact on the rate changes in Exhibits 4 and 5.</p> <p>d. In section B, 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 form, product, or plan design option.</p> <p>e. In section C, list any “file and use” rate submissions which impact the rate tables in this filing. If the current rates were implemented by a file and use rate filing, and these current rates are being revised with this Section 3231(e)(1) or Section 4308(c) rate filing, or if the percentage changes reported in Exhibits 4 or 5 are impacted by a file and use filing, then list the applicable file and use rate filing(s).</p>	
<p><b>Exhibit 7</b></p>		<p><b>Historical Data by Each Policy Form Included in the Rate Adjustment Filing (formerly the Summary Template).</b></p> <p>a. This exhibit must be submitted as an Excel file even if it is also submitted as an Adobe PDF file. The format of the exhibit is fixed; add more columns to the right as needed; copy to additional tabs in the Excel workbook as needed to create additional exhibits.</p> <p>b. A separate exhibit is to be submitted for each rating pool (i.e., permitted aggregation of base medical policy forms). Create additional tabs as needed. Data is to be submitted 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.</p> <p>c. 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>d. Indicate for each base medical policy form the form number, the product name as in the rate manual, and the street product name. Also indicate the other base medical policy forms this form is aggregated with for rate setting. Add additional columns as needed. Add a rightmost column with aggregate values for the entire rating pool (for the appropriate rows). Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar</p>	

**NEW YORK INSURANCE DEPARTMENT**

**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>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 first 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 based on members. For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarters of 2012. Rates are for a 12 month period. Indicate the average rate change percentage from the 1<sup>st</sup> quarter of 2011 rate tables to the 1<sup>st</sup> quarter 2012 rate tables.)</p> <p>i. For the number of policyholders affected and the number of covered lives affected, 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, enter the expected loss ratio incorporated into the rate tables of the first rolling rate period of the rolling rate structure.</p> <p>k. The experience entered for the two indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.</p>	<p>See Supporting Documentation tab in SERFF submission.</p>
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**NEW YORK INSURANCE DEPARTMENT**

**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"> <li>(i) Each experience period is to be for 12 months (or shorter if a new form).</li> <li>(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, 2012. The recent experience period cannot have an ending date earlier than June 30, 2011, i.e., 12 months prior to July 1, 2012.).</li> <li>(iii) The prior period is the immediately prior 12 month experience period (or shorter period if a new form).</li> <li>(iv) The incurred claims for each of the two experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. 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.</li> <li>l. Enter the annual composite medical trend assumption used for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown.</li> <li>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 exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology is to be included as part of the actuarial memorandum. The same standard rate level is used for both of the experience periods.</li> <li>n. If the rating differential between the New York rating regions is being revised with this rate filing, separate versions of Exhibit 7 are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined.</li> </ul>	
<b>ACTUARIAL MEMORANDUM</b>	11NYCRR 52.40(a)(1)	Actuarial qualifications: <ul style="list-style-type: none"> <li>a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and</li> <li>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</li> </ul>	See Supporting Documentation tab in SERFF submission.
Justification of Rates	§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b)	<ul style="list-style-type: none"> <li>a. Description of proposed changes in rates, including the following:               <ul style="list-style-type: none"> <li>(i) The member 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</li> </ul> </li> </ul>	See Actuarial Memorandum and supporting exhibits in Supporting Documentation tab of SERFF submission.

**NEW YORK INSURANCE DEPARTMENT**

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

	11NYCRR 360.11	<p>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 Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months.</p> <p>(ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3<sup>rd</sup> quarter 2011. The change from each of the 2<sup>nd</sup> quarter 2011 rolling rate tables to the corresponding 3<sup>rd</sup> quarter 2011 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated.</p> <p>(iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment submission, 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 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</p>	
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NEW YORK INSURANCE DEPARTMENT

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>changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an 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:</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 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 2011 and first and second quarter 2012. Rates are for 12 month periods. Show the rates for the third quarter 2010, the proposed rates for the third quarter 2011, and the dollar and percentage change from third quarter 2010 to the proposed third quarter 2011 rates. Show a similar table for the proposed fourth quarter 2011, and first and second quarter 2012 rates as well.)</p> <p>d. Discuss the standard premium development used in Exhibit 7. See discussion above on 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</p>	
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NEW YORK INSURANCE DEPARTMENT

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>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> <ul style="list-style-type: none"><li>(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.</li><li>(iii) Discuss the credibility of such source data. Since the NAIC and HHS have adopted for the federal MLR rebate calculation 75,000 life years (900,000 member months) as required for full credibility and less than 1,000 life years (12,000 member months) as non credible, the credibility of the source data should be discussed consistent with these parameters.</li><li>(iv) Include an exhibit showing the source data and indicate all adjustments made 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.</li></ul> <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> <ul style="list-style-type: none"><li>(i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend.</li><li>(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.</li><li>(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.</li></ul> <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"><li>(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</li></ul>	
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**NEW YORK INSURANCE DEPARTMENT**

**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>a rolling rate structure, how the percentage change from the existing 2<sup>nd</sup> quarter 2011 rate table to the proposed 3<sup>rd</sup> quarter 2011 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.</p> <p>(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 3<sup>rd</sup> quarter 2011 rate table to the 4<sup>th</sup> quarter 2011 rate table). Provide justification for these changes between the rolling rate tables.</p> <p>(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.</p> <p>(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 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).</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</p>	
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**NEW YORK INSURANCE DEPARTMENT**

**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 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. Indicate for each permitted policy form aggregation, within each rating region aggregation, the non-claim expense components incorporated into the current premium rates and into the proposed premium rates as a percentage of gross premiums and as \$pmpm. This is to be shown for the non-rolling rate tables and/or the first rate table of each rolling rate structure. Include the following components:</p> <ul style="list-style-type: none"> <li>(i) Regulatory authority licenses and fees, including New York State 332 assessment expenses;</li> <li>(ii) Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplemental Health Care Exhibit;</li> <li>(iii) Commissions and broker fees;</li> <li>(iv) Premium taxes;</li> <li>(v) Other administrative expenses;</li> <li>(vi) After-tax underwriting margin (profit/contribution to surplus);</li> <li>(vii) State income taxes (and applicable state income tax rate);</li> <li>(viii) Federal income taxes (and applicable federal income tax rate);</li> <li>(ix) Reduction for net investment income, if any; and</li> <li>(x) Net of the above.</li> </ul> <p>Discuss how administrative expenses are allocated to the various market segments and product lines.</p>	
<p>Minimum Loss Ratio Requirements</p>	<p>§3231(e)(1)(B)          §4308(c)(3)          11NYCRR52.45(i)          11NYCRR59.5(b)</p>	<p>a. The minimum loss ratio for community rated products, other than the official Medicare 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.</p> <p>b. The minimum loss ratio for the official Medicare Supplemental products is:</p> <ul style="list-style-type: none"> <li>(i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance</li> </ul>	<p>Actuarial Memorandum and supporting exhibits in Supporting Documentation tab of SERFF submission.</p>

**NEW YORK INSURANCE DEPARTMENT**

**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>Law, as amended by Chapter 107 of the Laws of 2010; and</p> <p>(ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52).</p>	
Actuarial Certification	11NYCRR 52.40(a)(1)	<p>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</p> <p>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.</p> <p>c. The expected loss ratio 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.</p> <p>d. The benefits are reasonable in relation to the premiums charged.</p> <p>e. The rates are not unfairly discriminatory.</p>	See Supporting Documentation tab in SERFF submission.
<b>REVISED RATE MANUAL PAGES</b>	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	<p><b>Rate Manual.</b></p> <p>a. Table of contents.</p> <p>b. Rate pages, including a page indicating the composition of each rating region.</p> <p>c. Insurer/corporation name on each consecutively numbered rate page.</p> <p>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</p> <p>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</p> <p>f. Description of revised rating classes, factors and discounts, as applicable.</p> <p>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.</p> <p>h. Commission schedule(s) and fees.</p> <p>i. Underwriting guidelines and/or underwriting manual, to the extent applicable.</p> <p>j. Expected loss ratio(s).</p>	See Rate/Rule Schedule tab in SERFF submission.
<b>NOTICES TO POLICYHOLDERS Initial &amp; Final</b> Circular Letter No. XX (2011) Pending	§3231(e)(1)(A) §4308(c)(2)	<p>a. A sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Insurance Department.</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 Insurance Department.</p> <p>(ii) A range can be used to indicate the rate change provided that the range is no wider than 5 percentage points.</p> <p>(iii) 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>	See Supporting Documentation tab of SERFF filing.

**NEW YORK INSURANCE DEPARTMENT**

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

		b. A sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.	Supp. Documentation tab of SERFF filing.
<b>RATE FILINGS THAT ARE SUBJECT TO REVIEW</b>	PPACA §1003	HHS has defined a “rate filing that is subject to review” as any rate filing where the rate increase over the prior 12 months equals or exceeds a stated threshold. For rate filings that HHS has defined to be a “rate filing that is subject to review”, submit a copy of all documentation required to be submitted to HHS for such rate filing.	

# GHI HMO Select (GHI HMO)

## RATE FILING FOR HEALTHY NEW YORK ACTUARIAL MEMORANDUM

GHI HMO is submitting a prior approval rate filing for its Healthy New York HMO products. The proposed premium rates are based on a non-rolling rate structure with effective dates of January – December 2012 (CY12).

The proposed rates represent a 19.8% increase for 2012 over 2011 rates, which applies to all Small Group products and across all rate tiers.

Appendix A: Premium Rate Change outlines the rate increases for renewing groups as well as historical rate increase history. The impact of PPACA is included in the January 2011 premium rate change.

### Aggregation of Policy Forms

There is only GHI HMO Healthy New York Policy Form, so there is no aggregation.

The experience for these policy forms can be found in Exhibit 7: Historical Data. The GHI HMO Healthy New York policy aggregation is partially credible under NAIC guidelines. However, the Healthy New York policy aggregation is fully credible under HIP's filed experience-rated methodology.

### Justification

In order to calculate the quarterly rate increase needed for 2012 Healthy New York products, we compared the projected CY12 cohort medical claims with our target loss ratio to the 4<sup>th</sup> quarter 2011 Standardized Premium. The following chart shows how we developed our needed rate increase.

2010 Medical PMPM	240.76
2011 Projected Trend	19.2%
2012 Projected Trend	19.4%
1Q12 Cohort Projected Medical PMPM	347.95
Target Loss Ratio	82.0%
Required Premium PMPM	424.33
4Q11 Standardized Premium	295.23
Needed Rate Increase	43.7%
Proposed Rate Increase	19.8%

Using a target loss ratio of 82%, this methodology produces a needed increase of 43.7% increase over 2011.

As mentioned above, we are proposing a 19.8% annual increase for 2012. This increase will be applied to all Healthy New York Products across and all rate tiers.

There is no change to the tier structure relationships or conversion factor used to convert PMPM results to subscriber results included in this rate filing.

### **Description of Provider Networks and Benefits**

GHI HMO's provider network consists of a fee-for-service network (FFS).

### **Source Data**

The source data for this filing is experience from January 2010 through December 2010 with recast adjustments to reflect claims run out through April 2011. The prior experience period is January 2009 through December 2009 with recast adjustments through April 2010.

The buildup of the projected claims is shown in Appendix B: Source Data. We start with the base experience paid through 12/31/2010 and then adjust for recast based on paid claims from 1/1/2011 through 4/30/2011. The recast adjusted base experience was then projected 12 months using 2011/2010 trends, and 13 months using 2012/2011 trends. In addition to trends, 2010, 2011 and 2012 experience have also been adjusted by the New York Stop Loss Fund payments.

### **New State Stop Loss Fund:**

Healthy New York – On June 30, we received notification from Alicare that our Total Payment from the Stop Loss Fund for 2010 will be \$1,460,194. This represents approximately 78% of our total 2010 paid claims which fell within the stop loss corridor. This is converted to a 2010 PMPM value of \$101.57.

Because we expect continuing decline in payout percentages from the pool to offset any positive trend in claim cost, we apply a 0% trend to pools payments for both 2011 and 2012.

These anticipated credits are a component of the 2012 medical expense.

### **Trends**

As noted above, the trends used to project the base experience two years are segmented into two time periods. Using projected 2012 member months, in aggregate they produce a 19.2% trend for 2011 and a 19.4% trend for 2012 for Healthy New York.

### **Medical Fee For Service Trends**

The 2010 through 2012 trends used in the claim projections for claims paid on a fee for service basis are summarized in Appendix E. This section splits the total trend into utilization and unit cost trends for the following claim types:

- Inpatient claims for members in the FFS network
- Outpatient claims for members in the FFS network
- Professional claims for members in the FFS network\*

Due to the lack of credibility for the smaller coverages (i.e. the Healthy New York), note that the equivalent HIP Health Plan of New York trends was used as the basis for projected trend assumptions for all Community Rated lines of business. For example, the GHI HMO Healthy New York projected trends were based on the HIP Health Plan of New York Healthy New York projected trends.

In Appendix E, we have displayed actual 2010/2009 medical expense PMPM trends. The exhibit includes all HIP and HIPIC commercial business but only the HIP Healthy New York trends are used for this filing. Note that these trends are based upon calendar year incurred data with three months of runoff.

The development of the 2011 and 2012 projected trend is discussed below:

#### Contracted Cost:

- **Facility:** The contracted cost trend component for inpatient and outpatient services was determined using expected contracted increases for our most frequently utilized facilities, and determining a composite increase weighted by 2010 provider-specific dollar weights. The facility specific increases are displayed in Appendix F-1 for inpatient facilities and Appendix F-2 for outpatient facilities.
- **Professional:** For our physician services, we assumed a 2.0% contracted cost increase for 2011 and a 4.8% contracted cost increase for 2012. Appendix F-3 provides provider specific 2011 increases. HIP has many professional fee schedules. Our direct schedule, which mainly applies to independent and small physician groups, has a majority of CPT-4 code payment amounts tied to RBRVS values. We also have many fee schedules which are negotiated with larger IPA physician groups. These typically provide for a mixture of CPT codes paid at stated percentages of RBRVS as well as some CPT codes paid at negotiated levels.
- **Pharmacy:** For Rx claims, we analyzed emerging ingredient cost trend for our community rated commercial products -- see Appendices G-1 and G-2 which show 2009 and 2010 drug experience by product at various levels of detail. 2010 ingredient cost trend was 7.4% for 2010. Projected 2011 contracted cost trend are expected to emerge at 5% and 2012 should emerge somewhat lower at 4%.

**Utilization:** The 2011 and 2012 utilization components for all service types were based on the actual 2010 utilization.

**CMI/Age Sex:** This component is to account for the aging of the covered population and the increase in the intensity of services beyond what is accounted for in the aging. Appendix H calculates the impact that aging has had over time.

For each product, composite medical trends were applied using the following formula to derive the claims PMPM projections:

$$1Q12 \text{ claims PMPM} = [2010 \text{ PMPM}] * [1 + 2011 \text{ trend \%}] * [1 + 2012 \text{ trend \%}]^{(13/12)}$$

$$2Q12 \text{ claims PMPM} = [1Q12 \text{ claims PMPM}] * [1 + 2012 \text{ trend \%}]^{(3/12)}$$

$$3Q12 \text{ claims PMPM} = [2Q12 \text{ claims PMPM}] * [1 + 2012 \text{ trend \%}]^{(3/12)}$$

$$4Q12 \text{ claims PMPM} = [3Q12 \text{ claims PMPM}] * [1 + 2012 \text{ trend \%}]^{(3/12)}$$

### Implementation of Trends

The base experience PMPMs (January 2010 – December 2010) broken into expense categories were trended forward 12 months using the 2011/2010 trends discussed above. Once a 2011 level was established we trended the 2011 PMPMs by the 2012/2011 trends for 13 months which result in the projected PMPMs (January 2012 – March 2013).

### Standardized Premium Development

Appendix C: Standardized Premium provides the support for the development of standardized premiums for the experience periods.

#### Standardized Premium Development

For the Base Experience, factors for each policy form and market segment grouping were developed to determine the relationship between Base Earned Premiums and December 2011 Standardized Premiums. All rates used in this development were from the 2008 through 2012 GHI HMO Rate Manual base rates, and it was assumed that rate increases applied to base rates were reflective of rate increases applied to total premium which includes both base rate premium and rider premium.

In this development, January 2009 – December 2009 Average Weighted Base Rates were used as a proxy for the prior base period Earned Premium PMPMs. These were developed first by calculating a blended base rate for each month of renewal. For example, for a February 2009 renewal, the average prior period rate reflects one month of the 1<sup>st</sup> Quarter 2008 Base Rate and 11 months of the 1<sup>st</sup> Quarter 2009 Base Rate as displayed below:

$$\text{February 2009 Average Rate} = [(1 * \text{Q1 2008 Base Rate}) + (11 * \text{Q1 2009 Base Rate})] / 12$$

Once the blended base rate premium was developed for each renewal month, these were assigned weights based upon the proportion of total premiums received by renewal month. This weighting of the blended base rates resulted in the prior period Average Weighted Base Rate.

The 4<sup>th</sup> Quarter 2011 GHI HMO Rate Manual base rates were then divided by the 2009 Average Weighted Base Rates to develop factors at the policy form and market segment level of detail described above. These factors were multiplied by the prior base period Earned Premium in order to calculate the Standardized Premium at the same level of detail and which are summarized in the Prior experience period section of the Summary template.

The same approach was used to develop factors measuring the relationship between 4<sup>th</sup> Quarter 2011 GHI HMO Rate Manual individual base rates and the base period Average Weighted Rates. These factors were similarly applied to the January 2010 – December 2010 Earned Premiums in order to develop the Standardized Premium in the Most Recent experience period section of the Summary template.

Note that the Standardized Premium calculation does not reflect shifts in membership or changes in underlying benefits experienced over the last several years.

**Expected Loss Ratios**

Based upon the trend development outlined above and the proposed premium increases, the expected loss ratios for Healthy New York are as follows:

1Q12	98.4%
2Q12	102.8%
3Q12	107.5%
4Q12	112.4%

**Administrative Expenses**

The table below displays projected 2011 GHI HMO Healthy New York administrative expense by component.

<b><u>2011 Admin</u></b>	<b>% of Prem</b>	<b>PMPM</b>
Regulatory authority fees	0.9%	2.60
Health care quality admin	0.3%	0.83
Commissions	1.4%	4.17
Premium Taxes	1.5%	4.43
Other Admin	14.1%	41.64
State income Taxes	0.0%	-
Federal income taxes	0.0%	-
Reduction for net investment income	0.0%	-
<b>Net</b>	<b>18.2%</b>	<b>53.66</b>

The table below displays projected 2012 GHI HMO Healthy New York administrative expense by component. We have added provision for contribution to surplus, risk charge, and after tax underwriting margin.

<b>2012 Admin</b>	<b>% of Prem</b>	<b>PMPM</b>
Regulatory authority fees	0.9%	\$3.81
Health care quality admin	0.3%	\$1.22
Commissions	1.4%	\$6.12
Premium Taxes	1.5%	\$6.50
Other Admin	14.1%	\$61.15
Statutory contribution to surplus	0.0%	\$0.00
Risk charge	0.0%	\$0.00
After Tax UW margin	0.0%	\$0.00
State income Taxes	0.0%	\$0.00
Federal income taxes	0.0%	\$0.00
Reduction for net investment income	0.0%	\$0.00
<b>Net</b>	<b>18.2%</b>	<b>\$78.80</b>

#### **EmblemHealth Administrative Expense Allocation Process**

Activities produce administrative expenses (Admin), which are either indirectly or directly related to the consumer (internal or external) receiving them. Therefore, we allocate a business unit's (BU) Admin down to a consumer level. As consumers are tied directly to a line of business (LOB), market (Mkt) and delivery system (DS); we are able to allocate our Admin to this level of detail based on activities of said business unit. This is done through a set of drivers or business metrics recorded during the reporting period. These drivers "track" activities based on the activity focused on (i.e. Billing may use Revenue).

The Activity Based Costing (ABC) model is focused on the activities incurred by specific cost centers (CC). A cost center is defined as a "department" or "sub-department" which may contain one or more activities related to the overall business objective of the BU. A cost center's activities are determined based on its respective business partner management. CCs are divided into two distinct categories "direct" or "supporting/indirect". A direct CC generally services an external customer and focuses on meeting the objectives of the BU whether this be claims processing, billing, marketing, etc. An indirect CC generally services the BU as a whole or specific direct cost centers examples would include Finance, Human Resources or IT.

An important attribute of the ABC model is the customization component. Certain CCs focus heavily on specific LOBs. The ABC model takes this into consideration. For example, there may be multiple Marketing CCs each focused on a specific segment of business. The model allows for restrictions to be placed on CC activities that would allow expenses to only be allocated to specific LOBs. Additionally, CCs which weigh heavily in a certain Mkt or LOB may have a weight adjustment driver or weighed activities. These drivers' formulas are based on senior management's direction and allow the allocation to correspond to the business the CC performs.

Initial costs are assigned directly to a CC and BU. From this point indirect CC costs are processed to direct CCs based on a series of indirect drivers (HR may use FTEs, Finance may use Total BU Expenses). After this first allocation is done, the expenses are considered fully loaded and reside solely in direct CCs. This is where the business managers' logic in conjunction with the driver metrics is utilized. Expenses are then allocated to the LOB, Mkt and DS levels based on the driver information.

### Summary

The proposed increase of 19.8% for 2012 over 2011 is reasonable given the items presented in this narrative. The increase is driven by increases in health care cost and utilization.

### Actuarial Certification

I certify that the premium rates derived according to the above methodology are reasonable in relation to the benefits provided, and make adequate provision for both the claim costs and administrative expense costs associated with these plans, and are not unfairly discriminatory. I further certify that to the best of my knowledge, this filing is in compliance with all applicable laws and regulations of the State of New York, and is also in compliance with Actuarial Standard of Practice number 8.

The anticipated loss ratios for the Small Groups receiving the premium rates proposed under this rate filing are in excess of the 82% applicable to this business under New York State requirements.

All required information as specified in the Insurance Department's "Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law" are included in this SERFF submission under the "Supporting Documentation" tab. Please refer to Standard Exhibit 2 to identify which portions of this rate filing are subject to Article 6 of the New York Public Officer's Law (FOIL).

Please let me know if there are any questions or if any additional information is needed.



Senior Director, EmblemHealth Actuarial Services  
July 19 2011

## EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	GHI HMO Select, Inc. <small>Company submitting the rate adjustment request</small>	HMO <small>Type of insurer</small>	<input checked="" type="checkbox"/> For Profit  <input type="checkbox"/> Non Profit  95835 <small>Company NAIC Code</small>
	55 Water St. New York, NY, 10041 <small>Company mailing address</small>		
B. Contact Person:	[REDACTED] <small>Rate filing contact person name, title</small>	[REDACTED] <small>Contact phone number</small>	[REDACTED] <small>Contact Email address</small>
C. Actuarial Contact (If different from above):	 <small>Actuary name, title</small>	 <small>Actuary phone number</small>	 <small>Actuary Email address</small>
D. New Rate Information (See Note #1):	1/1/2012-12/31/2012 <small>New rate applicability period</small>	01/01/2012 <small>New rate effective date</small>	GRPH-127320298 <small>SERFF Tracking Number</small>
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	Healthy NY		
F. Provide responses for the following questions:	<b>Response</b>		
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No		
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No		
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Yes		
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes		

**Notes:**

(1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date. 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.

## EXHIBIT 2: FOIL EXEMPTION REQUEST

**Instructions:**

1. A request that the New York State Insurance Department ("Department") exempt from public disclosure any information included in this submission, pursuant to New York Public Officers Law § 87(2)(d) (the "Trade Secret/Competitive Injury Exemption"), must be
2. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department.
3. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that:
  - (a) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied;
  - (b) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and
  - (c) where applicable, indicates where redactions would suffice to protect the exempt information.
4. In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to prot

**A. Insurer Information:**      GHI HMO Select, Inc.      95835      GRPH-127320298  
Company submitting the rate adjustment request      Company NAIC Code      SERFF tracking number

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

[REDACTED]      [REDACTED]  
Mailing address      Fax number

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

We request that the actuarial memorandum accompanying this application, signed by [REDACTED] to be exempt from disclosure pursuant to FOIL in its entirety.

We request that a portion of Exhibit 4, Exhibit 5, Exhibit 6 and Exhibit 7, and any computer files referenced therein, be deemed exempt from disclosure under FOIL as set forth in the redacted version of these exhibits submitted on July 22, 2011, after the initial application, as instructed above. A more detailed list of exhibits, computer files and attachments will be provided at that time with a revised version of this Exhibit 2.

**D.** Provide a separate list of all documents, exhibits, and attachments, of which a portion has been redacted, including the file names of See response to item C above.

**E.** Statement of necessity as discussed in Instructions # 3, above.

All of the items listed in the items C and D above related to the GHI HMO community rated product application contain trade secret information, which if disclosed would cause substantial injury to the competitive position of GHI HMO. The exhibits to the rate application listed above contain the claims data, medical loss ratio information, along with the proposed rates. The supporting exhibits set forth the claims experience by product, forms and the trend over the past two years. Both the presentation and data provided are not available at this level of detail by product in any other disclosure or regulatory filing. Release of such information to competitors would permit them to price products and target markets in a way that causes clients of GHI HMO's current book of business to shift to other plans.

The actuarial memos referenced above, summarize the overall rate impact across all products in the community rated category. As with the schedules discussed above, this information is not available through any other public or regulatory disclosure. Revealing this information will permit competition to access the overall financial performance of GHI HMO's community rated products. This information may be used by competition to market to the disadvantage of GHI HMO.

## **INFORMATION ABOUT YOUR 2012 GHI HMO HEALTHY NEW YORK RATES**

GHI HMO is a part of the EmblemHealth group of companies. It is a for-profit health service corporation organized under Article 44 of the New York Insurance Law to provide coverage for the costs of health care. The income generated is used to benefit members, either as claim payments or to provide administrative services to operate the company, which serves approximately 4,400, of which about 950 are GHI HMO Healthy New York members.

### **The Components of Your Premium Rate**

Your premium rate consists of two components: the costs associated with providing medical care and administrative expenses. By far, the largest component is the cost of medical care. Medical costs are represented in the minimum loss ratio (MLR). This is the percentage of the premium used to pay for medical care. New York State law requires that the MLR must be at least 82 percent of the premium charged.

Administrative expenses include: costs for processing claims and appeals; maintenance and upgrading of systems needed to comply with HIPAA, federal health reform mandates and other legal requirements; costs for consumer education, wellness programs and programs for managing chronic and complex medical conditions; costs of maintaining our provider network; costs to operate Web-based information and services for members and providers; costs associated with conducting medical reviews; taxes and other fees.

Before we apply for a rate increase, we thoroughly review claims data and expenses to determine future costs and expenses.

### **The Components of Our 2012 Rate Increase**

GHI HMO is requesting a premium rate increase for its GHI HMO Healthy New York business, which would become effective on your plan's 2012 policy renewal date. The reason for the requested rate increase is that health care costs have risen dramatically during the past year. The major factors driving rising health care costs are: the increased use of health care services; the growing needs of an aging population that is to a larger extent living with chronic conditions; and the development of costly new medical technologies and prescription drugs. If this premium rate increase is approved, it will be added to your 2011 renewal premium rate. This increase will apply to all GHI HMO Healthy New York plans renewing during 2012.

The premium rate increase we are requesting is shown below.

**Percent Increase from 2011 to 2012: 19.8%**

**Final Rate Increase**

Your final renewal rate may be different from the proposed increase shown above. NYSID may approve, modify or deny this adjustment. We will notify you of your final, approved rate approximately 60 days before your renewal date

At this time, we have not filed any benefit changes to these plans with the New York State Insurance Department (NYSID). In the event that we file benefit changes to this plan — for example, due to new benefits mandated by New York State law — those benefit changes may also impact your final premium rate.

**2 of 2 pages**

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

- => Use this Exhibit for the policy forms/products included in the rate adjustment submission.
- => Submit separate exhibits by market segment such as Large Group, Small Group, Sole Proprietor, Individual, etc. If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor is t
- Submit separate exhibits by rating region if the rate changes differ by rating region.  
Submit separate exhibits for each rolling rate table of a rolling rate structure.
- => This form must be submitted as an Excel file, even if a version is submitted as a PDF file.
- => 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).
- => If one policy form is used for more than one products, then a separate row should be entered for each policy form/product name/product street name combination.
- => The format of this exhibit is discussed below and should be tailored to the specific rate filing submission. Extend the worksheet to add more rows or tabs as needed.

Group Health Inc. HMO  
Company submitting the rate adjustment request

95835  
Company NAIC Code

GRPH-127320298  
SERFF tracking number

**A. BASE MEDICAL PLAN**

- Market Segment:** Healthy New York => Provide a list of proposed rate changes for each base medical plan type, by product name/street name.
- Rating Region:** All => The "proposed rate change" is just for the base medical product, excluding the impact of any riders.
- Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
  - Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
  - The weighted average should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

**Non Rolling Rate Product**

Policy Form #	Product Name	Product Street Name	Effective Date of New Rate	Proposed Percentage Rate Change		
				Lowest	Highest	Weighted Avg
GHI HMO HNY-GRI-2001	Healthy New York	Healthy New York	1/1/2012 - 12/31/2012	19.8%	19.8%	19.8%

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

**B. DRUG RIDERS**

- Market Segment:** \_\_\_\_\_ => Provide a list of proposed rate changes for drug riders available with base medical products.
- Rating Region:** \_\_\_\_\_ => 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.

**Non Rolling Rate Product**

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



## EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

**Company Name:** GHI HMO Select, Inc.

**NAIC Code:** 95835

**SERFF Number:** GRPH-127320298

**Instructions:**

- This Exhibit summarizes all benefit/rate changes filed with the Health Bureau's Albany office 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).
- Extend the worksheet to add more rows as needed.

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

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date

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

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change

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

SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Benefit/Rate Change Effective Date

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

**Company Name:** GHI HMO Select, Inc.  
**NAIC Code:** 95835  
**SERFF Number:** GRPH-127320298

- A. Complete a separate response for each base medical policy form included in the rate adjustment filing.
  - Information requested applies to New York State business only.
  - Include riders that may be available with that policy form in each policy form response.
  - Submit a separate exhibit for each rating pool. Create additional tabs for each rating pool as needed.
  - Append additional columns to right of the existing columns (as needed) to include all base medical policy forms included in that rating pool. Add a rightmost column with the aggregate values for that entire rating pool.
- B. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Driven 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.
- C. 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).
- D. Note that many cells include a drop down list. Use the drop down list or enter applicable items.
- E. If members, covered lives or member months are not known, use reasonable estimates (note methodology used).
- F. This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

Data Item for Specified Base Medical Policy Form	Response
1a. Base medical policy form number	GHI HMO HNY-GRI-2001
1b. Product Name as in Rate Manual	Healthy New York
1c. Product Street Name as indicated to consumers	Healthy New York
2. Aggregated for rate development with these base medical policy form numbers	GHI HMO HNY-GRI-2001
3. Effective date of rate change (MM/DD/YYYY)	1/1/2012
4. Market Segment (large group, small group, individual, or sole proprietor) [drop down menu]	Healthy New York
5. Product type (see above for examples) [drop down menu]	HMO
6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	No
7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	No
8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	Open
9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.)	12
10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	19.80%
11. Number of policyholders affected by rate change. For group business this is number of groups.	580
12. Number of covered lives affected by rate change	951
13. Expected NY statewide loss ratio for base medical policy form including associated riders	96.0%

Data Item for Specified Base Medical Policy Form	Response
<b>Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)</b>	
14.1 Beginning Date of the experience period (MM/DD/YYYY)	1/1/2010
14.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2010
14.3 Member months for experience period	14,376
14.4 Earned premiums for experience period (\$)	4,186,601
14.5 Standardized earned premiums for experience period (\$)	4,244,168
14.6 Paid claims for experience period (\$)	3,266,839
14.7 Incurred claims for experience period (\$)	3,461,155
14.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	1,721,888
14.9 Earned premiums for experience period (\$mpm)	291.22
14.10 Standardized premiums for experience period (\$mpm)	295.23
14.11 Paid claims for experience period (\$mpm)	227.24
14.12 Incurred claims for experience period (\$mpm)	240.76
14.13 Administrative expenses for experience period (\$mpm) (including commissions and premium taxes, but excluding federal and state income taxes)	119.78
14.14 Ratio: Incurred Claims / Earned Premiums	0.827
14.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.816
14.16 Ratio: Administration Expenses / Earned Premiums	0.411
14.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	1.238
<b>Prior Experience Period (NY statewide experience, base medical policy form + associated riders)</b>	
15.1 Beginning date of the experience period (MM/DD/YYYY)	1/1/2009
15.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2009
15.3 Member months for experience period	18,177
15.4 Earned premiums for experience period (\$)	5,005,254
15.5 Standardized earned premiums for experience period (\$)	5,417,780
15.6 Paid claims for experience period (\$)	3,064,144
15.7 Incurred claims for experience period (\$)	3,282,855
15.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	704,438
15.9 Earned premiums for experience period (\$mpm)	275.36
15.10 Standardized premiums for experience period (\$mpm)	298.06
15.11 Paid claims for experience period (\$mpm)	168.57
15.12 Incurred claims for experience period (\$mpm)	180.60
15.13 Administrative expenses for experience period (\$mpm) (including commissions and premium taxes, but excluding federal and state income taxes)	38.75
15.14 Ratio: Incurred Claims / Earned Premiums	0.656
15.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.606
15.16 Ratio: Administrative Expenses / Earned Premiums	0.141
15.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.797

Data Item for Specified Base Medical Policy Form	Response
<b>Annualized Medical Trend Factors (%)</b>	
16.1 All benefits combined, composite	19.33%
16.2 Due to utilization	5.77%
16.3 Due to unit cost	12.82%
<b>Ratios: Most Recent Experience Period to Prior Period</b>	
17.1 Member months	0.791
17.2 Earned premiums (\$pmpm)	1.058
17.3 Standardized premiums (\$pmpm)	0.991
17.4 Paid claims (\$pmpm)	1.348
17.5 Incurred claims (\$pmpm)	1.333
17.6 Administrative expenses (\$pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	3.091
<b>Ratio: Standard Premium to Earned Premium</b>	
18.1 Most Recent Experience Period	1.014
18.2 Prior Experience Period	1.082



Administration  
PO Box 4332  
Kingston, NY 12402

**Advance Notice About Changes to Your  
GHI HMO Premium Rates**

<<Date>>

<<Group\_Name1>> <<Group\_Name2>>  
<<Contact Name>>  
<<Street Add 1>>  
<<City,>> <<State>> <<Zip Code>>

Dear <<Contact Name>>:

We are writing to let you know that we are applying to the New York State Insurance Department (NYSID) for rate changes to your GHI HMO Healthy New York group plan. If the changes are approved, your current premium rates will increase by 19.8%. Your new rates would take effect on your 2012 policy renewal date.

Any increase in your rates may be different from the percentage shown above. The Superintendent of Insurance may approve, modify or deny the proposed rate changes. We will notify you of your final, approved premium rates about 60 days before your 2012 renewal date.

To find information about the reasons for the proposed rate changes, please log on to [www.emblemhealth.com/2012rates](http://www.emblemhealth.com/2012rates). You can also submit written comments to us or NYSID within 30 days of the date of this letter:

**EmblemHealth**

PremiumRateFilings@emblemhealth.com

EmblemHealth  
Attn: Premium Rate Filings  
PO Box 2890  
New York, NY 10117-2087

**New York State Insurance Department**

PremiumRateIncreases@ins.state.ny.us  
**1-800-342-3736**

Health Bureau – Premium Rate Adjustments  
New York State Insurance Department  
25 Beaver Street  
New York, NY 10004

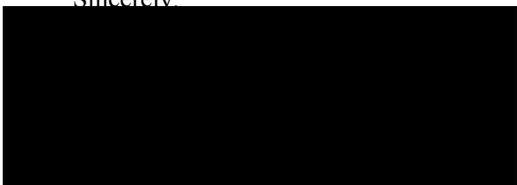
[www.ins.state.ny.us](http://www.ins.state.ny.us)

**Please notify your covered employees of the proposed rate changes and about the potential changes to their premium contribution as soon as possible after receiving this letter.**

Also, please note that you will receive a recertification form about 90 days before your renewal date.

We greatly value our relationship with you and look forward to continuing to meet your health coverage needs.

Sincerely,



Vice President  
Commercial Account Management

GHI\_GR\_HNY\_HMO\_LTR\_5488

GHI HMO is an EmblemHealth company.



**Important Information About Your  
GHI HMO Premium Rates**

<<Date>>

<<Group\_Name1>> <<Group\_Name2>>  
<<Contact Name>>  
<<Street Add 1>>  
<<City>>, <<State>> <<Zip Code>>

Dear <<Contact Name>>:

We recently mailed you a recertification form that you must complete and submit to us to certify your continued eligibility in the GHI HMO Healthy New York plan. We are writing to you now to give you your new premium rates, which will take effect <<Rate\_Eff\_Date>>.

Upon our approval of your recertification form, we will renew your GHI policy at the monthly rates shown below:

<u>Coverage</u>	<u>Renewal Rate</u>
Individual	<<INDIVIDUAL>>
Employee and Spouse	<<EMPLOYEE_AND_SPOUSE>>
Employee and Child(ren)	<<EMPLOYEE_AND_CHILDREN>>
Family (Employee, Spouse and Children)	<<FAMILY>>

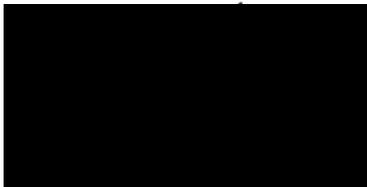
Please note that these rates reflect a XX% increase, as approved by the New York State Insurance Department (NYSID).

As a reminder, you are required to give your covered employees notice of this rate increase and any additional premium contribution as soon as possible after receiving this letter. If your benefit plan requires employees to make a premium contribution, the notice should include the amount your employees will be expected to contribute based on the new rates

If you have questions about your renewal or health coverage, please call Pat Kaniuka at **1-518-446-8075**, Monday through Friday, 9 am to 5 pm.

EmblemHealth is committed to providing access to quality health care at the lowest possible cost. We look forward to continuing to meet your health coverage needs.

Sincerely,



Vice President  
Commercial Account Management

**GHI HMO Healthy New York (Sample Final Notice)**

**GHI HMO Select Inc. (“GHI HMO”)  
441 Ninth Avenue  
New York, New York 10001**

**GHI HMO’s Commission and Fee Schedule**

This GHI HMO Commission and Fee Schedule ("Schedule") is effective January 1, 2006.

1. General Provisions.

The term “Group” as described herein shall mean a group of at least one insurable individual who is insured pursuant to one insurance policy consistent with New York law and GHI HMO’s underwriting policies and procedures. Commission is payable only so long as the Contracted Selling Agents, and/or General Agents (“Agent”) are continuously:

- a. Licensed to sell insurance;
- b. Contracted with GHI HMO as an Agent; and
- c. Servicing the Group in a manner satisfactory to GHI HMO and consistent with GHI HMO's policies and procedures.

2. Commissions.

1. Agents receive commission equal to 4% of the Group’s premium. For cases with no Agent involvement, no commission is payable. In addition, certain products do not pay commissions, currently including individual HNY products and Direct Pay products. There are no bonus programs for Agents applicable to GHI HMO coverage.

3. Administrative Fees.

This section describes alternative compensation available to Agents who perform administrative services normally performed by GHI HMO employees (“Administrative Services”). Such Administrative Services are compensated based upon a per contract per month methodology (“PCPM”). The PCPM amount is \$6 or \$13 PCPM, depending upon the scope and extent of the services provided, the experience and reputation of the Agent and negotiated market forces. Some of the more common Administrative Services are set forth below:

- i. Process insurance applications;
- ii. Bill, collect and receive premium due;
- iii. Generate and issue the appropriate termination documentation;
- iv. Generate and issue change in enrollment/eligibility forms;
- v. Perform routine services for Groups;
- vi. Recruit Selling Agents;
- vii. Provide other administrative functions, at GHI HMO’s discretion, consistent with GHI HMO policies and procedures; and
- viii. Provide appropriate reporting services.

As relates to Administrative Services currently performed by Agents, please note the following:

<b>Administrative Services Performed:</b>	<b>PCPM</b>	<b>Fee:</b>
Facilitate Agent recruitment and marketing on behalf of GHI HMO. This is the principal administrative service provided. In addition, these Agents provide other administrative functions including servicing and can also provide collection and remittance of premium.		\$6.00
Facilitate Agent recruitment and marketing on behalf of GHI HMO. In addition, this Agent actively bills, collects and remits premium; and provides other administrative functions such as generating and issuing termination notices, providing partial premium payment services, providing eligibility reconciliation services and related reporting services.		\$13.00

# Small Group Underwriting Guidelines<sup>1</sup>

## New York

FOR BUSINESSES WITH 2-50 EMPLOYEES



**GHIHMO**

# Small Group Underwriting Guidelines

GHI HMO community-rated plans are available for purchase by qualified small groups that employ no fewer than two (2) and no more than fifty (50) eligible employees.

<b>Application</b>	<ul style="list-style-type: none"><li>▪ The initial payment equivalent to one month's premium must be made payable to GHI HMO and submitted with the new group application form. Only business checks are acceptable forms of payment.</li><li>▪ Contract periods will begin on the 1<sup>st</sup> or 15<sup>th</sup> of a month.</li><li>▪ Documentation requested by GHI HMO to determine group or employee eligibility must be supplied within <b>five (5) business days</b> from the date of GHI HMO request in order to secure the requested effective date of coverage. If documentation is not supplied within five (5) business days, GHI HMO will establish an effective date of coverage pending receipt and verification of the data.</li></ul> <p><b>Family verification</b></p> <ul style="list-style-type: none"><li>▪ GHI HMO will request a Federal 1040 form and/or a marriage certificate to verify the marriage of two individuals with different last names. In addition, GHI HMO will require a birth certificate and/or Federal 1040 Form as proof that a dependent is eligible for coverage if the dependent has a last name different from the subscriber.</li></ul>
<b>Benefit Changes</b>	<p><b>Benefit downgrades:</b></p> <p>A plan change is a downgrade when the premium rates for the new product are lower than the premium rates for the old product as of the requested plan change date.</p> <ul style="list-style-type: none"><li>▪ A group can downgrade its coverage at any time during the year <u>except in the ninety (90) days preceding the contract anniversary date</u>. The effective date of the benefit downgrade will become the group's new anniversary date.</li></ul> <p><b>Benefit upgrades:</b></p> <ul style="list-style-type: none"><li>• A group can only upgrade coverage at its contract anniversary date.</li></ul> <p><b>All plan change requests must be received by GHI HMO five business days prior to the desired effective date.</b></p>

<p><b>Domestic Partners</b></p>	<p>Domestic partner coverage is available with GHI HMO.</p> <ul style="list-style-type: none"> <li>▪ A domestic partner will be treated as a dependent.</li> <li>▪ Eligible dependents of the domestic partner may be added.</li> <li>▪ Domestic partners are not recognized by the IRS and may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts).</li> <li>▪ Domestic partners must submit the following form to GHI HMO. This form must be notarized.             <ol style="list-style-type: none"> <li>1. GHI HMO Declaration of Cohabitation &amp; Financial Interdependence Form (DCFIF). In addition, the partners must also provide three documents showing a similar residence and financial interdependence. The specific list of acceptable documents is shown on the Declaration of Cohabitation &amp; Financial Interdependence Form.</li> </ol> </li> </ul>
<p><b>Product Offerings</b></p>	<ul style="list-style-type: none"> <li>• All GHI HMO plans must have the same rating tier structure. If GHI HMO does not offer the desired products on a same tier basis, then they cannot be offered as a multiple option.</li> <li>• A group may change the Plan Types offered only on the group's anniversary.</li> <li>• An employee may only change the plan option elected only on the group's anniversary.</li> </ul>
<p><b>Rating Tiers</b></p>	<ul style="list-style-type: none"> <li>• GHI HMO small group business (2-50 eligible employees) will only be offered on a 2-tier rating basis.</li> </ul>
<p><b>Employee Eligibility</b></p>	<p>Groups must demonstrate an employer/employee relationship for all eligible employees.</p> <p>GHI HMO evaluates eligibility based on the United States Internal Revenue Service's definition of an employee of an employer group or a bona fide employer member of an association group.</p> <ul style="list-style-type: none"> <li>▪ For business associations, GHI HMO would cover the eligible employees of the association's member employers.</li> <li>▪ GHI HMO only covers full-time employees. GHI HMO defines full-time eligible employees as employees who work <b>20 or more hours per week</b>, each week. If an employer requires a longer number of hours worked in order to meet eligibility, then GHI HMO will use the employer's criteria to define full-time eligible employees.</li> <li>▪ The following categories of employees are <b>not eligible for coverage</b>:             <ul style="list-style-type: none"> <li>▪ Retirees and their dependent(s).</li> <li>▪ Individuals who receive 1099 Forms and their dependents.</li> <li>▪ Seasonal employees and their dependents.</li> <li>▪ Leased employees.</li> </ul> </li> </ul> <p>A group must provide proof of employment for each employee at the time of application or at the time of a periodic survey. Each employee to be enrolled must appear on a NYS-45 or NYS-45-ATT.</p> <ul style="list-style-type: none"> <li>▪ The NYS-45 or NYS-45-ATT must be the filed copy for the quarter preceding the desired effective date of coverage. The status of each employee must be indicated on the form as applicable: Full-time, Part-time (less than 20 hours worked per week), Permanent, Temporary, Waiving, Eligible, not-Eligible, Enrolling, Class distinction if applicable.</li> <li>▪ In the absence of providing a NYS-45 or a NYS-45-ATT, the group must provide a signed copy of its full tax return, such as an 1120, 1065, 1120S, LLC or LLP with Schedule K-1, Schedule C or Schedule E.</li> <li>▪ If the employer has a benefit waiting period, the employer must provide documentation verifying the terms of the waiting period.</li> </ul>

### Recent Hires

- In the event that a newly hired employee is not yet listed on filed tax documentation, then a copy of the employee's W-4 or recent payroll check stub must be supplied. If a payroll check stub is supplied, it must include the company name, employee name, number of hours worked and payroll dates. The payroll dates cannot be more than 30 days prior to the date of application.
- The group must produce tax documents within 90 days after the effective date of coverage to substantiate a recent hire's eligibility. If acceptable documentation is not provided to GHI HMO, then coverage will be terminated.

### COBRA Members

- COBRA enrollees must supply a letter of election and a copy of their last payroll report.

### Employer Eligibility

A group must be actively operating its business at all times that GHI HMO coverage will be in effect.

A group applying for a community-rated plan must provide GHI HMO with all of the following documentation:

- a Federal Employer Identification Number (EIN) and evidence of authority to conduct business in New York State
- confirmation that the group's worksite(s) is in New York State. Street addresses must be provided even for worksite(s) with post office box listings.
- a copy of the most-recently paid invoice from its current carrier.

If a new business is not able to supply the data above, then GHI HMO Letter of Certification from the group's attorney or certified public accountant explaining the specific situation will temporarily suffice. Neither the attorney nor the C.P.A. can be an employee or the relative of an employee of the group. In addition, the Letter of Certification must be accompanied by:

- Articles of Incorporation issued by the State of New York, or
- a certificate to do business issued by the State of New York and
- a payroll record acceptable to GHI HMO.

The group must produce tax documents within 90 days after the effective date of coverage to substantiate its business operation. Coverage will be terminated if acceptable documentation is not provided within 90 days.

- If a group has been terminated within the prior 12 months due to **non-payment of premium**, GHI HMO will not issue the group a contract.

### Enrollment Policy

- New enrollees must enroll as of their date of hire.
- If the employer has a benefit waiting period, the employee must enroll on the first day of benefit eligibility.
- New groups enrolling with GHI HMO may waive the waiting period for all employees at the time of initial enrollment.

**Eligible employees and/or dependents who do not enroll on the first day of benefit eligibility will not be eligible to enroll until the employer's next annual enrollment period, except in the circumstances below.** The enrollment period commences on the anniversary date of coverage and ends after 30 days.

- The individual was covered under another plan or policy at the time the individual was initially eligible to enroll and has lost coverage under the other plan or policy as a result of exhaustion of the period of continuation under State of Federal law or
- The loss of eligibility was related to one or more of the following reasons:
  - termination of employment
  - termination of the other plan or contract
  - death of the spouse
  - legal separation, divorce or annulment
  - reduction in the number of hours of employment
  - contract holder contributions toward the payment of premium for the other plan or contract were terminated.

	<ul style="list-style-type: none"> <li>A court has ordered coverage be provided for a spouse or minor children under a covered employee or member's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order.</li> </ul>
<b>Headquarters in New York</b>	<p>If a group has:</p> <ul style="list-style-type: none"> <li>its principal location <b>within</b> New York State and</li> <li>it employs no fewer than two (2) and no more than fifty (50) eligible employees at a worksite(s) in New York State</li> </ul> <p>then the group can purchase community-rated coverage for its eligible employees, subject to any applicable service area restrictions.</p> <p>Groups with more than one office/location within the State of New York must identify each location and the employees that work at that location.</p>
<b>Headquarters outside New York</b>	<p>If a group has:</p> <ul style="list-style-type: none"> <li>its principal location <b>outside</b> New York State and</li> <li>it employs no fewer than two (2) and no more than fifty (50) eligible employees at a worksite(s) in New York State</li> </ul> <p>then,</p> <ul style="list-style-type: none"> <li>The group can purchase community-rated coverage for its New York employees. The contract for coverage must be delivered to a New York worksite and the contract will only cover employees working at the New York worksite(s).</li> </ul>
<b>Ongoing Qualification</b>	<p>Periodic surveys of enrolled small groups may be taken by GHI HMO and/or GHI HMO designated administrators to ensure that the group is actively operating its business and remains qualified to be enrolled in a community-rated product.</p> <p>The survey can include, but not be limited to, any or all of the following to verify continued eligibility:</p> <ul style="list-style-type: none"> <li>The group's most recently-filed NYS-45 or NYS-45-ATT</li> <li>Tax documentation as requested by GHI HMO and/or GHI HMO designated administrators.</li> <li>Payroll information as requested by GHI HMO and/or GHI HMO designated administrators.</li> </ul>
<b>Pre-existing Conditions</b>	<ul style="list-style-type: none"> <li>Month-for-month credit will be given to enrollees who had Medicaid coverage and/or other prior creditable coverage provided there is no lapse in coverage of more than 63 days.</li> <li>GHI HMO will provide credit toward pre-existing condition limitations for prior creditable coverage under foreign plans to the same extent and according to the same standards that apply to domestic plans.</li> </ul>
<b>Premium Rates</b>	<p>Premium rates are based on the group's New York State worksite location(s). Premium rates are <b>not</b> based on the residence of the employee.</p> <ul style="list-style-type: none"> <li>Premium rates for satellite office(s) within New York State but outside of the principal worksite's rating region will be rated based on the rating region of the satellite office.</li> </ul>

<sup>1</sup> These guidelines do not encompass Government Sponsored programs that GHI HMO may offer for sale ( e.g., Medicare, Healthy New York, etc.) The product sponsor should be consulted for policies and procedures that are applicable to their products.

"EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York, GHI HMO Select Inc., The PerfectHealth Insurance Company, Connecticare of New York Inc. and EmblemHealth Services Company, L.L.C."

**Appendix A: Premium Rate Increases**

			1Q 2010	2Q 2010	3Q 2010	4Q 2010	1Q 2011	2Q 2011	3Q 2011	4Q 2011	1Q 2012	2Q 2012	3Q 2012	4Q 2012
			/ 1Q 2009	/ 2Q 2009	/ 3Q 2009	/ 4Q 2009	/ 1Q 2010	/ 2Q 2010	/ 3Q 2010	/ 4Q 2010	/ 1Q 2011	/ 2Q 2011	/ 3Q 2011	/ 4Q 2011
HMO	SG/DP	Healthy NY	4.4%	4.4%	4.4%	9.7%	5.1%	5.1%	5.1%	0.0%	19.8%	19.8%	19.8%	19.8%
			1Q 2010	2Q 2010	3Q 2010	4Q 2010	1Q 2011	2Q 2011	3Q 2011	4Q 2011	1Q 2012	2Q 2012	3Q 2012	4Q 2012
			/ 4Q 2009	/ 1Q 2010	/ 2Q 2010	/ 3Q 2010	/ 4Q 2010	/ 1Q 2011	/ 2Q 2011	/ 3Q 2011	/ 4Q 2011	/ 1Q 2012	/ 2Q 2012	/ 3Q 2012
HMO	SG/DP	Healthy NY	4.4%	0.0%	0.0%	5.1%	0.0%	0.0%	0.0%	0.0%	19.8%	0.0%	0.0%	0.0%

## Appendix B: Source Data

GHI HMO  
SG/SP/DP  
Healthy NY

**Base Member Months**                    **14,376**

**Base Experience 2010 a/o 12/31/2010**

Professional Claims	1,862,986
Inpatient Claims	16,788
Outpatient Claims	896,429
Medical Group Capitations	-
Ancillary Capitations	1,920
Global Capitations	-
RX Claims	434,250
HCRA Pool Expenses	228,218
<b>Total Expenses</b>	<b>3,440,591</b>

**Base Recast a/o 4/30/2010**

Professional Claims	(42,572)
Inpatient Claims	(78,340)
Outpatient Claims	(52,840)
<b>Total Recast</b>	<b>(173,752)</b>

**Total Expenses with Recast**            **3,266,839**

**Base PMPMs**

Professional Claims	126.63
Inpatient Claims	(4.28)
Outpatient Claims	58.68
Medical Group Capitations	-
Ancillary Capitations	0.13
Global Capitations	-
RX Claims	30.21
HCRA Pool Expenses	15.87
<b>Total Base PMPM</b>	<b>227.24</b>

**2011/2010 Trends**

Professional Claims	10.5%
Inpatient Claims	-337.8%
Outpatient Claims	20.2%
Medical Group Capitations	#DIV/0!
Ancillary Capitations	0.0%
Global Capitations	#DIV/0!
RX Claims	7.6%
HCRA Pool Expenses	11.4%
<b>Aggregate Trend</b>	<b>19.2%</b>

**2012/2011 Trends**

Professional Claims	13.5%
Inpatient Claims	154.6%
Outpatient Claims	18.3%
Medical Group Capitations	#DIV/0!
Ancillary Capitations	0.0%
Global Capitations	#DIV/0!
RX Claims	9.7%
HCRA Pool Expenses	11.1%
<b>Aggregate Trend</b>	<b>19.4%</b>

**2012 Projected Claims**

Professional Claims	158.84
Inpatient Claims	25.92
Outpatient Claims	83.40
Medical Group Capitations	-
Ancillary Capitations	0.13
Global Capitations	-
RX Claims	35.65
HCRA Pool Expenses	19.64
<b>Total Projected PMPM</b>	<b>323.59</b>

Appendix C: Standardized Premium Calculation

**GHI HMO HNY HMO**

2009 Earned Premium PMPM 275.36  
 2010 Earned Premium PMPM 291.22

1Q 2008 Base Rate Ratio 1.000  
 2Q 2008 Rate Ratio 1.000  
 3Q 2008 Rate Ratio 1.000  
 4Q 2008 Rate Ratio 1.000  
 1Q 2009 Rate Ratio 1.130  
 2Q 2009 Rate Ratio 1.130  
 3Q 2009 Rate Ratio 1.130  
 4Q 2009 Rate Ratio 1.130  
 1Q 2010 Rate Ratio 1.180  
 2Q 2010 Rate Ratio 1.180  
 3Q 2010 Rate Ratio 1.180  
 4Q 2010 Rate Ratio 1.180  
 1Q 2011 Rate Ratio 1.180  
 2Q 2011 Rate Ratio 1.180  
 3Q 2011 Rate Ratio 1.180  
**4Q 2011 Rate Ratio 1.180**  
 1Q 2012 Rate Ratio 1.414 19.8%  
 2Q 2012 Rate Ratio 1.414 0.0%  
 3Q 2012 Rate Ratio 1.414 0.0%  
 4Q 2012 Rate Ratio 1.414 0.0%

**Renewal Distribution**

Jan 6.6%  
 Feb 5.4%  
 Mar 10.3%  
 Apr 7.9%  
 May 8.8%  
 Jun 7.5%  
 Jul 6.0%  
 Aug 10.9%  
 Sep 8.9%  
 Oct 9.5%  
 Nov 8.6%  
 Dec 9.6%

**Average 2009 Rate by renewal month**

Jan 1.130  
 Feb 1.119  
 Mar 1.108  
 Apr 1.098  
 May 1.087  
 Jun 1.076  
 Jul 1.065  
 Aug 1.054  
 Sep 1.043  
 Oct 1.033  
 Nov 1.022  
 Dec 1.011

**Average 2009 Rate Ratio**

**1.067**  
 A February case would have 1 month at the 1Q2008 rate and 11 months at the 1Q2009 rate

**Average 2010 Rate by renewal month**

Jan 1.180  
 Feb 1.176  
 Mar 1.172  
 Apr 1.168  
 May 1.163  
 Jun 1.159  
 Jul 1.155  
 Aug 1.151  
 Sep 1.147  
 Oct 1.143  
 Nov 1.138  
 Dec 1.134

**Average 2010 Rate Ratio**

**1.156**

**2009 Standardized Premium**

Average 2009 Rate Ratio 1.067  
 4Q 2011 Rate Ratio 1.180  
 % Change 1.106  
 Standardized Premium PMPM **304.56**

**2010 Standardized Premium**

Average 2010 Rate Ratio 1.156  
 4Q 2011 Rate Ratio 1.180  
 % Change 1.021  
 Standardized Premium PMPM **297.34**



## PRELIMINARY RATE FILING HIP Community Rated Commercial Projected Trends (excl. PPACA)

Product	Avg 2010 Members	2010/2009 Trends			2011/2010 Projected Trends				2012/ 2011 Projected Trends			
		Total Trend	Utiliza- tion	Total Cost	Utiliza- tion <sup>(2)</sup>	Contracted Cost <sup>(1)</sup>	CMI / AgeSex	Total Trend	Utiliza- tion <sup>(2)</sup>	Contracted Cost <sup>(1)</sup>	CMI / AgeSex	Total Trend
<b>Inpatient Facility - FFS</b>												
HMO Large Group	141,974	<b>10.2%</b>	-0.4%	10.6%	1.3%	11.5%	0.0%	<b>13.0%</b>	1.0%	9.3%	0.0%	<b>10.3%</b>
HMO Small Group	7,601	<b>6.8%</b>	-1.0%	7.9%	9.6%	11.5%	0.0%	<b>22.3%</b>	6.8%	9.3%	0.0%	16.7%
HMO Direct Pay	2,556	36.0%	12.5%	20.9%	5.1%	11.5%	0.0%	17.2%	3.6%	9.3%	0.0%	13.2%
HMO Comprehealth	3,257	271.1%	119.1%	69.4%	19.6%	11.5%	0.0%	33.4%	16.9%	9.3%	0.0%	27.7%
HMO Healthy New York	3,012	86.8%	27.1%	47.0%	3.0%	11.5%	0.0%	14.9%	4.4%	9.3%	0.0%	14.1%
POS Large Group	941	-19.3%	-16.6%	-3.3%	11.2%	10.7%	0.0%	23.1%	8.0%	9.5%	0.0%	18.2%
POS Small Group	1,088	9.2%	19.7%	-8.7%	15.2%	10.7%	0.0%	27.5%	10.8%	9.5%	0.0%	21.3%
POS Direct Pay	55	-16.8%	53.5%	-45.8%	15.2%	10.7%	0.0%	27.5%	10.8%	9.5%	0.0%	21.3%
EPO Large Group	589	-30.2%	10.3%	-36.7%	59.7%	10.7%	0.0%	76.9%	42.7%	9.0%	0.0%	55.5%
EPO Small Group	12,019	<b>12.7%</b>	0.7%	11.9%	7.2%	10.7%	0.0%	<b>18.7%</b>	5.1%	9.0%	0.0%	<b>14.6%</b>
PPO Large Group	51	-9.8%	122.6%	-59.5%	2.0%	12.3%	0.0%	14.6%	1.4%	10.3%	0.0%	11.9%
PPO Small Group	4,960	<b>24.3%</b>	8.7%	14.3%	2.2%	12.3%	0.0%	<b>14.8%</b>	1.6%	10.3%	0.0%	<b>12.1%</b>
<b>Outpatient Facility - FFS</b>												
HMO Large Group		<b>16.3%</b>	1.6%	14.5%	6.3%	10.8%	2.0%	<b>20.1%</b>	3.3%	9.0%	2.0%	<b>14.8%</b>
HMO Small Group		<b>10.5%</b>	2.2%	8.2%	10.0%	10.8%	2.0%	<b>24.3%</b>	5.2%	9.0%	2.0%	17.0%
HMO Direct Pay		31.9%	4.7%	26.0%	8.8%	10.8%	2.0%	23.0%	4.6%	9.0%	2.0%	16.3%
HMO Comprehealth		115.9%	52.8%	41.3%	20.0%	10.8%	2.0%	35.6%	15.2%	9.0%	2.0%	28.1%
HMO Healthy New York		16.8%	5.2%	11.0%	6.4%	10.8%	2.0%	20.2%	6.4%	9.0%	2.0%	18.3%
POS Large Group		-34.5%	-26.2%	-11.3%	12.0%	11.2%	2.0%	27.0%	7.9%	9.7%	2.0%	20.7%
POS Small Group		33.0%	7.9%	23.3%	15.2%	11.2%	2.0%	30.6%	10.0%	9.7%	2.0%	23.0%
POS Direct Pay		-46.0%	-22.9%	-30.0%	15.2%	11.2%	2.0%	30.6%	10.0%	9.7%	2.0%	23.0%
EPO Large Group		12.5%	10.5%	1.8%	22.4%	10.6%	2.0%	38.0%	7.2%	9.7%	2.0%	20.0%
EPO Small Group		<b>35.8%</b>	20.9%	12.4%	13.2%	10.6%	2.0%	<b>27.7%</b>	8.6%	9.7%	2.0%	<b>21.6%</b>
PPO Large Group		-32.0%	-10.5%	-24.0%	13.0%	10.8%	2.0%	27.7%	8.5%	9.5%	2.0%	21.2%
PPO Small Group		<b>43.8%</b>	0.3%	43.4%	15.2%	10.8%	2.0%	<b>30.2%</b>	10.0%	9.5%	2.0%	<b>22.8%</b>

## PRELIMINARY RATE FILING HIP Community Rated Commercial Projected Trends (excl. PPACA)

Product	Avg 2010 Members	2010/2009 Trends			2011/2010 Projected Trends				2012/ 2011 Projected Trends			
		Total Trend	Utiliza- tion	Total Cost	Utiliza- tion <sup>(2)</sup>	Contracted Cost <sup>(1)</sup>	CMI / AgeSex	Total Trend	Utiliza- tion <sup>(2)</sup>	Contracted Cost <sup>(1)</sup>	CMI / AgeSex	Total Trend
<b>Professional - FFS</b>												
HMO Large Group		5.1%	-1.7%	6.9%	3.2%	2.0%	2.0%	7.4%	1.7%	4.8%	2.0%	8.7%
HMO Small Group		6.1%	-1.6%	7.8%	5.1%	2.0%	2.0%	9.3%	2.6%	4.8%	2.0%	9.8%
HMO Direct Pay		4.6%	-1.0%	5.6%	8.0%	2.0%	2.0%	12.4%	4.2%	4.8%	2.0%	11.4%
HMO Comprehealth		41.6%	56.8%	-9.7%	15.1%	2.0%	2.0%	19.7%	12.6%	4.8%	2.0%	20.4%
HMO Healthy New York		11.7%	-1.1%	12.9%	6.2%	2.0%	2.0%	10.5%	6.2%	4.8%	2.0%	13.6%
POS Large Group		-5.2%	-6.4%	1.2%	10.1%	2.0%	2.0%	14.5%	4.8%	4.8%	2.0%	12.1%
POS Small Group		18.9%	-5.0%	25.2%	5.2%	2.0%	2.0%	9.4%	2.5%	4.8%	2.0%	9.6%
POS Direct Pay		-6.4%	-12.5%	7.0%	5.2%	2.0%	2.0%	9.4%	2.5%	4.8%	2.0%	9.6%
EPO Large Group		-3.9%	-8.1%	4.6%	23.1%	2.0%	2.0%	28.1%	5.2%	4.8%	2.0%	12.5%
EPO Small Group		10.6%	1.1%	9.5%	8.2%	2.0%	2.0%	12.6%	3.9%	4.8%	2.0%	11.1%
PPO Large Group		0.0%	-1.3%	1.3%	2.0%	2.0%	2.0%	6.1%	1.0%	4.8%	2.0%	8.0%
PPO Small Group		8.6%	0.3%	8.3%	1.2%	2.0%	2.0%	5.3%	0.6%	4.8%	2.0%	7.6%

<b>Pharmacy<sup>(3)(4)</sup></b>												
HMO Large Group	183,691	6.2%	-0.6%	6.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
HMO Small Group					3.0%	5.0%	2.0%	10.3%	3.0%	4.0%	2.0%	9.3%
HMO Direct Pay					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
HMO Comprehealth					13.0%	5.0%	2.0%	21.0%	13.0%	4.0%	2.0%	19.9%
HMO Healthy New York					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Large Group	24,979	12.5%	9.3%	2.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
POS Direct Pay					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
EPO Large Group	31,274	20.5%	8.1%	11.4%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
EPO Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
PPO Large Group	9,483	26.2%	9.8%	14.9%	1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%
PPO Small Group					1.5%	5.0%	2.0%	8.7%	1.5%	4.0%	2.0%	7.7%

(1) Contracted Cost assumptions from Provider Relations

(2) Projected utilization assumptions from Medical Management

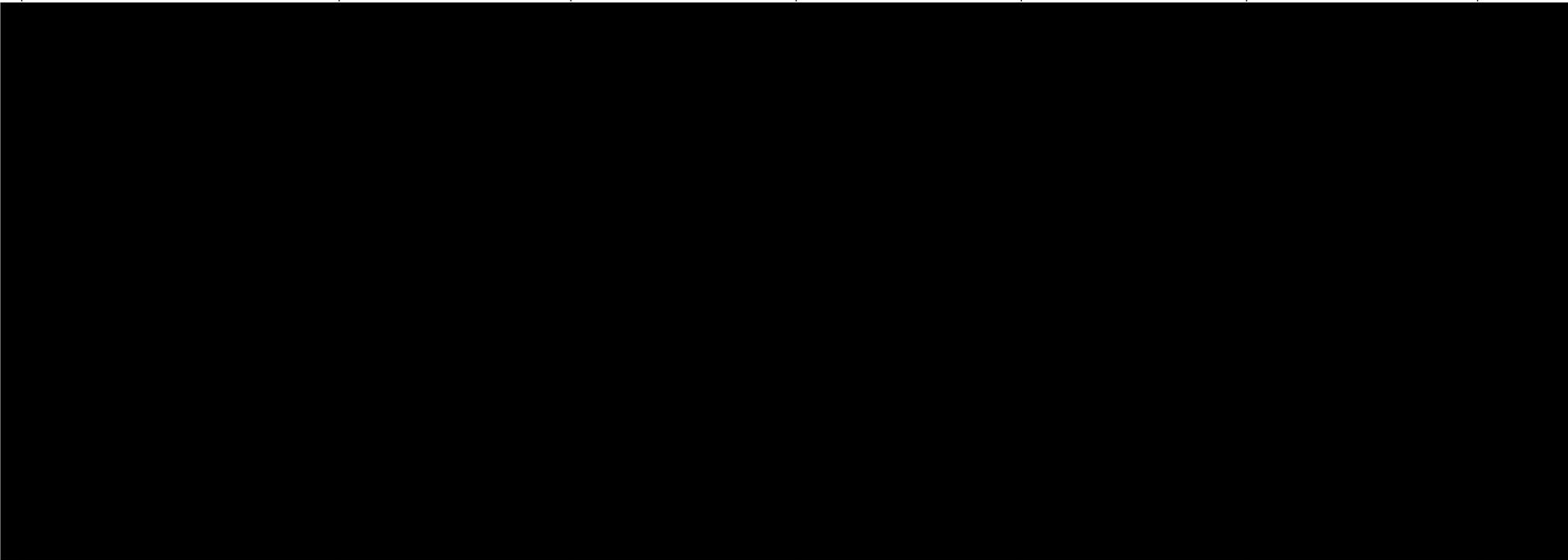
(3) Pharmacy data and trend assumptions from Medical Management

(4) 2010 Rx Members include Community Rated &amp; Experience Rated members with a Pharmacy benefit

APPENDIX F-1 REDACTED  
HIP/HIPIC COMMUNITY RATED Inpatient Facility Mix Study  
Jan 2010 - Dec 2010 Incurrals with 3 months runout

PROVNUM	FAXIDNUM	PROVIDER NAME	HMO			Point of Service			EPO			PPO			TOTAL		
			\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase



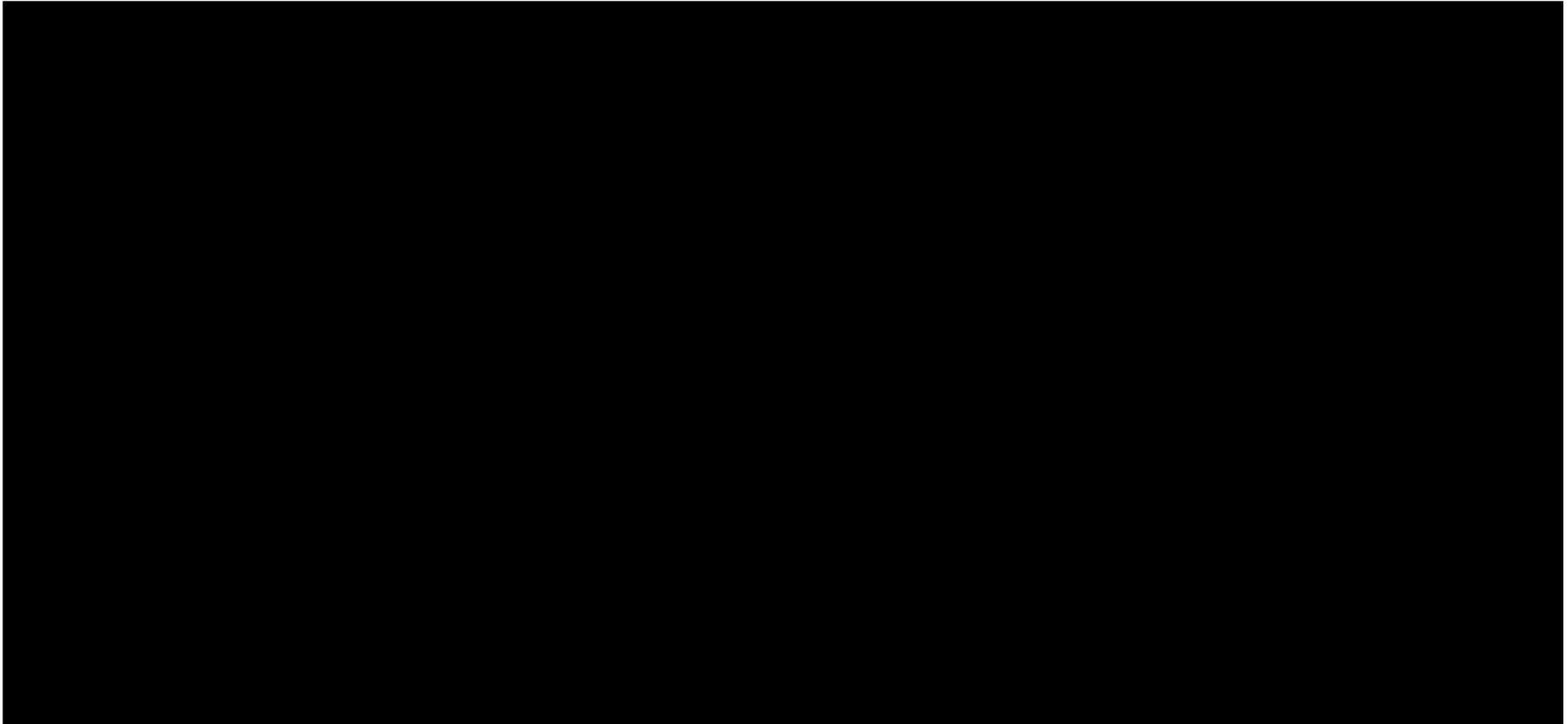


TOTAL Top Contracted IP Facilities	285,078,941	11.5%	9.3%	2,173,205	10.7%	9.5%	11,672,293	10.7%	9.0%	4,401,881	12.3%	10.3%	303,326,321	11.5%	9.3%
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APPENDIX F-2 REDACTED  
HIP/HIPIC COMMUNITY RATED Outpatient Facility Mix Study  
Jan 2010 - Dec 2010 Incrrals with 3 months runout

PROVNUM	FAXIDNUM	PROVIDER NAME	HMO			Point of Service			EPO			PPO			TOTAL		
			\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase	\$ Weights	Contracted 2011 % Increase	Projected 2012 % Increase





TOTAL Top Contracted OP Facilities	136,314,388	10.8%	9.0%	1,207,783	11.2%	9.7%	7,971,014	10.6%	9.7%	2,241,031	10.8%	9.5%	147,734,216	10.8%	9.1%
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**APPENDIX G-1 REDACTED  
HIP/HIPIC COMMERCIAL COMMUNITY RATED CY 2009 ACTUALS**

<b>RETAIL</b>						
<b>Table 1</b>	<b>Number of Scripts by Drug Category for 2009 per 1000 members</b>					
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months
HMO	5,982.8	2,400.7	169.4	909.9	9,462.9	2,204,291
POS	5,152.4	2,085.3	44.0	1,063.7	8,345.5	299,745
EPO	4,547.8	1,015.5	11.1	531.8	6,106.2	375,290
PPO	5,507.9	2,231.3	22.6	1,441.8	9,203.6	113,792

<b>MAIL</b>						
<b>Number of Scripts by Drug Category for 2009 per 1000 members</b>						
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	
276.9	194.9	80.1	64.7	616.5	2,204,291	
289.0	201.0	22.3	83.8	596.1	299,745	
72.0	68.3	8.1	27.2	175.6	375,290	
271.7	222.7	7.9	115.4	617.7	113,792	

<b>TOTAL</b>						
<b>Number of Scripts by Drug Category for 2009 per 1000 members</b>						
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	
6,259.7	2,595.6	249.5	974.6	10,079.4	2,204,291	
5,441.4	2,286.3	66.3	1,147.6	8,941.6	299,745	
4,619.8	1,083.8	19.2	559.0	6,281.8	375,290	
5,779.6	2,454.1	30.5	1,557.2	9,821.3	113,792	

<b>RETAIL</b>					
<b>Table 4</b>	<b>Allowed Cost per Script for 2009</b>				
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total
HMO	\$20.66	\$174.42	\$156.75	\$167.52	\$76.22
POS	\$21.87	\$201.32	\$177.92	\$293.78	\$102.19
EPO	\$17.06	\$145.09	\$844.98	\$132.81	\$49.94
PPO	\$23.82	\$210.17	\$701.95	\$178.88	\$94.96

<b>MAIL</b>					
<b>Allowed Cost per Script for 2009</b>					
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	
\$44.86	\$225.26	\$929.83	\$212.64	\$234.41	
\$44.89	\$237.49	\$1,286.05	\$270.29	\$187.88	
\$46.14	\$227.88	\$1,030.89	\$266.27	\$196.44	
\$45.57	\$256.52	\$1,492.65	\$249.83	\$178.32	

<b>TOTAL</b>					
<b>Allowed Cost per Script for 2009</b>					
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	
\$21.73	\$178.23	\$404.84	\$170.51	\$85.90	
\$23.09	\$204.50	\$549.97	\$292.06	\$107.90	
\$17.52	\$150.31	\$923.55	\$139.29	\$54.03	
\$24.85	\$214.38	\$907.15	\$184.14	\$100.20	

<b>RETAIL</b>				
<b>Table 8</b>	<b>Dispensing Fees for 2009</b>			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

<b>MAIL</b>			
<b>Dispensing Fees for 2009</b>			
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs

<b>TOTAL</b>			
<b>Dispensing Fees for 2009</b>			
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs

<b>RETAIL</b>				
<b>Table 10</b>	<b>Rebate % for 2009</b>			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

<b>MAIL</b>			
<b>Rebate % for 2009</b>			
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs

<b>TOTAL</b>			
<b>Rebate % for 2009</b>			
Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs

**APPENDIX G-2 REDACTED  
HIP/HIPIC COMMERCIAL COMMUNITY RATED CY 2010 ACTUALS**

Table 1	RETAIL						MAIL						TOTAL						2010/2009 Util %
	Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months	
HMO	6,132.8	2,330.0	128.8	778.5	9,370.1	2,071,728	291.0	195.4	74.7	83.4	644.6	2,071,728	6,423.8	2,525.4	203.5	862.0	10,014.7	2,071,728	-0.6%
POS	5,795.1	2,371.1	37.4	1,099.7	9,303.3	149,639	211.5	167.8	27.8	66.6	473.7	149,639	6,006.6	2,538.9	65.2	1,166.2	9,777.0	149,639	9.3%
EPO	4,984.7	1,075.5	12.6	534.1	6,606.9	356,129	84.3	66.7	9.6	24.1	184.8	356,129	5,069.0	1,142.2	22.2	558.2	6,791.6	356,129	8.1%
PPO	6,281.4	2,433.8	26.5	1,364.7	10,106.4	81,469	316.8	256.3	7.5	100.0	680.7	81,469	6,598.2	2,690.1	34.0	1,464.7	10,787.0	81,469	9.8%
<b>Total</b>																		<b>1.12%</b>	

Table 4	RETAIL						MAIL						TOTAL						2010/2009 Cost %
	Allowed Cost per Script for 2010						Allowed Cost per Script for 2010						Allowed Cost per Script for 2010						
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total		
HMO	\$22.04	\$199.36	\$234.50	\$173.05	\$81.60		\$50.59	\$263.08	\$1,011.90	\$160.45	\$240.62		23.3	204.3	519.8	171.8	\$91.83		6.9%
POS	\$24.67	\$248.87	\$356.80	\$191.19	\$102.83		\$53.36	\$323.35	\$1,205.80	\$447.50	\$272.11		25.7	253.8	719.2	205.8	\$111.03		2.9%
EPO	\$18.41	\$175.10	\$908.60	\$149.84	\$56.24		\$49.46	\$281.37	\$929.18	\$229.90	\$202.45		18.9	181.3	917.5	153.3	\$60.22		11.4%
PPO	\$25.88	\$252.90	\$1,128.22	\$212.19	\$108.60		\$55.92	\$317.97	\$1,707.88	\$320.17	\$211.66		27.3	259.1	1,256.2	219.6	\$115.10		14.9%
<b>Total</b>																		<b>7.4%</b>	

Table 8	RETAIL			
	Dispensing Fees for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

Table 8	MAIL			
	Dispensing Fees for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

Table 8	TOTAL			
	Dispensing Fees for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

Table 10	RETAIL			
	Rebate % for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

Table 10	MAIL			
	Rebate % for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

Table 10	TOTAL			
	Rebate % for 2010			
Product Line	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
HMO				
POS				
EPO				
PPO				

**APPENDIX H-1  
HIP/HIPIC Large Group Community Rated Age/Sex Factors  
Calculated Using Milliman Age Bands and Factors**

Month	HMO Fee-for-service		HMO Medical Group		POS Fee-for-service		POS Medical Group		Total HIP (2009 Member Mix)		EPO		PPO		Total HIPIC (2009 Member Mix)		Total HIP & HIPIC (2009 Member Mix)	
	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS	Members	Avg AS
		Factor		Factor		Factor		Factor		Factor		Factor		Factor		Factor		Factor
Jan-09	148,610	1.144	173,251	1.144	1,090	1.391	150	1.419	324,766	1.242	1,479	1.223	135	1.269	1,614	1.227	326,380	1.227
Feb-09	147,907	1.141	173,283	1.141	1,080	1.392	150	1.424	323,473	1.242	1,484	1.220	136	1.278	1,620	1.225	325,403	1.225
Mar-09	147,593	1.142	173,271	1.142	1,060	1.374	142	1.427	322,909	1.243	1,473	1.215	132	1.295	1,605	1.222	324,514	1.222
Apr-09	144,838	1.141	173,267	1.141	1,030	1.380	149	1.386	320,688	1.242	1,443	1.225	132	1.245	1,575	1.226	322,426	1.226
May-09	145,017	1.142	173,260	1.142	1,015	1.375	147	1.411	320,187	1.243	1,430	1.232	135	1.244	1,565	1.233	322,452	1.233
Jun-09	144,799	1.143	173,270	1.143	1,023	1.378	147	1.406	319,677	1.244	1,370	1.216	125	1.260	1,495	1.220	322,487	1.220
Jul-09	145,118	1.143	173,289	1.143	1,050	1.356	140	1.434	318,605	1.244	1,380	1.229	126	1.297	1,506	1.234	320,411	1.234
Aug-09	145,061	1.143	173,286	1.143	1,096	1.366	137	1.446	318,162	1.244	1,388	1.236	123	1.318	1,511	1.243	319,467	1.243
Sep-09	145,542	1.144	173,305	1.144	1,043	1.359	128	1.510	317,618	1.245	1,149	1.234	77	1.355	1,226	1.242	318,484	1.242
Oct-09	145,354	1.145	173,307	1.145	1,100	1.347	127	1.497	316,888	1.246	946	1.218	78	1.337	1,024	1.227	317,461	1.227
Nov-09	145,544	1.146	169,315	1.146	1,077	1.348	119	1.487	316,255	1.248	926	1.217	77	1.302	1,003	1.223	317,478	1.223
Dec-09	145,358	1.147	169,321	1.147	1,107	1.351	117	1.500	315,803	1.249	786	1.231	73	1.279	859	1.235	316,662	1.235
Jan-10	146,415	1.149	164,444	1.149	1,104	1.345	121	1.488	324,766	1.255	586	1.263	66	1.352	1,614	1.270	326,380	1.270
Feb-10	144,302	1.156	166,772	1.156	1,063	1.377	117	1.545	323,473	1.267	548	1.302	68	1.342	1,620	1.306	325,693	1.306
Mar-10	143,947	1.156	166,591	1.156	1,074	1.389	121	1.553	322,909	1.266	602	1.269	56	1.462	1,605	1.285	324,614	1.285
Apr-10	142,614	1.157	166,589	1.157	1,032	1.382	121	1.555	320,688	1.266	644	1.257	54	1.420	1,575	1.271	322,663	1.271
May-10	142,382	1.159	166,562	1.159	1,038	1.384	117	1.584	320,187	1.267	652	1.246	52	1.369	1,565	1.257	322,672	1.257
Jun-10	141,993	1.160	159,574	1.160	950	1.363	116	1.590	319,677	1.269	649	1.228	52	1.385	1,495	1.241	322,697	1.241
Jul-10	140,587	1.162	158,580	1.162	906	1.418	135	1.645	318,605	1.269	653	1.210	49	1.309	1,506	1.219	320,691	1.219
Aug-10	140,027	1.163	157,671	1.163	879	1.428	128	1.627	318,162	1.271	623	1.195	49	1.309	1,511	1.205	319,767	1.205
Sep-10	140,659	1.164	156,682	1.164	808	1.444	126	1.638	317,618	1.272	659	1.201	42	1.359	1,226	1.211	318,744	1.211
Oct-10	140,920	1.163	156,683	1.163	826	1.441	125	1.647	316,888	1.273	624	1.226	40	1.382	1,024	1.238	317,712	1.238
Nov-10	140,208	1.165	153,696	1.165	810	1.448	126	1.675	316,255	1.274	594	1.245	39	1.388	1,003	1.256	317,758	1.256
Dec-10	139,531	1.165	153,691	1.165	803	1.435	127	1.702	315,803	1.275	584	1.262	39	1.388	859	1.273	316,762	1.273
Jan-11	131,134	1.170	133,966	1.170	769	1.451	119	1.713	324,766	1.293	607	1.269	38	1.417	1,614	1.281	329,380	1.281
Feb-11	127,477	1.174	133,889	1.174	724	1.468	128	1.613	323,473	1.288	622	1.248	35	1.351	1,620	1.257	325,893	1.257
Mar-11	127,469	1.172	133,879	1.172	718	1.483	122	1.568	322,909	1.288	514	1.279	38	1.439	1,605	1.292	323,814	1.292
Apr-11	127,698	1.170	133,864	1.170	740	1.458	118	1.619	320,688	1.289	502	1.309	37	1.434	1,575	1.320	322,893	1.320

**Age/Sex Factors**

Product	Apr 09, 10, 11 Experience					
	Apr 09	Apr 10	Apr 11	Trend	Trend	Rate Filing Trend
HMO FFS	1.141	1.157	1.170	1.3%	1.2%	2.0%
HMO MG	1.325	1.355	1.386	2.3%	2.3%	2.0%
POS FFS	1.380	1.382	1.458	0.2%	5.5%	2.0%
POS MG	1.386	1.555	1.619	12.2%	4.1%	2.0%
<b>Total HIP (Apr 09 Member Mix)</b>	<b>1.242</b>	<b>1.266</b>	<b>1.289</b>	<b>1.9%</b>	<b>1.8%</b>	<b>2.0%</b>
EPO	1.225	1.257	1.309	2.6%	4.2%	2.0%
PPO	1.245	1.420	1.434	14.1%	1.0%	2.0%
<b>Total HIPIC (Apr 09 Member Mix)</b>	<b>1.226</b>	<b>1.271</b>	<b>1.320</b>	<b>3.6%</b>	<b>3.9%</b>	<b>2.0%</b>
<b>Total HIP/HIPIC (Apr 09 Member Mix)</b>	<b>1.242</b>	<b>1.266</b>	<b>1.289</b>	<b>1.9%</b>	<b>1.9%</b>	<b>2.0%</b>

**Milliman Factors**

Age Band	Male	Female
0-1	1.754	1.754
2-6	0.305	0.305
7-18	0.364	0.364
19-22	0.566	0.566
23-24	0.476	1.120
25-29	0.487	1.277
30-34	0.578	1.327
35-39	0.702	1.236
40-44	0.889	1.182
45-49	1.177	1.288
50-54	1.613	1.574
55-59	2.233	1.932
60-64	2.992	2.491
65+	4.033	3.377

**APPENDIX H-2**  
**HIP/HIPIC Small Group, Sole P, & Direct Pay Community Rated Age/Sex Factors**  
**Calculated Using Milliman Age Bands and Factors**

Month	HMO & Healthy New York Fee-for-service		HMO & Healthy New York Medical Group		POS Fee-for-service		POS Medical Group		Total HIP (2009 Member Mix)		EPO		PPO		Total HIPIC (2009 Member Mix)		Total HIP & HIPIC (2009 Member Mix)	
	Avg AS		Avg AS		Avg AS		Avg AS		Avg AS		Avg AS		Avg AS		Avg AS		Avg AS	
	Members	Factor	Members	Factor	Members	Factor	Members	Factor	Members	Factor	Members	Factor	Members	Factor	Members	Factor	Members	Factor
Jan-09	22,516	1.420	9,448	1.429	2,251	1.360	183	1.480	34,398	1.419	18,022	1.091	7,838	1.335	25,860	1.165	60,258	1.310
Feb-09	21,986	1.419	9,142	1.430	2,187	1.364	167	1.492	33,482	1.418	18,037	1.096	7,816	1.337	25,853	1.169	59,335	1.310
Mar-09	21,563	1.422	9,002	1.429	2,109	1.362	165	1.498	32,839	1.420	18,077	1.097	7,656	1.347	25,733	1.172	58,572	1.311
Apr-09	20,602	1.427	9,022	1.418	2,037	1.352	142	1.469	31,803	1.420	18,133	1.099	7,404	1.353	25,537	1.173	57,340	1.310
May-09	20,428	1.431	8,975	1.418	2,026	1.348	138	1.452	31,567	1.422	18,135	1.101	7,155	1.356	25,290	1.173	56,857	1.311
Jun-09	19,848	1.432	8,778	1.427	1,891	1.366	133	1.458	30,650	1.427	17,803	1.107	6,958	1.364	24,761	1.180	55,411	1.316
Jul-09	19,214	1.440	8,697	1.424	1,848	1.357	125	1.453	29,884	1.430	17,621	1.111	6,826	1.371	24,447	1.183	54,331	1.319
Aug-09	18,800	1.443	8,681	1.425	1,785	1.371	112	1.489	29,378	1.433	17,513	1.116	6,696	1.376	24,209	1.188	53,587	1.322
Sep-09	18,451	1.444	8,539	1.426	1,667	1.375	107	1.534	28,764	1.435	17,450	1.118	6,442	1.385	23,892	1.190	52,656	1.324
Oct-09	18,096	1.453	8,600	1.414	1,583	1.385	102	1.494	28,381	1.438	17,273	1.122	6,297	1.392	23,570	1.194	51,951	1.327
Nov-09	17,711	1.457	8,430	1.425	1,537	1.394	100	1.502	27,778	1.444	17,096	1.125	6,187	1.392	23,283	1.196	51,061	1.331
Dec-09	17,304	1.466	8,408	1.419	1,519	1.397	100	1.523	27,331	1.448	17,209	1.134	6,017	1.401	23,226	1.203	50,557	1.336
Jan-10	17,091	1.468	8,114	1.427	1,449	1.402	85	1.541	34,398	1.453	16,959	1.139	5,877	1.409	25,860	1.221	60,258	1.353
Feb-10	16,753	1.482	8,069	1.427	1,366	1.423	88	1.556	33,482	1.463	16,639	1.148	5,709	1.427	25,853	1.232	59,335	1.362
Mar-10	16,562	1.482	7,827	1.437	1,309	1.421	84	1.568	32,839	1.466	16,413	1.152	5,627	1.425	25,733	1.233	58,572	1.364
Apr-10	16,508	1.473	7,977	1.430	1,255	1.425	82	1.512	31,803	1.458	16,441	1.151	5,340	1.445	25,537	1.236	57,340	1.359
May-10	16,487	1.465	8,036	1.424	1,223	1.420	81	1.507	31,567	1.451	16,535	1.150	5,120	1.444	25,290	1.234	56,857	1.354
Jun-10	16,589	1.459	8,279	1.411	1,151	1.426	80	1.496	30,650	1.444	16,892	1.150	4,962	1.450	24,761	1.234	55,411	1.350
Jul-10	16,482	1.457	8,547	1.392	1,079	1.462	78	1.495	29,884	1.439	16,869	1.152	4,799	1.461	24,447	1.238	54,331	1.349
Aug-10	15,923	1.461	8,304	1.402	1,032	1.479	76	1.453	29,378	1.444	16,782	1.155	4,676	1.470	24,209	1.242	53,587	1.353
Sep-10	16,204	1.452	8,730	1.385	1,028	1.480	75	1.456	28,764	1.433	16,989	1.160	4,541	1.474	23,892	1.245	52,656	1.348
Oct-10	15,996	1.455	8,694	1.382	968	1.482	74	1.464	28,381	1.434	16,693	1.163	4,429	1.480	23,570	1.248	51,951	1.350
Nov-10	16,259	1.451	9,004	1.374	945	1.496	71	1.459	27,778	1.430	16,513	1.165	4,290	1.486	23,283	1.250	51,061	1.348
Dec-10	16,247	1.448	9,251	1.363	902	1.483	70	1.487	27,331	1.424	16,515	1.167	4,155	1.500	23,226	1.253	50,557	1.346
Jan-11	16,244	1.438	9,216	1.356	798	1.462	59	1.410	34,398	1.417	16,326	1.171	4,074	1.493	25,860	1.269	60,258	1.353
Feb-11	13,874	1.492	12,042	1.294	745	1.481	64	1.410	33,482	1.437	13,458	1.162	6,245	1.409	25,853	1.237	59,335	1.349
Mar-11	14,383	1.470	12,473	1.282	709	1.476	62	1.405	32,839	1.418	13,902	1.162	5,642	1.430	25,733	1.242	58,572	1.341
Apr-11	15,212	1.442	11,857	1.292	694	1.483	59	1.446	31,803	1.402	14,161	1.162	5,186	1.452	25,537	1.246	57,340	1.333

Product	Age/Sex Factors					
	Apr 09, 10, 11 Experience					
	Apr 09	Apr 10	Apr 11	Trend	Trend	Rate Filing Trend
HMO FFS	1.427	1.473	1.442	3.2%	-2.1%	2.0%
HMO MG	1.418	1.430	1.292	0.9%	-9.7%	2.0%
POS FFS	1.352	1.425	1.483	5.3%	4.1%	2.0%
POS MG	1.469	1.512	1.446	3.0%	-4.4%	2.0%
<b>Total HIP (Nov 10 Member Mix)</b>	<b>1.420</b>	<b>1.458</b>	<b>1.402</b>	<b>2.7%</b>	<b>-3.8%</b>	<b>2.0%</b>
EPO	1.099	1.151	1.162	4.7%	0.9%	2.0%
PPO	1.353	1.445	1.452	6.8%	0.5%	2.0%
<b>Total HIPIC (Nov 10 Member Mix)</b>	<b>1.173</b>	<b>1.236</b>	<b>1.246</b>	<b>5.4%</b>	<b>0.8%</b>	<b>2.0%</b>
<b>Total HIP/HIPIC (Nov 10 Member Mix)</b>	<b>1.310</b>	<b>1.359</b>	<b>1.333</b>	<b>3.8%</b>	<b>-2.0%</b>	<b>2.0%</b>

Age Band	Milliman Factors	
	Male	Female
0-1	1.754	1.754
2-6	0.305	0.305
7-18	0.364	0.364
19-22	0.566	0.566
23-24	0.476	1.120
25-29	0.487	1.277
30-34	0.578	1.327
35-39	0.702	1.236
40-44	0.889	1.182
45-49	1.177	1.288
50-54	1.613	1.574
55-59	2.233	1.932
60-64	2.992	2.491
65+	4.033	3.377