

SERFF Tracking Number: GRPH-127168276 State: New York
Filing Company: Group Health Incorporated State Tracking Number: 2011070100
Company Tracking Number:
TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: GHI Direct Pay
Project Name/Number: Rate Increase - 2012/

Filing at a Glance

Company: Group Health Incorporated
Product Name: GHI Direct Pay
TOI: H15I Individual Health -
Hospital/Surgical/Medical Expense
Sub-TOI: H15I.001 Health -
Hospital/Surgical/Medical Expense
Filing Type: Rate Adjustment pursuant to
Section 4308(c)

SERFF Tr Num: GRPH-127168276 State: New York
SERFF Status: Closed-APPR State Tr Num: 2011070100
Approved
Co Tr Num: State Status:

Reviewer(s): [REDACTED]

Authors: [REDACTED]

Disposition Date: 10/13/2011

Implementation Date Requested: 01/01/2012
State Filing Description:

Disposition Status: APPR Approved
Implementation Date: 01/01/2012

General Information

Project Name: Rate Increase - 2012
Project Number:
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized
Date Approved in Domicile:
Domicile Status Comments: Group Health
Incorporated is licensed to write health
insurance in New York State.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/18/2011
State Status Changed:

Deemer Date:
Submitted By: [REDACTED]
PPACA: Not PPACA-Related

Created By: [REDACTED]
Corresponding Filing Tracking Number:

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PPACA Notes: null

Filing Description:

This submission contains the 2012 GHI Direct Pay rate increase application.

Company and Contact

Filing Contact Information

[REDACTED]

EmblemHealth

55 Water Street

New York, NY 10041

Filing Company Information

Group Health Incorporated

441 Ninth Avenue

New York, NY 10001

(212) 615-0878 ext. [Phone]

[REDACTED]

[REDACTED]

[REDACTED]

CoCode: 55239

Group Code: -99

Group Name:

FEIN Number: 13-5511997

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: Article 43
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No. Individual non-HMO
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is an out-of-state filing.): 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 Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law

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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 Submission

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

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Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 12.550%
Effective Date of Last Rate Revision: 01/01/2011
Filing Method of Last Filing: Prior Approval

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Group Health Incorporated	Increase	9.800%	9.800%	\$3,616,898	3,682	\$36,907,128	9.800%	9.800%
Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								4,436
Policy Holders:								3,682

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Rate Review Details

COMPANY:

Company Name: Group Health Incorporated
HHS Issuer Id: 88000
Product Names: Direct Pay Core, Direct Pay Value
Trend Factors:

FORMS:

New Policy Forms:
Affected Forms:
Other Affected Forms: PLH-DPC-410, PLH-DPC-710

REQUESTED RATE CHANGE

INFORMATION:

Change Period: Annual
Member Months: 64,512
Benefit Change: None
Percent Change Requested: Min: 9.8 Max: 9.8 Avg: 9.8

PRIOR RATE:

Total Earned Premium: 36,907,128.00
Total Incurred Claims: 28,647,813.00
Annual \$: Min: 517.20 Max: 853.98 Avg: 572.10

REQUESTED RATE:

Projected Earned Premium: 31,834,931.00
Projected Incurred Claims: 26,429,749.00
Annual \$: Min: 639.15 Max: 1,055.35 Avg: 701.00

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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Checklist-Community Rated
 Medical Renewal Rate Review

Comments:

Please see the attached, as well as the Medical Renewal Rate Filing Summary and Actuarial Memorandum below.

Attachment:

CR Checklist 2012 GHI DP.pdf

Item Status: **Status**
Date:

Satisfied - Item: Medical Renewal Rate Filing
 Summary Template

Comments:

The Rate filing Summary and all rate/data exhibits pertaining to the actuarial memorandum are attached; in Excel and PDF formats.

Please note the Excel version of the Act Memo exhibits is split into two files due to file size constraints.

Attachments:

GHI_DP_ActMemo_Appendix1.xls
 GHI_DP_ActMemo_Appendix2.xls
 GHI_DP_Standard_Exhibits.xls
 GHI_DP_Standard_Exhibits.pdf
 GHI_DP_WEB_5477_2012 GHI DP Rate Narr_Exhibit3.pdf
 GHI_DP_ActMemo_Appendix.pdf

Item Status: **Status**
Date:

Satisfied - Item: Notice of Proposed Rate
 Adjustment

Comments:

A copy of the initial written notice sent to policyholders of the proposed rate adjustment is attached below. A copy of the final written notice to be sent to policyholders after the proposed rates are finalized is also attached below.

Attachments:

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Project Name/Number: Rate Increase - 2012/
GHI_SG_2012_inital_notice_sample.pdf
GHI_SG_2012_final_notice_sample.pdf

Item Status: **Status**
Date:

Satisfied - Item: Actuarial Memorandum

Comments:

The Actuarial memorandum is attached below.

Attachment:

GHI_DP_ActMemo.pdf

Item Status: **Status**
Date:

Satisfied - Item: Rate Manual Pages

Comments:

The rate manual pages are attached below.

Attachments:

Section One-Direct Pay 01 Base.pdf

Section One-Direct Pay 02 Drug Riders.pdf

Item Status: **Status**
Date:

Satisfied - Item: Benefit Descriptions

Comments:

The benefit descriptions for these products are attached below.

Attachment:

DPBenefitDescr.pdf

Item Status: **Status**
Date:

Satisfied - Item: Commisison schedule

Comments:

The commisison schedule is attached below.

Attachment:

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Company Tracking Number:
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Product Name: GHI Direct Pay
Project Name/Number: Rate Increase - 2012/
CommissionSchedule.pdf

Item Status: **Status**
Date:

Satisfied - Item: Premium Rate Change Exhibits

Comments:

The premium rate change exhibits are attached below.

Attachments:

Section Four-Direct Pay 01 Base.pdf

Section Four-Direct Pay 02 Drug Riders.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
DEFINITIONS	a.	<p>Company refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing.</p> <p>b. A company’s commercial book of business includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus.</p> <p>c. Loss ratio refers to incurred claims divided by earned premiums for a given period of time. 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. Market segment refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc.</p> <p>e. Product street name refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department.</p> <p>f. Rate applicability period 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. Standardized earned premium is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective).</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3rd and 4th quarters 2011 and 1st and 2nd quarters 2012. The 2nd quarter 2011 rates have already been approved. Therefore, the 2nd quarter 2011 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2nd quarter 2011 rate level. If the 2nd 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>ROLLING RATE STRUCTURE</p>	<p>a.</p>	<p>Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates).</p> <p>b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period.</p> <p>c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates).</p>	<p>See Rate/Rule Schedule tab in SERFF submission.</p>
<p>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</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 1st, 2nd, 3rd and 4th quarter of 2011. The company can not revise the 1st and 2nd quarter 2011 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3rd and 4th quarter 2011 and 1st and 2nd 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>STANDARD EXHIBITS 1 - 7</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>Exhibit 1</p>		<p>General information about the rate adjustment submission.</p> <ol style="list-style-type: none"> The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit. For Type of Insurer, select from the drop down list (HMO, Article 42, Article 43) or make an entry. For “For Profit” or “Non Profit” click on the applicable box and a check mark will appear. 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. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected. This exhibit may be submitted as an Adobe PDF file or as an Excel file. 	<p>See Supporting Documentation tab of SERFF submission.</p>
<p>Exhibit 2</p>		<p>FOIL Exemption Request.</p> <ol style="list-style-type: none"> 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. A request that the Department apply the Trade Secret/Competitive Injury 	<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"> (i) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied; (ii) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and (iii) where applicable, indicates where redactions would suffice to protect the exempt information. 	
Exhibit 3		<p>Narrative Summary.</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>Exhibit 4</p>		<p>Summary of Proposed Percentage Rate Change to Existing Rate.</p> <ul style="list-style-type: none"> a. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. 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. 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. 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. 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. 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. e. The weighted averages may be based on membership instead of premium volume. 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>Exhibits 4 and 5: 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>Exhibit 5</p>		<p>Distribution of Contracts Affected by the Proposed Rate Adjustments.</p> <ul style="list-style-type: none"> 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. b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. 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. 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. 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. f. Enter in section A the information for the various products that do not use a rolling rate structure. 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. 	
<p>Exhibit 6</p>		<p>Summary of Policy Form and Product Changes.</p> <ul style="list-style-type: none"> a. This exhibit summarizes all rate changes filed pursuant to sections of the New 	<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>Exhibit 7</p>		<p>Historical Data by Each Policy Form Included in the Rate Adjustment Filing (formerly the Summary Template).</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 1st, 2nd, 3rd, and 4th quarters of 2012. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2011 rate tables to the 1st 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"> (i) Each experience period is to be for 12 months (or shorter if a new form). (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.). (iii) The prior period is the immediately prior 12 month experience period (or shorter period if a new form). (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. 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. 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. 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. 	
ACTUARIAL MEMORANDUM	11NYCRR 52.40(a)(1)	Actuarial qualifications: <ul style="list-style-type: none"> a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	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"> a. Description of proposed changes in rates, including the following: <ul style="list-style-type: none"> (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 	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 3rd quarter 2011. The change from each of the 2nd quarter 2011 rolling rate tables to the corresponding 3rd quarter 2011 rolling rate table is to be indicated.) 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"> (ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data. (iii) Discuss the credibility of such source data. 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. (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. <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"> (i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <ul style="list-style-type: none"> (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for 	
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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 2nd quarter 2011 rate table to the proposed 3rd 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 3rd quarter 2011 rate table to the 4th 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"> (i) Regulatory authority licenses and fees, including New York State 332 assessment expenses; (ii) Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplemental Health Care Exhibit; (iii) Commissions and broker fees; (iv) Premium taxes; (v) Other administrative expenses; (vi) After-tax underwriting margin (profit/contribution to surplus); (vii) State income taxes (and applicable state income tax rate); (viii) Federal income taxes (and applicable federal income tax rate); (ix) Reduction for net investment income, if any; and (x) Net of the above. <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"> (i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance 	<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.
REVISED RATE MANUAL PAGES	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	<p>Rate Manual.</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.
NOTICES TO POLICYHOLDERS Initial & Final 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.
RATE FILINGS THAT ARE SUBJECT TO REVIEW	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.	

EXHIBIT 1: GENERAL INFORMATION ABOUT THE RATE ADJUSTMENT SUBMISSION

A. Insurer Information:	<u>Group Health Incorporated</u> <small>Company submitting the rate adjustment request</small>	<u>Article 43</u> <small>Type of insurer</small>	<input type="checkbox"/> For Profit <input checked="" type="checkbox"/> Non Profit <u>55239</u> <small>Company NAIC Code</small>
	<u>55 Water Street, New York, NY, 10041</u> <small>Company mailing address</small>		
B. Contact Person:	<div style="background-color: black; width: 100%; height: 1.2em;"></div> <small>Rate filing contact person name, title</small>	<div style="background-color: black; width: 100%; height: 1.2em;"></div> <small>Contact phone number</small>	<div style="background-color: black; width: 100%; height: 1.2em;"></div> <small>Contact Email address</small>
C. Actuarial Contact (If different from above):	<small>Actuary name, title</small>	<small>Actuary phone number</small>	<small>Actuary Email address</small>
D. New Rate Information (See Note #1):	<u>1/1/2012 - 12/31/2012</u> <small>New rate applicability period</small>	<u>1/1/2012</u> <small>New rate effective date</small>	<u>GRPH-127168276</u> <small>SERFF Tracking Number</small>
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	<u>Individual</u>		
F. Provide responses for the following questions:	Response		
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No		
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	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 made by completing this exhibit.
2. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information contained in this submission that is not included in this exhibit may not be honored by the Department.
3. A request that the Department apply the Trade Secret/Competitive Injury Exemption to any information included in this submission must be accompanied by a written statement of necessity that:
 - (a) identifies the specific parts of the submission for which the Company believes the Trade Secret/Competitive Injury Exemption should be applied;
 - (b) specifies the reasons why the submission, or parts thereof, should be exempt from disclosure pursuant to the Trade Secret/Competitive Injury Exemption; and
 - (c) where applicable, indicates where redactions would suffice to protect the exempt information.
4. In light of the open government purpose underlying FOIL, the Department favors redacting portions of documents, and disclosing the balance of such documents, as opposed to withholding documents in their entirety, where such redactions will suffice to protect the exempt information. Therefore, the Company should submit to the Department both the original document and a redacted version of the original document, which omits or blocks the information it wishes to exempt from disclosure. (The Department will accept the redacted version of the original document within one week after original filing was submitted.)

A. Insurer Information: Group Health Incorporated 55239 GRPH-127168276
Company submitting the rate adjustment request Company NAIC Code SERFF tracking number

B. FOIL Contact Person: [REDACTED] [REDACTED] [REDACTED]
[REDACTED] Mailing address [REDACTED] 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 _____ be exempt from disclosure 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 computer files that are included with the application. The unredacted portion(s) of the redacted documents may be deemed to be public.

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 community rated product application contain trade secret information, which, if disclosed, would cause substantial injury to the competitive position of GHI. 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's current book of business to shift to other plans.

The actuarial memos are 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's community rated products. This information may be used by competition to market to the disadvantage of GHI.

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: GHI
NAIC Code: 55239
SERFF Tracking #: GRPH-127168276

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

- The Narrative Summary will be a public document and will be posted on the Department's website and furnished by the Department to the public upon request.
- It is strongly encouraged that the company submit the Narrative Summary to the Department ten (10) days before submitting a rate adjustment application.
- It is suggested that once reviewed by the Department, the company post the Narrative Summary on its website. Any changes made to the Narrative Summary subsequent to the posting are required to be submitted to the Department.
- The Narrative Summary should include, but not be limited to, the following information:
 - 1) The name of the company submitting the rate adjustment request.
 - 2) A summary of the proposed rate adjustments, which can be a range as long as the range is consistent with the range stated in the initial notice to policyholders for the various products, and rating region.
 - 3) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect certain policyholders in a market segment (e.g., Small Group), or with certain products (indicate the "street name" of the products affected), or only a certain renewal cohort (e.g., policyholders renewing mm/dd/yyyy – mm/dd/yyyy).
 - 4) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
 - 5) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders.
For example:
 - (a) For a non-guaranteed rate structure: All policyholders will receive the rate adjustment on mm/dd/yyyy.
 - (b) For a rate structure with a 12 month rate guarantee: A policyholder will receive the rate adjustment on the policyholder's next anniversary on or after mm/dd/yyyy.
 - 6) The number of policyholders/members affected by the proposed rate adjustment(s); aggregated across all market segments and products affected by the rate adjustments submission.
 - 7) An explanation, in plain-language, as to why it is necessary to request such rate changes. As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type.
- Each page of the Narrative Summary should be numbered (i.e., [page] of [pages]).

Please see supporting document **GHI_DP_WEB_5477_2012 GHI DP Rate Narr_Exhibit3.doc**

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

GHI

 Company submitting the rate adjustment request

55239

 Company NAIC Code

GRPH-127168276

 SERFF tracking number

- => 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 to be reported.
- Submit separate exhibits by rating region if the rate changes differ by rating region.
- Submit separate exhibits for each rolling rate table of a rolling rate struct
- => 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.

A. BASE MEDICAL PLAN

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

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

- Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of
- 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
- 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 Rate Change (year/year)		
				Lowest	Highest	Weighted Avg
PLH-DPC-410	Core	Core	Jan. 2012	9.8%	9.8%	9.8%
PLH-DPC-710	Value	Value	Jan. 2012	9.8%	9.8%	9.8%

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

GHI
 Company submitting the rate adjustment request

55239
 Company NAIC Code

GRPH-127168276
 SERFF tracking number

- => 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 to be reported.
- Submit separate exhibits by rating region if the rate changes differ by rating region.
- Submit separate exhibits for each rolling rate table of a rolling rate struct
- => 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).

B. DRUG RIDERS

Market Segment: Individual
 Rating Region: All

- Provide a list of proposed rate changes for drug riders available with base medical products.
- => 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 Rate Change (year/year)		
				Lowest	Highest	Weighted Avg
Core Drug Rider	PLH-DPC-410	Core	Jan. 2012	9.8%	9.8%	9.8%
Value Drug Rider	PLH-DPC-710	Value	Jan. 2012	9.8%	9.8%	9.8%

EXHIBIT 5: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS

Company Name: GHI
 NAIC Code: 55239
 SERFF Tracking #: GRPH-127168276

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

A. FOR A NON-ROLLING RATE STRUCTURE -- Distribution of Non Rolling Rate Contracts by Proposed Rate Adjustment

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of members as of 3/31/2011	Number of Members with Proposed Percentage Rate Change at Renewal										
						Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher
	Individual	All	Core	9.8%	659				659							
	Individual	All	Value	9.8%	3,777				3777							
	Market Segment Total:					4,436				4436						

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: GHI _____
 NAIC Code: 55239 _____
 SERFF Number: GRPH-127168276 _____

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
 NAIC Code: 55239
 SERFF Number: GRPH-127168276

- 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	Core	Response	
1a. Base medical policy form number	PLH-DPC-410	PLH-DPC-710	
1b. Product Name as in Rate Manual	Core	Value	Total
1c. Product Street Name as indicated to consumers	Core	Value	Direct Pay
2. Aggregated for rate development with these base medical policy form numbers	All Of The Above	All Of The Above	
3. Effective date of rate change (MM/DD/YYYY)	01/01/2012	01/01/2012	
4. Market Segment (large group, small group, individual, or sole proprietor) [drop down menu]	Individual	Individual	
5. Product type (see above for examples) [drop down menu]	PPO	PPO	
6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	No	No	
7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	No	No	
8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	Open	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.)	0	0	
10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	9.8%	9.8%	9.8%
11. Number of policyholders affected by rate change. For group business this is number of groups.	524	3,158	3,682
12. Number of covered lives affected by rate change	659	3,777	4,436
13. Expected NY statewide loss ratio for base medical policy form including associated riders	72.4%	84.9%	82.1%

Data Item for Specified Base Medical Policy Form	Core	Response	
1a. Base medical policy form number	PLH-DPC-410	PLH-DPC-710	
1b. Product Name as in Rate Manual	Core	Value	Total
1c. Product Street Name as indicated to consumers	Core	Value	Direct Pay
Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)			
14.1 Beginning Date of the experience period (MM/DD/YYYY)	01/01/2010	01/01/2010	01/01/2010
14.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2010	12/31/2010	12/31/2010
14.3 Member months for experience period	10,516	53,996	64,512
14.4 Earned premiums for experience period (\$)	8,980,440	27,926,687	36,907,128
14.5 Standardized earned premiums for experience period (\$)	10,107,486	31,431,487	41,538,972
14.6 Paid claims for experience period (\$)	5,769,635	20,804,731	26,574,366
14.7 Incurred claims for experience period (\$)	6,231,629	22,416,184	28,647,813
14.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	733,281	3,765,141	4,498,422
14.9 Earned premiums for experience period (\$pmpm)	853.98	517.20	572.10
14.10 Standardized premiums for experience period (\$pmpm)	961.15	582.11	643.90
14.11 Paid claims for experience period (\$pmpm)	548.65	385.30	411.93
14.12 Incurred claims for experience period (\$pmpm)	592.59	415.15	444.07
14.13 Administrative expenses for experience period (\$pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	69.73	69.73	69.73
14.14 Ratio: Incurred Claims / Earned Premiums	0.694	0.803	0.776
14.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.617	0.713	0.690
14.16 Ratio: Administration Expenses / Earned Premiums	0.082	0.135	0.122
14.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.776	0.938	0.898

Data Item for Specified Base Medical Policy Form	Core	Response	
1a. Base medical policy form number	PLH-DPC-410	PLH-DPC-710	
1b. Product Name as in Rate Manual	Core	Value	Total
1c. Product Street Name as indicated to consumers	Core	Value	Direct Pay
Prior Experience Period (NY statewide experience, base medical policy form + associated riders)			
15.1 Beginning date of the experience period (MM/DD/YYYY)	01/01/2009	01/01/2009	01/01/2009
15.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2009	12/31/2009	12/31/2009
15.3 Member months for experience period	14,879	62,262	77,141
15.4 Earned premiums for experience period (\$)	10,243,787	26,257,939	36,501,726
15.5 Standardized earned premiums for experience period (\$)	13,777,893	35,316,928	49,094,822
15.6 Paid claims for experience period (\$)	8,580,698	24,810,374	33,391,072
15.7 Incurred claims for experience period (\$)	8,625,009	24,955,838	33,580,847
15.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	1,238,251	4,259,187	5,497,438
15.9 Earned premiums for experience period (\$pmpm)	688.47	421.73	473.18
15.10 Standardized premiums for experience period (\$pmpm)	926.00	567.23	636.43
15.11 Paid claims for experience period (\$pmpm)	576.70	398.48	432.86
15.12 Incurred claims for experience period (\$pmpm)	579.68	400.82	435.32
15.13 Administrative expenses for experience period (\$pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	83.22	68.41	71.26
15.14 Ratio: Incurred Claims / Earned Premiums	0.842	0.950	0.920
15.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.626	0.707	0.684
15.16 Ratio: Administrative Expenses / Earned Premiums	0.121	0.162	0.151
15.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.963	1.113	1.071
Annualized Medical Trend Factors (%)			
16.1 All benefits combined, composite	13.5%	14.2%	14.1%
16.2 Due to utilization	3.1%	3.1%	3.1%
16.3 Due to unit cost	10.1%	10.8%	10.7%
Ratios: Most Recent Experience Period to Prior Period			
17.1 Member months	0.707	0.867	0.836
17.2 Earned premiums (\$pmpm)	1.240	1.226	1.209
17.3 Standardized premiums (\$pmpm)	1.038	1.026	1.012
17.4 Paid claims (\$pmpm)	0.951	0.967	0.952
17.5 Incurred claims (\$pmpm)	1.022	1.036	1.020
17.6 Administrative expenses (\$pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	0.838	1.019	0.978
Ratio: Standard Premium to Earned Premium			
18.1 Most Recent Experience Period	1.125	1.126	1.125
18.2 Prior Experience Period	1.345	1.345	1.345

INFORMATION ABOUT YOUR GHI DIRECT PAY 2012 RATES

GHI is part of the EmblemHealth group of companies. It is a not-for-profit health service corporation organized under Article 43 of the New York Insurance Law to provide coverage for the costs of health care. Income generated is used to benefit members, either as claim payments or to provide administrative services to operate the company, which serves over 1.8 million members, including approximately 4,500 GHI Direct Pay 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 is requesting a premium rate increase for its GHI Direct Pay business, effective January 1, 2012. The reason for the requested rate increase is that health care costs have risen dramatically during the past year. The major factors driving 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 Direct Pay subscribers renewing on January 1, 2012.

The premium rate increase we are requesting is shown below.

Percent Increase from January 1, 2011 to January 1, 2012: 9.8%

Final Rate Increase

Your final renewal rate may be different from the proposed increases shown above. NYSID may approve, modify or deny these adjustments. We will notify you of your final, approved rates 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 these plans – for example due to new benefits mandated by New York State law – those benefit changes may also impact your final premium rates.

**APPENDIX B-1
2009 Experience Period**

Product Type	Product Name	01	02	03	04	05	06					Earned	Incurred	Admin	Standardized
		Member Months	Earned Premium	Paid Claims	Incurred Claims	Administrative Expenses	Standardized Premium	04 / 02	04 / 06	05 / 02	(05+04) / 02	PMPM	PMPM	PMPM	PMPM
Direct Pay	Core	14,879	\$10,243,787	\$8,580,698	\$8,625,009	\$1,238,251	\$13,777,893	84.2%	62.6%	12.1%	96.3%	\$688.47	\$579.68	\$83.22	\$926.00
Direct Pay	Value	62,262	\$26,257,939	\$24,810,374	\$24,955,838	\$4,259,187	\$35,316,928	95.0%	70.7%	16.2%	111.3%	\$421.73	\$400.82	\$68.41	\$567.23
Direct Pay		77,141	\$36,501,726	\$33,391,072	\$33,580,847	\$5,497,438	\$49,094,822	92.0%	68.4%	15.1%	107.1%	\$473.18	\$435.32	\$71.26	\$636.43

**APPENDIX B-2
2010 Experience Period**

Product Type	Product Name	01	02	03	04	05	06					Earned	Incurred	Admin	Standardized
		Member Months	Earned Premium	Paid Claims	Incurred Claims	Administrative Expenses	Standardized Premium	04 / 02	04 / 06	05 / 02	(05+04) / 02	Premium PMPM	Claims PMPM	Expenses PMPM	Premium PMPM
Direct Pay	Core	10,516	\$8,980,440	\$5,769,635	\$6,231,629	\$733,281	\$10,107,486	69.4%	61.7%	8.2%	77.6%	\$853.98	\$592.59	\$69.73	\$961.15
Direct Pay	Value	53,996	\$27,926,687	\$20,804,731	\$22,416,184	\$3,765,141	\$31,431,487	80.3%	71.3%	13.5%	93.8%	\$517.20	\$415.15	\$69.73	\$582.11
Direct Pay		64,512	\$36,907,128	\$26,574,366	\$28,647,813	\$4,498,422	\$41,538,972	77.6%	69.0%	12.2%	89.8%	\$572.10	\$444.07	\$69.73	\$643.90

APPENDIX C
Value

2010 Earned Premium PMPM	\$517.20
2010 Rate Ratio	1.126
Standardized Premium PMPM	\$582.11

APPENDIX D-1
Source Data Exhibit / 2012 Projection Development

Product Type	Product Name
--------------	--------------

Direct Pay Core
Direct Pay Value
Direct Pay

Standardized Premium PMPM	2010 Member Months
---------------------------	--------------------

\$961.15 10,516
\$582.11 53,996
\$643.90 64,512

2012 Annual Increase	2012 Projected Premium
----------------------	------------------------

9.8% 1,055.35
9.8% 639.15
9.8% \$707.00

Product Type	Product Name
--------------	--------------

Direct Pay Core
Direct Pay Value
Direct Pay

2010 Incurred Claims PMPM	Annualized Medical		Projected Re-class Expense PMPM	2012 Projected Clms PMPM
	2011 Trend	2012 Trend		

\$592.59 13.3% 13.7% \$1.31 772.71
\$415.15 14.2% 14.3% \$0.82 548.69
\$444.07 14.0% 14.2% \$0.90 \$585.21

Product Type	Product Name
--------------	--------------

Direct Pay Core
Direct Pay Value
Direct Pay

2012 Expected MLR

73.2%
85.8%
82.8%

*Total Direct Pay Projected Premium and Claims PMPM weighted by 2010 projected membership

**Projected expenses reclassified from Administrative expense to Medical expense are added to projected 2012 claims

APPENDIX D-2
Source Data Exhibit / 2012 Projection Development

Product Type	Product Name	2010	Standardized	2012	2012	2012
		Member Months	Premium PMPM	Projected Member Months	Annual Increase	Projected Premium
Direct Pay	Core	10,516	\$961.15	6,748	9.8%	1,055.35
Direct Pay	Value	53,996	\$582.11	38,666	9.8%	639.15
Direct Pay		64,512	\$638.43	45,414	9.8%	\$701.00

Product Type	Product Name	2010	Annualized		Projected	2012
		Incurred Claims PMPM	Medical 2011 Trend	Medical 2012 Trend	Re-class Expense PMPM	Projected Clms PMPM
Direct Pay	Core	\$592.59	13.3%	13.7%	\$1.31	764.50
Direct Pay	Value	\$415.15	14.2%	14.3%	\$0.82	542.63
Direct Pay		\$441.51	14.0%	14.2%	\$0.89	\$575.59

Product Type	Product Name	2012
		Expected MLR
Direct Pay	Core	72.4%
Direct Pay	Value	84.9%
Direct Pay		82.1%

*Total Direct Pay Projected Premium and Claims PMPM weighted by 2010 projected membership

**Projected expenses reclassified from Administrative expense to Medical expense are added to projected 2012 claims

**APPENDIX E-1
GHI COMMUNITY RATED TREND COMPONENTS**

Product	Avg 2010 Members	2010/ 2009 Trends					2011/2010 Projected Trends					2012/2011 Projected Trends				
		Total Trend	Total Utilization	Total Cost	Contracted Cost	Risk Score	Contracted Cost	Utilization	Cost Share Leverage	Risk Score	Total Trend	Contracted Cost	Utilization	Cost Share Leverage	Risk Score	Total Trend
Inpatient Facility																
EPO	78,575	23.3%	3.6%	19.0%	9.3%	3.2%	9.0%	4.0%	0.5%	1.6%	15.8%	9.0%	3.0%	0.5%	1.6%	14.6%
EPO Share	28,039	54.7%	6.3%	45.5%	8.5%	6.2%	8.2%	5.0%	1.0%	3.1%	18.3%	8.3%	5.0%	1.0%	3.1%	18.4%
EPO CDHP	33,894	48.1%	5.9%	39.8%	9.1%	20.9%	8.8%	7.0%	5.0%	3.0%	25.9%	8.7%	7.0%	5.0%	3.0%	25.8%
PPO	12,053	19.7%	2.0%	17.4%	9.1%	1.9%	9.4%	4.0%	0.5%	0.9%	15.5%	9.0%	2.5%	0.5%	0.9%	13.4%
PPO CDHP	15,717	100.4%	32.1%	51.7%	9.6%	9.7%	8.9%	12.0%	2.5%	4.8%	31.1%	8.5%	12.0%	2.5%	4.8%	30.5%
SBAP	1,834	68.1%	12.7%	49.2%	9.5%	1.9%	7.5%	6.0%	0.5%	0.9%	15.6%	7.8%	6.0%	0.5%	0.9%	16.0%
HNY EPO	12,471	16.8%	4.0%	12.3%	10.3%	3.2%	9.4%	3.0%	1.0%	1.9%	16.0%	8.8%	3.0%	1.0%	1.9%	15.4%
HCTC	37	2335.0%	166.5%	813.6%	0.0%	1.9%	0.0%	3.0%	1.0%	1.9%	6.0%	8.8%	3.0%	1.0%	1.9%	15.4%
Direct Pay	5,406	-8.6%	0.7%	-9.2%	8.9%	1.9%	8.3%	3.0%	2.5%	1.9%	16.5%	8.4%	3.0%	2.5%	1.9%	16.6%
MedSupp	2,981	-14.4%	4.6%	-18.2%	8.1%	1.9%	8.0%	3.0%	0.5%	1.9%	13.9%	7.8%	3.0%	0.5%	1.9%	13.7%
Total	191,007															

Outpatient Facility																
EPO	78,575	11.5%	-2.9%	14.9%	8.3%	3.2%	6.9%	3.0%	0.5%	1.6%	12.5%	8.1%	3.0%	0.5%	1.6%	13.7%
EPO Share	28,039	29.4%	-2.0%	32.0%	7.9%	6.2%	6.9%	4.0%	1.0%	3.1%	15.8%	7.7%	1.8%	1.0%	3.1%	14.1%
EPO CDHP	33,894	71.2%	11.7%	53.2%	8.2%	20.9%	7.3%	9.0%	5.0%	3.0%	26.5%	8.3%	8.0%	5.0%	3.0%	26.4%
PPO	12,053	10.0%	5.7%	4.1%	9.2%	1.9%	7.0%	6.0%	0.5%	0.9%	15.1%	8.6%	6.0%	0.5%	0.9%	16.8%
PPO CDHP	15,717	36.8%	13.2%	20.8%	8.7%	9.7%	7.4%	8.0%	2.5%	4.8%	24.6%	8.4%	5.8%	2.5%	4.8%	23.3%
SBAP	1,834	-34.5%	-12.8%	-24.8%	8.7%	1.9%	5.7%	4.0%	0.5%	0.9%	11.6%	8.1%	1.8%	0.5%	0.9%	11.6%
HNY EPO	12,471	9.1%	-3.4%	13.0%	9.4%	3.2%	7.7%	4.0%	1.0%	1.9%	15.2%	8.6%	1.8%	1.0%	1.9%	13.8%
HCTC	37	84.6%	23.2%	49.9%	6.5%	1.9%	2.7%	4.0%	1.0%	1.9%	9.9%	1.9%	1.8%	1.0%	1.9%	6.7%
Direct Pay	5,406	10.9%	2.0%	8.7%	7.9%	1.9%	5.4%	4.0%	2.5%	1.9%	14.5%	7.0%	1.8%	2.5%	1.9%	13.8%
MedSupp	2,981	-6.6%	0.5%	-7.1%	8.6%	1.9%	7.3%	4.0%	0.5%	1.9%	14.3%	7.8%	1.8%	0.5%	1.9%	12.4%
Total	191,007															

GHI COMMUNITY RATED TREND COMPONENTS

Product	Avg 2010 Members	2010/ 2009 Trends					2011/2010 Projected Trends					2012/2011 Projected Trends				
		Total Trend	Total Utilization	Total Cost	Contracted Cost	Risk Score	Contracted Cost	Utilization	Cost Share Leverage	Risk Score	Total Trend	Contracted Cost	Utilization	Cost Share Leverage	Risk Score	Total Trend
Professional Par																
EPO	78,575	10.1%	5.2%	4.6%	2.5%	3.2%	1.1%	5.0%	0.5%	1.6%	8.4%	2.7%	5.0%	0.5%	1.6%	10.1%
EPO Share	28,039	13.5%	8.8%	4.3%	2.5%	6.2%	1.1%	8.0%	1.0%	3.1%	13.7%	2.7%	8.0%	1.0%	3.1%	15.5%
EPO CDHP	33,894	71.8%	19.6%	43.6%	2.2%	20.9%	1.1%	10.0%	5.0%	3.0%	20.3%	2.7%	9.3%	5.0%	3.0%	21.4%
PPO	12,053	3.6%	-0.9%	4.6%	2.5%	1.9%	1.1%	3.0%	0.5%	0.9%	5.6%	2.7%	3.0%	0.5%	0.9%	7.3%
PPO CDHP	15,717	26.4%	7.6%	17.5%	2.0%	9.7%	1.1%	10.0%	2.5%	4.8%	19.5%	2.7%	9.3%	2.5%	4.8%	20.6%
SBAP	1,834	-10.3%	-11.8%	1.7%	2.5%	1.9%	1.1%	3.0%	0.5%	0.9%	5.6%	2.7%	3.0%	0.5%	0.9%	7.3%
HNY EPO	12,471	-1.4%	-3.7%	2.4%	2.5%	3.2%	1.1%	3.0%	1.0%	1.9%	7.2%	2.7%	3.0%	1.0%	1.9%	8.9%
HCTC	37	4.1%	13.1%	-8.0%	2.5%	1.9%	1.1%	3.0%	1.0%	1.9%	7.2%	2.7%	3.0%	1.0%	1.9%	8.9%
Direct Pay	5,406	14.7%	-0.7%	15.5%	2.5%	1.9%	1.1%	3.0%	2.5%	1.9%	8.8%	2.7%	3.0%	2.5%	1.9%	10.5%
MedSupp	2,981	0.0%	0.0%	0.0%	2.5%	1.9%	1.1%	3.0%	0.5%	1.9%	6.6%	2.5%	3.0%	0.5%	1.9%	8.1%
Total	191,007															

Professional Non Par																
EPO	78,575	10.3%	0.8%	9.5%	2.0%	3.2%	1.1%	1.0%	0.5%	1.6%	4.3%	2.7%	1.0%	0.5%	1.6%	5.9%
EPO Share	28,039	6.5%	-7.0%	14.5%	2.0%	6.2%	1.1%	1.0%	1.0%	3.1%	6.3%	2.7%	1.0%	1.0%	3.1%	8.0%
EPO CDHP	33,894	11.8%	-18.0%	36.2%	2.0%	20.9%	1.1%	3.0%	5.0%	3.0%	12.6%	2.7%	3.0%	5.0%	3.0%	14.4%
PPO	12,053	8.9%	6.0%	2.7%	2.0%	1.9%	1.1%	5.0%	0.5%	0.9%	7.7%	2.7%	5.0%	0.5%	0.9%	9.4%
PPO CDHP	15,717	107.5%	44.7%	43.5%	2.5%	9.7%	1.1%	20.0%	2.5%	4.8%	30.4%	2.7%	20.0%	2.5%	4.8%	32.4%
SBAP	1,834	47.4%	104.9%	-28.1%	2.0%	1.9%	1.1%	2.0%	0.5%	0.9%	4.6%	2.7%	2.0%	0.5%	0.9%	6.3%
HNY EPO	12,471	4.2%	3.2%	1.0%	2.0%	3.2%	1.1%	2.0%	1.0%	1.9%	6.1%	2.7%	2.0%	1.0%	1.9%	7.8%
HCTC	37	13.9%	-8.4%	24.3%	2.0%	1.9%	1.1%	2.0%	1.0%	1.9%	6.1%	2.7%	2.0%	1.0%	1.9%	7.8%
Direct Pay	5,406	-3.2%	3.5%	-6.4%	2.0%	1.9%	1.1%	2.0%	2.5%	1.9%	7.7%	2.7%	2.0%	2.5%	1.9%	9.4%
MedSupp	2,981	-9.0%	-14.0%	5.8%	2.0%	1.9%	1.1%	2.0%	0.5%	1.9%	5.6%	2.5%	2.0%	0.5%	1.9%	7.1%
Total	191,007															

Pharmacy																
EPO	78,575	15.2%	9.3%	5.5%		3.2%	5.0%	3.0%	0.5%	1.6%	10.4%	4.0%	3.0%	0.5%	1.6%	9.4%
EPO Share	28,039	16.7%	10.8%	5.3%		6.2%	5.0%	3.0%	1.0%	3.1%	12.6%	4.0%	3.0%	1.0%	3.1%	11.5%
EPO CDHP	33,894	34.1%	30.1%	3.1%		20.9%	5.0%	3.0%	5.0%	3.0%	16.9%	4.0%	3.0%	5.0%	3.0%	15.8%
PPO	12,053	24.3%	13.6%	9.4%		1.9%	5.0%	3.0%	0.5%	0.9%	9.7%	4.0%	3.0%	0.5%	0.9%	8.7%
PPO CDHP	15,717	22.0%	19.3%	2.2%		9.7%	5.0%	3.0%	2.5%	4.8%	16.2%	4.0%	3.0%	2.5%	4.8%	15.1%
SBAP	1,834	-13.7%	-16.8%	3.8%		1.9%	5.0%	3.0%	0.5%	0.9%	9.7%	4.0%	3.0%	0.5%	0.9%	8.7%
HNY EPO	12,471	3.4%	6.6%	-3.0%		3.2%	5.0%	3.0%	1.0%	1.9%	11.3%	4.0%	3.0%	1.0%	1.9%	10.2%
HCTC	37	-4.9%	-7.2%	2.5%		1.9%	5.0%	3.0%	1.0%	1.9%	11.3%	4.0%	3.0%	1.0%	1.9%	10.2%
Direct Pay	5,406	11.8%	9.4%	2.2%		1.9%	5.0%	3.0%	2.5%	1.9%	12.9%	4.0%	3.0%	2.5%	1.9%	11.9%
MedSupp	2,981	0.0%	0.0%	0.0%		1.9%	5.0%	3.0%	0.5%	1.9%	10.7%	4.0%	3.0%	0.5%	1.9%	9.7%
Total	191,007															

**APPENDIX E-2
GHI Direct Pay Trends**

2010 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			SMC Pooling			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
Core	-18.2%	-6.2%	-23.3%	-0.7%	2.1%	1.4%	1.8%	10.0%	12.0%	12.5%	13.8%	28.1%	9.4%	2.2%	11.8%	0.0%	3.0%	3.0%	0.0%	196.6%	196.6%		
Value	6.2%	-9.4%	-3.8%	2.1%	11.7%	14.0%	5.9%	16.6%	23.4%	6.6%	-15.8%	-10.2%	9.4%	2.2%	11.8%	0.0%	-6.0%	-6.0%	0.0%	196.6%	196.6%		1.5%
2011 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			SMC Pooling			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
Core	3.0%	13.1%	16.5%	4.0%	10.1%	14.5%	3.0%	5.6%	8.8%	2.0%	5.6%	7.7%	3.0%	9.7%	12.9%	0.0%	0.0%	0.0%	0.0%	-0.5%	-0.5%		13.3%
Value	3.0%	13.1%	16.5%	4.0%	10.1%	14.5%	3.0%	5.6%	8.8%	2.0%	5.6%	7.7%	3.0%	9.7%	12.9%	0.0%	0.0%	0.0%	0.0%	-0.5%	-0.5%		14.2%
2012 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			SMC Pooling			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
Core	3.0%	13.2%	16.6%	1.8%	11.8%	13.8%	3.0%	7.3%	10.5%	2.0%	7.3%	9.4%	3.0%	8.6%	11.9%	0.0%	0.0%	0.0%	0.0%	-0.5%	-0.5%		13.7%
Value	3.0%	13.2%	16.6%	1.8%	11.8%	13.8%	3.0%	7.3%	10.5%	2.0%	7.3%	9.4%	3.0%	8.6%	11.9%	0.0%	0.0%	0.0%	0.0%	-0.5%	-0.5%		14.3%

GH Community Rated
 Inpatient Facility Cost Analysis
 Claims Incurred CY 2010, Paid thru March 2011

Provider TIN	Provider	GH-FFO			GH-EFO			EFO Share			CDIP FFO			CDIP EFO			SBAP			HNS EFO			Direct Pay			Med Supp		
		\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected	\$ Weight (CMI	2011 Contracted	2012 Projected
		Adjusted	Trend	Trend																								
[Redacted Data]																												
Top 100 Facilities		\$9,177,567	9.8%	9.2%	\$47,153,696	9.2%	9.1%	\$12,867,889	8.4%	8.4%	\$8,428,472	9.2%	8.6%	\$17,012,006	8.9%	8.8%	\$1,565,548	7.6%	8.0%	\$8,642,685	9.5%	8.8%	\$3,671,254	8.9%	8.8%	\$894,754	9.0%	8.6%
Exnet (Excludes Non-Pay Facilities)		\$1,182,798	6.9%	7.8%	\$1,829,359	6.6%	7.7%	\$1,786,066	6.5%	7.5%	\$1,166,653	7.0%	7.7%	\$1,434,817	6.6%	7.7%	\$298,683	6.9%	7.2%	\$311,988	7.1%	6.9%	\$889,958	7.9%	6.8%	\$799,339	6.8%	7.6%
Total		\$10,360,365	9.4%	9.0%	\$50,776,086	9.0%	9.0%	\$14,653,955	8.7%	8.3%	\$9,595,125	8.9%	8.5%	\$18,446,822	8.8%	8.7%	\$1,864,231	7.5%	7.8%	\$9,054,673	9.4%	8.8%	\$4,551,112	8.9%	8.4%	\$1,694,093	8.0%	7.8%

APPENDIX F-2
 GH Community Rated
 Outpatient Facility Cost Analysis
 Claims Incurred CY 2010, Paid thru March 2011

Provider TIN	Provider Name	GHI EPO			CDHP EPO			EPO Share			GHI PPO			CDHP PPO			HNY EPO			Direct Pay			SBAP			Med Supp		
		\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected	\$ Weight	2011 Contracted	2012 Projected
[REDACTED]																												
Top 100 Facilities		\$41,851,388	7.0%	8.3%	\$16,744,342	7.5%	8.5%	\$12,968,789	7.1%	7.9%	\$10,190,770	7.1%	8.9%	\$8,037,796	7.5%	8.7%	\$6,353,733	7.7%	8.7%	\$4,843,340	5.7%	7.6%	\$1,453,095	5.6%	8.2%	\$551,984	7.6%	8.2%
Other (Including Non Par)		\$6,966,273	6.4%	7.1%	\$3,138,399	6.4%	6.9%	\$2,940,186	6.1%	6.7%	\$2,228,805	6.7%	7.4%	\$1,830,323	6.8%	7.2%	\$647,190	6.9%	7.6%	\$1,800,846	4.6%	5.5%	\$259,121	6.7%	7.5%	\$214,765	6.6%	6.8%
Total		\$48,817,662	6.9%	8.1%	\$19,882,741	7.3%	8.3%	\$15,908,975	6.9%	7.7%	\$12,419,575	7.0%	8.6%	\$9,868,018	7.4%	8.4%	\$7,000,923	7.7%	8.6%	\$6,644,187	5.4%	7.0%	\$1,711,217	5.7%	8.1%	\$766,759	7.3%	7.8%

Professional Bank Account Summary by Line of Business

GHI LOB	IPA/PC	Percent of Annual Spend* Annual Spend Total	Unit Cost				CMS Impact		Total	
			Result: Negotiated Percent Increase	Negotiated Projected Annual Spend	Agreement Status	Open/Closed	Projected 2011 CMS Update	Projected CMS Incremental Impact	Total Projected Percent Increase	Total Projected Incremental Increase
Commercial										
Commercial										
Commercial										
Commercial										
Commercial										
Commercial										
Commercial										
Commercial										
Commercial										
COMMERCIAL PPO TOTAL		\$443,718,170		\$447,742,519			\$703,304		\$4,727,653	
PROJECTED NEGOTIATED UNIT COST TREND INCREASE									0.9%	
PROJECTED CMS TREND INCREASE									0.2%	
PROJECTED TOTAL UNIT COST AND CMS TREND INCREASE									1.1%	

Excludes COB, Non-NY and Non-Physician claims (DME, Anesthesia, Lab, Radiology, MH/SA and ER physician claims). IPA's/large groups encompass 5 or more providers.

**APPENDIX G-1
GHI COMMERCIAL COMMUNITY RATED CY 2009 ACTUALS**

Table 1	RETAIL					
	Number of Scripts by Drug Category for 2009 per 1000 members					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months
PPO	5,468.0	1,945.8	154.2	2,176.5	9,744.6	264,118
EPO	5,042.8	1,296.6	83.2	1,461.6	7,884.2	733,998
Share EPO	4,735.8	1,082.8	71.4	1,204.8	7,094.7	160,710
CDHP PPO	3,549.4	1,100.0	91.3	1,352.6	6,093.3	64,791
CDHP EPO	3,397.9	964.6	51.9	1,037.3	5,451.6	122,618
SBAP	5,575.4	1,398.1	64.9	1,636.6	8,675.0	19,218
HNY EPO	4,565.0	1,098.0	67.3	1,477.1	7,207.3	90,438
HCTC	7,440.9	1,505.4	129.0	1,290.3	10,365.6	558
Direct Pay	6,565.9	2,223.5	106.9	2,271.9	11,168.2	74,326

Table 1	MAIL					
	Number of Scripts by Drug Category for 2009 per 1000 members					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months
PPO	534.4	325.9	18.2	268.1	1,146.6	264,118
EPO	351.9	191.9	10.0	148.0	701.8	733,998
Share EPO	333.5	170.4	9.6	132.9	646.4	160,710
CDHP PPO	191.3	100.4	7.6	97.8	397.1	64,791
CDHP EPO	122.2	63.5	4.7	49.1	239.6	122,618
SBAP	1,323.8	705.0	13.1	525.1	2,567.0	19,218
HNY EPO	421.5	227.7	4.6	180.3	834.2	90,438
HCTC	3,139.8	1,075.3	43.0	752.7	5,010.8	558
Direct Pay	968.5	406.2	13.2	340.7	1,728.7	74,326

Table 1	TOTAL					
	Number of Scripts by Drug Category for 2009 per 1000 members					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	Member Months
PPO	6,002.4	2,271.7	172.4	2,444.6	10,891.1	264,118
EPO	5,394.6	1,488.6	93.2	1,609.6	8,586.0	733,998
Share EPO	5,069.3	1,253.2	81.0	1,337.7	7,741.1	160,710
CDHP PPO	3,740.7	1,200.4	98.9	1,450.4	6,490.3	64,791
CDHP EPO	3,520.1	1,028.1	56.6	1,086.4	5,691.1	122,618
SBAP	6,899.2	2,103.0	78.1	2,161.7	11,242.0	19,218
HNY EPO	4,986.5	1,325.7	71.9	1,657.4	8,041.5	90,438
HCTC	10,580.6	2,580.6	172.0	2,043.0	15,376.3	558
Direct Pay	7,534.4	2,629.7	120.1	2,612.6	12,896.9	74,326

Table 2	RETAIL					
	Allowed Cost per Script for 2009					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	
PPO	\$24.78	\$162.97	\$1,322.41	\$132.83	\$97.04	
EPO	\$22.35	\$156.11	\$980.72	\$115.89	\$71.80	
Share EPO	\$21.09	\$146.93	\$793.44	\$108.75	\$62.95	
CDHP PPO	\$24.92	\$137.22	\$1,464.04	\$124.17	\$88.79	
CDHP EPO	\$22.73	\$146.43	\$1,195.29	\$110.63	\$72.50	
SBAP	\$24.80	\$176.28	\$496.40	\$116.77	\$70.10	
HNY EPO	\$22.45	\$148.54	\$279.23	\$111.36	\$62.28	
HCTC	\$25.72	\$155.32	\$473.80	\$83.69	\$57.33	
Direct Pay	\$22.95	\$157.12	\$469.10	\$114.40	\$72.53	

Table 2	MAIL					
	Allowed Cost per Script for 2009					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	
PPO	\$58.57	\$344.47	\$1,097.43	\$270.37	\$205.87	
EPO	\$59.48	\$372.47	\$2,181.92	\$280.01	\$221.89	
Share EPO	\$58.39	\$378.07	\$2,219.11	\$275.15	\$219.42	
CDHP PPO	\$61.66	\$290.28	\$3,718.57	\$280.48	\$243.28	
CDHP EPO	\$55.73	\$281.56	\$1,769.27	\$272.72	\$193.70	
SBAP	\$56.93	\$301.77	\$724.37	\$225.67	\$162.10	
HNY EPO	\$53.67	\$272.51	\$380.69	\$227.54	\$152.81	
HCTC	\$57.14	\$263.65	\$88.96	\$191.25	\$121.87	
Direct Pay	\$52.95	\$272.63	\$631.64	\$251.64	\$148.16	

Table 2	TOTAL					
	Allowed Cost per Script for 2009					
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	Total	
PPO	\$27.79	\$189.01	\$1,298.64	\$147.91	\$108.50	
EPO	\$24.77	\$184.01	\$1,109.88	\$130.98	\$84.06	
Share EPO	\$23.54	\$178.36	\$962.95	\$125.29	\$76.02	
CDHP PPO	\$26.80	\$150.02	\$1,637.14	\$134.71	\$98.24	
CDHP EPO	\$23.88	\$154.78	\$1,242.95	\$117.96	\$77.60	
SBAP	\$30.97	\$218.35	\$534.70	\$143.22	\$91.10	
HNY EPO	\$25.09	\$169.83	\$285.78	\$124.00	\$71.67	
HCTC	\$35.04	\$200.46	\$377.59	\$123.32	\$78.37	
Direct Pay	\$26.81	\$174.96	\$487.02	\$132.30	\$82.67	

Table 3	RETAIL				
	Dispensing Fees for 2009				
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	
PPO					
EPO					
Share EPO					
CDHP PPO					
CDHP EPO					
SBAP					
HNY EPO					
HCTC					
Direct Pay					

Table 3	MAIL			
	Dispensing Fees for 2009			
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO				
EPO				
Share EPO				
CDHP PPO				
CDHP EPO				
SBAP				
HNY EPO				
HCTC				
Direct Pay				

Table 3	TOTAL			
	Dispensing Fees for 2009			
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO				
EPO				
Share EPO				
CDHP PPO				
CDHP EPO				
SBAP				
HNY EPO				
HCTC				
Direct Pay				

Table 4	RETAIL				
	Rebate % for 2009				
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs	
PPO					
EPO					
Share EPO					
CDHP PPO					
CDHP EPO					
SBAP					
HNY EPO					
HCTC					
Direct Pay					

Table 4	MAIL			
	Rebate % for 2009			
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO				
EPO				
Share EPO				
CDHP PPO				
CDHP EPO				
SBAP				
HNY EPO				
HCTC				
Direct Pay				

Table 4	TOTAL			
	Rebate % for 2009			
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO				
EPO				
Share EPO				
CDHP PPO				
CDHP EPO				
SBAP				
HNY EPO				
HCTC				
Direct Pay				

GHI COMMERCIAL COMMUNITY RATE 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	
PPO	6,675.1	1,884.1	169.9	2,083.6	10,812.6	142,104	794.0	414.4	26.4	329.5	1,564.3	142,104	7,469.0	2,298.4	196.3	2,413.1	12,376.9	142,104	13.6%
EPO	5,868.1	1,216.4	89.2	1,345.6	8,519.4	881,991	462.3	222.7	13.9	164.3	863.2	881,991	6,330.4	1,439.1	103.1	1,510.0	9,382.6	881,991	9.3%
Share EPO	5,575.6	985.4	73.7	1,112.4	7,747.0	308,652	481.0	196.6	12.4	143.5	833.5	308,652	6,056.6	1,182.0	86.1	1,255.9	8,580.5	308,652	10.8%
CDHP PPO	4,626.8	1,106.1	98.4	1,432.2	7,263.5	190,428	241.3	128.9	8.5	103.9	482.6	190,428	4,868.0	1,235.0	106.9	1,536.1	7,746.1	190,428	19.3%
CDHP EPO	4,726.2	1,079.0	76.1	1,184.8	7,066.0	406,455	183.4	83.6	4.7	65.1	336.8	406,455	4,909.6	1,162.6	80.9	1,249.8	7,402.8	406,455	30.1%
SBAP	4,930.3	976.0	46.8	1,166.0	7,119.1	18,196	1,302.5	501.2	26.4	403.6	2,233.7	18,196	6,232.8	1,477.2	73.2	1,569.6	9,352.8	18,196	-16.8%
HNY EPO	5,425.2	980.3	67.4	1,336.1	7,809.0	117,222	411.0	199.9	4.4	147.6	763.0	117,222	5,836.2	1,180.2	71.8	1,483.7	8,571.9	117,222	6.6%
HCTC	6,177.7	1,339.4	0.0	1,202.7	8,719.8	439	3,444.2	1,148.1	54.7	902.1	5,549.0	439	9,621.9	2,487.5	54.7	2,104.8	14,268.8	439	-7.2%
Direct Pay	7,594.4	2,077.4	94.5	2,138.1	11,904.4	62,865	1,271.7	495.3	21.0	414.2	2,202.2	62,865	8,866.0	2,572.8	115.5	2,552.3	14,106.6	62,865	9.4%
Total CR																		13.5%	

Table 2	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		
PPO	\$25.76	\$169.41	\$1,567.69	\$165.01	\$101.85		\$65.24	\$409.40	\$1,422.37	\$328.62	\$234.82		\$29.96	\$212.67	\$1,548.13	\$187.35	\$118.66		9.4%
EPO	\$23.28	\$156.97	\$1,189.56	\$139.63	\$72.95		\$65.95	\$415.83	\$2,239.81	\$341.23	\$243.65		\$26.40	\$197.02	\$1,331.36	\$161.57	\$88.66		5.5%
Share EPO	\$21.71	\$148.47	\$965.65	\$138.45	\$63.57		\$65.92	\$439.40	\$2,349.07	\$326.69	\$232.88		\$25.22	\$196.86	\$1,164.98	\$159.96	\$80.02		5.3%
CDHP PPO	\$26.49	\$173.81	\$1,404.32	\$146.40	\$91.24		\$65.94	\$345.80	\$2,537.22	\$316.94	\$238.30		\$28.45	\$191.76	\$1,494.45	\$157.94	\$100.40		2.2%
CDHP EPO	\$21.93	\$155.61	\$1,165.25	\$138.01	\$74.13		\$57.25	\$335.09	\$1,935.22	\$321.53	\$203.62		\$23.25	\$168.52	\$1,210.23	\$147.57	\$80.02		3.1%
SBAP	\$26.47	\$167.89	\$588.65	\$128.20	\$66.22		\$68.13	\$345.98	\$1,230.72	\$292.53	\$184.75		\$35.18	\$228.32	\$820.03	\$170.46	\$94.53		3.8%
HNY EPO	\$23.04	\$148.96	\$292.70	\$135.54	\$60.42		\$60.55	\$290.67	\$264.29	\$271.09	\$162.76		\$25.68	\$172.97	\$290.96	\$149.02	\$69.53		-3.0%
HCTC	\$15.00	\$122.15	\$0.00	\$97.10	\$42.78		\$64.47	\$299.74	\$116.90	\$222.00	\$139.27		\$32.71	\$204.11	\$116.90	\$150.63	\$80.31		2.5%
Direct Pay	\$23.15	\$161.63	\$493.76	\$130.34	\$70.30		\$58.72	\$314.34	\$393.07	\$281.69	\$161.34		\$28.25	\$191.03	\$475.46	\$154.90	\$84.51		2.2%
Total CR																		4.0%	

Table 3	RETAIL					MAIL				TOTAL				
	Dispensing Fees for 2010					Dispensing Fees for 2010				Dispensing Fees for 2010				
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO														
EPO														
Share EPO														
CDHP PPO														
CDHP EPO														
SBAP														
HNY EPO														
HCTC														
Direct Pay														

Table 4	RETAIL					MAIL				TOTAL				
	Rebate % for 2010					Rebate % for 2010				Rebate % for 2010				
	Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs		Generic Drugs	Brand Formulary Drugs	Specialty Drugs	Non-Formulary Drugs
PPO														
EPO														
Share EPO														
CDHP PPO														
CDHP EPO														
SBAP														
HNY EPO														
HCTC														
Direct Pay														

APPENDIX H
EmblemHealth
GHI Community-Rated EPO and PPO Accounts
Prospective Risk Scores

	Jan 09 to Dec 09 DCG Time Period		Jan 10 to Dec 10 DCG Time Period		1210 / 1209
Line of Business:	Risk Rank	PPO Med, Hosp and Rx Model	Risk Rank	PPO Med, Hosp and Rx Model	Trend
EPO	2	88.74	2	91.59	3.2%
EPO Share	4	79.08	5	83.96	6.2%
EPO CDHP	5	70.66	4	85.43	20.9%
PPO	1	119.07	1	121.32	1.9%
PPO CDHP	3	79.92	3	87.66	9.7%



EmblemHealth®

GHI and HIP are EmblemHealth companies

55 Water Street, New York, New York 10041-8190

Advance Notice About Changes to Your Group Health Incorporated Premium Rates

«Date»

«Group Name1» «Group Name2»
«Group No»
«Contact First Name» «Contact Last Name»
«Street Add1» «Street Add2»
«City1», «State» «Zip Code»

Dear «Contact First Name» «Contact Last Name»:

State law requires us to notify you when we apply for a rate increase with the New York State Insurance Department (NYSID). Listed below are the increases for 2012 we are requesting for your «Plan Name» plan, by quarter. The increase for the quarter in which your plan renews applies to your group. Your plan’s renewal date is shown in the paragraph below.

	<u>Renewal Date</u>		<u>Requested Increase</u>
Janu	ary – March 2012	2	3.8%
A	pril – June 2012	1	7.0%
Ju	ly – September 2012	1	5.9%
O	ctober – December 2012	1	4.7%

If approved by NYSID, the increase will be added to your group’s NYSID-approved 2011 premium rate. Your group’s final renewal rate may be different from the proposed increases shown above; NYSID may approve, modify or deny them. We will notify you of your final, approved rates about 60 days before your «Rate Eff Date» renewal date. You will have an opportunity to discuss with your broker a variety of EmblemHealth plan options that might enable you to reduce your premiums.

Please note that you must notify your covered employees of the proposed changes, and of any potential changes to their premium contribution, as soon after receiving this letter as possible.

To find information about the reasons for the proposed rate change, please visit www.emblemhealth.com/2012rates. You can also submit written comments to us or NYSID within 30 days of the date of this letter:

EmblemHealth
EmblemHealth
Attn: Premium Rate Filings
PO Box 2890 2
New York, NY 10117-2087

New York State Insurance Department
Health Bureau-Premium Rate Adjustments
New York State Insurance Dept.
5 Beaver Street
New York, NY 10004

If you prefer, you may send an e-mail to:

PremiumRateFilings@emblemhealth.com

PremiumRateIncreases@.ins.state.ny.us

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_LTR_5566_SG

55 Water Street, New York, New York 10041-8190

**Important Information About Your
Group Health Incorporated Renewal Rates**

«Date»

«Group_Name1» «Group_Name2»
«Contact First Name» «Contact Last Name»
«Street Add 1» «Str
«Street Add 2» «Str
«City», «State» «Zip Code»

Selling Agent
«SA First Name» «SA Last Name»
«Street Add 1»
«Street Add 2»
«City», «State» «Zip Code»

Dear «Contact First Name» «Contact Last Name»:

A new law in New York State requires us to notify you approximately 60 days in advance of certain health plan premium rate changes. Therefore, we are writing to inform you of your premium rates for your «PLAN» plan under group number «GROUP_NO» effective «Rate_Eff_Date»:

	Type of Coverage	Mo	Monthly Rate
In	Individual Coverage	«	Tier_ID_1»
Em	Employee and Spouse	«	Tier_ID_3»
Em	Employee and Child(ren)	«	Tier_ID_2»
	Family (Employee, Spouse and Children)	«	Tier_ID_4»

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

EmblemHealth offers plan options that enable you to reduce your premiums. Cost-reduction options that are available to you, as well as information about additional riders you may wish to purchase, also appear on the reverse side of this letter.

As a reminder, you are required to notify your covered employees about this rate increase and any additional premium contribution as soon after receiving this letter as possible. If your benefit plan requires your 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 any questions about renewing your policy, please contact your broker or call EmblemHealth Account Services at **1-866-614-6040**, Monday through Friday from 9 am to 5 pm. For additional information about your premium rates, please visit us online at www.emblemhealth.com.

We greatly value our relationship with you and are committed to providing your group with quality health care coverage. We look forward to continuing to meet your health coverage needs.



Vice President, Commercial Account Management

Please see reverse side

A RANGE OF COVERAGE OPTIONS

Changes in benefits have an impact on your premium. If you are interested in making changes to your plan, EmblemHealth offers a range of coverage choices for your group, including flexible pharmacy and benefits designs and cost-sharing options designed to meet all budget levels. You have the option to offer your employees more than one EmblemHealth plan and can choose from among the EmblemHealth PPO, EPO and InBalance alternatives. Available statewide, these plans are served by the EmblemHealth National Network and underwritten by GHI, an EmblemHealth company. You can also choose CompreHealth, available in New York City and Nassau, Suffolk and Westchester counties. This option is served by the EmblemHealth NY Metro Network and underwritten by HIP, another EmblemHealth company.

ADDITIONAL RIDERS YOU CAN PURCHASE AT RENEWAL

Extended Dependent Coverage extends to age 29 the coverage age limit for all eligible dependents of your group members.

Mental Health and Substance Use Coverage Parity. The federal Mental Health Parity and Addiction Equity Act generally mandates that large-group health plans apply the same treatment and financial limits to mental health and substance use benefits as they do to hospital and medical benefits. As a small group, you can purchase a rider to similarly extend your group's coverage.

Mental Health Coverage Parity Under Timothy's Law.¹ All small groups receive the following mandated benefits: 20 outpatient visits and 30 inpatient days for the diagnosis and treatment of mental, nervous or emotional disorders. All member cost-sharing such as copays, deductibles and coinsurance must be the same as those that apply to comparable medical and hospital services under the applicable health benefit plan. These benefits are already included in your current coverage. Small groups may purchase coverage that exceeds the 20 outpatient visits and 30 inpatient days already provided. This additional coverage is for certain biologically-based mental illnesses (schizophrenia/psychotic disorder, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia and anorexia) and for certain serious emotional disturbances for individuals under the age of 18 (attention deficit disorder, disruptive behavior disorder and pervasive developmental disorder). If you purchase this coverage, services for biologically-based mental illnesses and serious emotional disturbances are not subject to any visit or day limit below the limits that apply to comparable medical and hospital coverage under your health benefit plan.

Inpatient Chemical Abuse and Dependence Coverage.¹ You can purchase coverage for inpatient hospital services or inpatient rehabilitation services in a hospital-based or free-standing chemical dependence facility, for the diagnosis and treatment of chemical abuse and chemical dependence, including alcohol substance abuse.

1. Available for purchase with CompreHealth plans only. Benefits that meet or exceed these benefits are included in other plans.

GROUP HEALTH INCORPORATED
RATE FILING FOR COMMUNITY RATED DIRECT PAYMENT
ACTUARIAL MEMORANDUM

GHI is submitting a prior approval rate filing for its Direct Payment 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 9.8% increase for 1Q12 over 1Q11 rates, which applies to all base products and riders, and across all regions and rate tiers.

For renewing groups, please refer to the Appendix A which summarizes the rate increases over current rates starting with 1Q10 actual rates through proposed 1Q12 rates. Note that 1Q11 rates include the approved rate adjustments for PPACA benefits averaging about 9.7%.

Background

As of GHI's March 31, 2011 statutory financial statement, our capital and surplus equaled \$169.1 million, only 51.6 % of the required Statutory Reserve of \$327.7 million. As of May 31, 2011 GHI's capital and surplus is only 47.4 % of the required Statutory Reserve.

In light of the capital and surplus deficiency mentioned above, we are requesting an increase that is necessary to maintain reasonable loss ratios for these products.

Aggregation of Policy Forms

We will aggregate our Direct Pay plans across all regions and form numbers. We historically have aggregated our forms in this manner, and continue to do so for purposes of this rate filing.

Proposed Rate Increases and Justification

In order to calculate the annual rate increase needed for 2012 direct pay products, we compared the projected CY12 cohort medical claims with our target loss ratio to the 1st quarter 2011 Standardized Premium. The following chart shows how we developed our needed rate increase.

2010 Medical PMPM	441.51
2011 Projected Trend	14.0%
2012 Projected Trend	14.2%
CY12 Projected Medical PMPM	574.70
Projected Expense due to Re-class	0.89
Total CY12 Projected PMPM	575.59
Target Loss Ratio	82.0%
Required Premium PMPM	701.94
1Q11 Standardized Premium	638.43
Needed Rate Increase	9.9%
Proposed Rate Increase	9.8%

Projected administrative expenses being re-classified as medical expense minus projected medical expenses re-classified as administrative expenses due to PPACA are added to the trended Medical PMPM. Using a target loss ratio of 82%, this methodology produces a needed increase of 9.9% increase over 4Q11.

As mentioned above, we are proposing a 9.8% annual increase for first quarter, second quarter, third quarter, and fourth quarter rates. These increases will be applied to all base products and riders, across all rate tiers and regions.

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. There is also no change to the rating differentials between the rating regions included in this rate filing.

Standardized Premiums

Standardized Premiums, displayed in both Exhibit 7 and Appendices B-1 and B-2, were calculated using the following methodology:

1. Direct Pay rates are on a non-rolling rate table, so for Experience Period 1, 1Q11 Standardized Premium equals approved 1Q10 and 1Q11 rate increases applied to the 2009 Earned Premium. The increases applied reflect only pure rate increases and not increases due to contract language, so exclude PPACA.
2. For Experience Period 2, 1Q11 Standardized Premium equals the approved 1Q11 rate increases applied to the 2010 Earned Premium excluding changes due to PPACA. An example which translates Direct Pay Value 2010 Earned Premium to the Standardized Premium is presented in Appendix C.

Source Data and Projection

Exhibit 7 displays the Department's template completed for each of GHI's products. For purposes of this rate filing, we have used the following experience periods:

Experience Period 1 – Actual claims incurred between January 2009 and December 2009, paid through March 2011. Claims have then been completed using our corporate completion factors for Direct Pay plans.

Experience Period 2 – Actual claims incurred between January 2010 and December 2010, paid through March 2011. Claims have then been completed using our corporate completion factors for Direct Pay plans.

The buildup of projected 2012 claim PMPMs is shown in Appendices D-1 and D-2. Appendix D-1 shows composite PMPMs using the 2010 membership mix and Appendix D-2 represents the 2012 projection where composite PMPMs are on a 2012 membership basis. We start with Experience Period 2 as the claims base and trend forward using the projected medical trends discussed in the section below. Projected administrative expenses being re-classified as medical expense minus projected medical expenses re-classified as administrative expenses due to PPACA are added to the trended 2010 base.

Note that the source data includes 64,512 member months, which the NAIC considers partially credible according to the federal MLR rebate calculation. However, using GHI's experience rating guidelines, the Healthy New York block would be considered 100% credible.

Based on the projected 2012 projected premiums, claims and membership mix, the expected Direct Pay CY12 loss ratio is 82.1% which is above the legally permissible minimum.

Trends

In Appendix E-1, we have displayed actual 2010/2009 medical expense PMPM trends by Small Group, Healthy New York EPO, and Direct Pay products, segmented between cost and utilization components. Note that these trends are based upon calendar year incurred data with three months of runoff. We further segment the cost component of the 2010/2009 trends into contracted cost trend and risk score trend.

In order to project trends for 2011 and 2012, we analyzed measurable components of the Experience Period 2 trends: utilization and cost, where cost is further segmented by contracted cost, cost share leveraging and risk scores. Appendix E-1 provides the details of these trend components, by service type and by product. The development of the 2011 and 2012 projected trend is discussed below:

Pure Cost:

- Facility: The pure 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 par and non-par physician services, we assumed a 1.1% pure cost increase for 2011 and a 2.7% pure cost increase for 2012. [Appendix F-3](#) provides provider specific 2011 increases.
- 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 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. We expect some level of adverse selection as typified by the Direct Pay market. Thus, for some products, we have adjusted our utilization assumptions to recognize this.

Cost Share Leverage: This component was developed using assumptions for the leverage impacts of copays and deductibles in our current plan designs.

Risk Scores: The risk score component was based upon 2010/2009 trend in prospective DCG risk scores (see [Appendix H](#)). DCG Prospective risk scores are an industry standard indicator of a population's future costs. For 2011 and 2012, we reviewed the GHI EPO and PPO emerging risk trend and assumed 1.9% for Direct Pay.

[Appendix E-2](#) further summarizes the direct pay medical trends, adds the impact of covered lives assessment (CLA) and SMC Pooling trend, and provides total composite trends by product.

A significant portion of the 2010/2009 trend was attributable to the favorable Regulation 146 market stabilization pool receivable. Note that for 2012, we are assuming that the SMC PMPM trend will be a nominal -0.5%. The table below shows the 2010 amount of SMC receivables and the projected receivable in 2012 after adjustments for membership and product mix are reflected. Note that the expected Regulation 146 market stabilization pool receivable of \$1,540,548 is the amount that is being built into the 2012 rate tables.

	SMC Rec.	PMPM
2010 Pool (Receipt)	(\$2,211,226)	(\$34.28)
Change In Member Count (multiply)	0.70	
Change In Benefit Mix (multiply)	0.99	
2012 Pool (Receipt)	(\$1,540,548)	(\$33.92)

We have also projected that the 2011 and 2012 trend in covered lives assessment PMPM would be 0%.

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

$$\text{CY12 claims PMPM} = [\text{2010 PMPM}] * [1 + \text{2011 trend \%}] * [1 + \text{2012 trend \%}] + \text{re-class expense PMPM}$$

Based upon the 2011 and 2012 projected annual trends, the proposed increases result in acceptable loss ratios levels.

Administrative Expenses

The table below displays projected 2011 GHI Small Group administrative expense by component.

2011 Admin	% of Prem	PMPM
Regulatory authority fees	0.8%	\$5.23
Health care quality admin	0.2%	\$1.45
Commissions	4.0%	\$25.51
Premium Taxes	0.0%	\$0.00
Other Admin	9.5%	\$60.62
State income Taxes	0.0%	\$0.00
Federal income taxes	0.0%	\$0.00
Reduction for net investment income	0.0%	\$0.00
Net	14.6%	\$92.82

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

2012 Admin	% of Prem	PMPM
Regulatory authority fees	0.9%	\$6.81
Health care quality admin	0.3%	\$1.93
Commissions	4.0%	\$30.17
Premium Taxes	0.0%	\$0.00
Other Admin	9.3%	\$70.51
Statutory contribution to surplus	1.0%	\$7.54
Risk charge	1.0%	\$7.54
After Tax UW margin	1.4%	\$10.56
State income Taxes	0.0%	\$0.00
Federal income taxes	0.0%	\$0.00
Reduction for net investment income	0.0%	\$0.00
Net	17.9%	\$135.06

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 annual increase of 9.8% for is required to make this product profitable. The resultant price of GHI Direct Pay products is consistent with products offered by our competitors. The increase is driven by increases in health care cost and utilization and is reasonable given the items presented in this narrative.

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.



Assistant Actuary, EmblemHealth Actuarial Services
July 15, 2011

GROUP HEALTH INCORPORATED
Alliance Core - PLH-DPC-410, HCR-2010

Direct Pay Group Conversion

Rate Effective Date: 1/1/2012

	<u>Monthly Rates*</u>
New York City	
Individual	1,098.74
Family	2,746.80
Mid-Hudson	
Individual	1,043.79
Family	2,609.46
Albany	
Individual	961.39
Family	2,403.47
Utica/Watertown	
Individual	917.42
Family	2,293.59
Syracuse	
Individual	955.89
Family	2,389.72
Rochester	
Individual	785.60
Family	1,963.95
Buffalo	
Individual	846.01
Family	2,115.03

*These are the monthly rates based upon a quarterly bill. For those individuals who request a monthly bill, a \$4 expense cost will be included in the bill.

GROUP HEALTH INCORPORATED
Alliance Value - PLH-DPC-710, HCR-2010

Direct Pay Open Enrollment and Group Conversion

Rate Effective Date: 1/1/2012

	Monthly Rates*
New York City	
Individual	579.55
Family	1,448.89
Mid-Hudson	
Individual	550.57
Family	1,376.45
Albany	
Individual	507.11
Family	1,267.78
Utica/Watertown	
Individual	483.93
Family	1,209.81
Syracuse	
Individual	504.19
Family	1,260.54
Rochester	
Individual	414.37
Family	1,035.95
Buffalo	
Individual	446.27
Family	1,115.66

*These are the monthly rates based upon a quarterly bill. For those individuals who request a monthly bill, a \$4 expense cost will be included in the bill.

GROUP HEALTH INCORPORATED
Prescription Drug Rider - PLH-DPC-411, HCR-2010

Available with Alliance Core - PLH-DPC-410

Rate Effective Date: 1/1/2012

	<u>Monthly Rates</u>
New York City	
Individual	183.93
Family	468.88
Mid-Hudson	
Individual	183.93
Family	468.88
Albany	
Individual	183.93
Family	468.88
Utica/Watertown	
Individual	183.93
Family	468.88
Syracuse	
Individual	183.93
Family	468.88
Rochester	
Individual	183.93
Family	468.88
Buffalo	
Individual	183.93
Family	468.88

GROUP HEALTH INCORPORATED
Prescription Drug Rider - PLH-DPC-711, HCR-2010

Available with Alliance Value - PLH-DPC-710

Rate Effective Date: 1/1/2012

	<u>Monthly Rates</u>
New York City	
Individual	183.93
Family	468.88
Mid-Hudson	
Individual	183.93
Family	468.88
Albany	
Individual	183.93
Family	468.88
Utica/Watertown	
Individual	183.93
Family	468.88
Syracuse	
Individual	183.93
Family	468.88
Rochester	
Individual	183.93
Family	468.88
Buffalo	
Individual	183.93
Family	468.88

GHI ALLIANCE DIRECT PAY PLANS

Hospital Coverage

	<i>Core</i>	<i>Value</i>	<i>365 Day Hospital Only</i>
Base Hospital Coverage per confinement	365 days	365 days	365 days
Hospital Deductible	None	None	None
Hospital Coinsurance	None	None	None
Routine Nursery Care	Covered in full	Covered in full	Covered in full
Outpatient Emergency Care 12 hours notification for sudden illness and 72 hours notification for accident or injury	\$50 copay	\$50 copay	\$50 copay
Outpatient Ambulatory Surgery	Covered in full	Covered in full	Covered in full
Pre-Admission Testing - no more than 7 days before scheduled surgery	Covered in full	Covered in full	Covered in full
Inpatient Psychiatric Care per calendar year	Not covered	Not covered	30 days managed recovery; Par only
Inpatient Substance Abuse Treatment per calendar year	Not covered	Not covered	5 days
Outpatient Substance Abuse Treatment - visits per calendar year	60 visits (including 20 visits for family therapy)	60 visits (including 20 visits for family therapy)	60 visits (including 20 visits for family therapy)
Outpatient Hospital-Based and Free-Standing Facility Dialysis	Covered in full	Covered in full	Covered in full
Inpatient Admissions for Physical Therapy, Physical Medicine & Rehabilitation	Not covered	Not covered	30 days per calendar year
Diagnostic Admissions	Not covered	Not covered	Not covered
Home Care Visits per calendar year	40 visits	40 visits	40 visits

GHI ALLIANCE DIRECT PAY PLANS

Hospital Coverage

	<i>Core</i>	<i>Value</i>	<i>365 Day Hospital Only</i>
Hospice Care - Lifetime	210 days (including 5 bereavement sessions)	210 days (including 5 bereavement sessions)	210 days (including 5 bereavement sessions)
Skilled Nursing Facility Care	Not covered	Not covered	Not covered
Managed Care - including Precertification, Voluntary and Mandatory Second Surgical Opinion and Large Case Management (LCM)	Yes	Yes	Yes
Centers of Specialized Care for cardiac procedures and heart transplants only	Yes	Yes	Not covered
Outpatient Referred Ambulatory Care: laboratory tests, physical therapy, diagnostic X-rays and radiation therapy and chemotherapy	Covered in full	Covered in full	Covered in full
Outpatient Laboratory Test and Diagnostic X-rays	\$25 copay	\$25 copay	Covered
Outpatient Mammography Screening and Pap Smear Screening	\$25 copay	Covered	Covered
Dependent Children Coverage	End of 19th calendar year	End of 19th calendar year	End of 19th calendar year
Dependent Student Coverage	End of 23rd calendar year	End of 23rd calendar year	End of 23rd calendar year

GHI ALLIANCE DIRECT PAY PLANS

Medical Coverage

	<i>Core</i>	<i>Value</i>
Base Par Benefit for Covered Services	GHI CBP Schedule of Allowances as payment-in-full	GHI CBP Schedule of Allowances as payment-in-full
Par Deductible and Coinsurance	None	None
Home and Office Copay (except covered well child visits)	\$10 per date of service	Not covered except mandates such as Child Health
Par Diagnostic Copay (includes diagnostic laboratory and x-ray procedures)	\$10 per provider per date of service	Outpatient lab tests not covered; Outpatient x-ray & radiological svcs covered with a \$20 copay per provider per date of service
Par Consultation Copay	\$10 per provider per date of service	Not covered
Annual Non-Par Deductible	\$250 per individual \$500 per family	\$250 per individual \$500 per family
Non-Par Reimbursement	GHI CBP Schedule of Allowances	GHI CBP Schedule of Allowances
Non-Par Reimbursement after Deductible is satisfied	100% GHI's CBP	100% GHI's CBP
Non-Par Stop Loss per individual or family	After \$10,000 of covered out-of-pocket expenses, then 100% Allowed Charge	After \$10,000 of covered out-of-pocket expenses, then 100% Allowed Charge
Annual Maximum Per Person - Non Par	\$100,000 of covered expenses	\$100,000 of covered expenses

GHI ALLIANCE DIRECT PAY PLANS

	Core	Value
Lifetime Maximum Per Person – Non-Par	\$1,000,000 of covered expenses	\$1,000,000 of covered expenses
In-Hospital and Out of Hospital Surgery	Covered	Covered
Chiropractic Care Par Only	\$10 copay per visit	Not covered
Physical Therapy per calendar year	10 visits; \$10 copay per visit	Not covered
Allergy Visits per calendar year	16 visits; \$10 copay per visit	Not covered
Diabetes Self-Management and Certain Supplies & Equipment	Covered	Not covered
Speech Therapy per calendar year	16 visits; \$10 copay per visit	Not covered
Ambulance	Covered up to GHI's UCR	Covered up to GHI's UCR
Out-of-Hospital Psychiatric Treatment	Not covered	Not covered
Dependent Children Coverage	End of 19th calendar year	End of 19th calendar year
Dependent Student Coverage	End of 23rd calendar year	End of 23rd calendar year
Mandatory Second Surgical Opinion	Limited to certain procedures	Limited to certain procedures
Routine Podiatric Care	Not covered	Not covered

GHI ALLIANCE DIRECT PAY PLANS

	<i>Core</i>	<i>Value</i>
Private Duty Nursing	Not covered	First 96 hours Not covered; 80% Allowed Charge after non-par deductible up to \$5,000 maximum per person per year
Durable Medical Equipment (DME) PPO	Not covered	\$100 deductible per person per year; Par - 100% reimbursement after deductible; Par only; \$10,000 annual maximum
Annual Physical	One annual physical checkup; Par only; \$10 copay per visit	Not covered
Well Baby Care	Covered	Covered
Well Child Care	Covered	Covered
Pediatric Immunizations	Covered	Covered
Pap Smear Screening	Covered	Covered
Mammography Screening	Covered	Covered

PAR: A GHI Participating Provider

Exhibit A

Commission Schedules

Selling Agents

Group Size

SA Commission Rate

Groups covering 1 to 50 employees:

Medical Plans:

Medicare Supplement	3%
Direct Pay Value Plan	3%
Small Business Advantage	3%
Healthy NY EPO Groups of 2+	4%
NYSSHIP	0%
New EPO Plans	5.0%*
New PPO Plans	4%
All other Plans	3.5%

Dental Plans:

Alliance Plans	3%
Preferred/ Preferred Plus	10%

Groups covering 51 or more employees:

Negotiated within the parameters set forth in Paragraph 3(A) above.

Note: Commissions are payable on Hospital only group coverage, Hospital-Medical; Medical only; Dental only; and Medicare Supplemental coverage. Commissions are payable on Vision plans and Prescription Card plans only when these plans are combined with GHI Hospital-Medical benefits. Group size is established annually at renewal.

Commissions are not payable on Direct Payment Group Conversion , Hospital Only Direct Pay plans, or on any non-small group Healthy New York EPO plans.

In the event that premium has been received by GHI for business sold before all of the appointment material has been received by GHI, GHI will pay retroactive commissions at the time of actual appointment. However, at the time of appointment, a broker will be paid those commissions earned on premium received within 6 months prior to the date of appointment.

* The enhanced commission rate only applies in year one. For any renewal periods of coverage, the commission is equal to 4%.

GENERAL AGENTS

Group Size

GA Override

Groups covering 1 to 50 employees:

Medical Plans:

Medicare Supplement	1%
Direct Pay Value Plan	1%
Small Business Advantage	1%
NYSSHIP	0%
New EPO Plans	3%*
New PPO Plans	2%
All other Plans	2%

Dental Plans

Alliance Plans	
2006 and Prior	1%
Beginning in 2007	0%
Preferred/ Preferred Plus	5%

Groups covering 51 or more employees:

Negotiated within the parameters set forth in Paragraph 3(A) above.

Note: Commissions are payable on Hospital only group coverage, Hospital-Medical; Medical only; Dental only; and Medicare Supplemental coverage. Commissions are payable on Vision plans and Prescription Card plans only when these plans are combined with GHI Hospital-Medical benefits. Group size is established annually at renewal.

Commissions are not payable on Direct Payment Group Conversion , Hospital Only Direct Pay plans, or on any Healthy New York plans.

In the event that premium has been received by GHI for business sold before all of the appointment material has been received by GHI, GHI will pay retroactive commissions at the time of actual appointment. However, at the time of appointment, a broker will be paid those commissions earned on premium received within 6 months prior to the date of appointment.

The corresponding General Agent override will be paid and will be based on the same premium used to determine the Selling Agent commission.

* The enhanced commission rate only applies in year one. For any renewal periods of coverage, the commission is equal to 2%.

GROUP HEALTH INCORPORATED
Alliance Core - PLH-DPC-410, HCR-2010
Direct Pay Group Conversion

PRESENT AND PROPOSED SUBSCRIBER RATES*

	1 Present Monthly Rate @1/1/11	2 Proposed Monthly Rate @1/1/12	3 Rate Change Dollars (2) - (1)	4 Rate Change Percentage (3) / (1)	Last Rate Adjustment Date	Any Prior Rate Change Within Last 12 Months	Total % Change Within Last 12 Months
New York City							
Individual	1,000.67	1,098.74	98.07	9.80	1/1/2011	No	n/a
Family	2,501.64	2,746.80	245.16	9.80	1/1/2011	No	n/a
Mid-Hudson							
Individual	950.63	1,043.79	93.16	9.80	1/1/2011	No	n/a
Family	2,376.56	2,609.46	232.90	9.80	1/1/2011	No	n/a
Albany							
Individual	875.58	961.39	85.81	9.80	1/1/2011	No	n/a
Family	2,188.95	2,403.47	214.52	9.80	1/1/2011	No	n/a
Utica/Watertown							
Individual	835.54	917.42	81.88	9.80	1/1/2011	No	n/a
Family	2,088.88	2,293.59	204.71	9.80	1/1/2011	No	n/a
Syracuse							
Individual	870.57	955.89	85.32	9.80	1/1/2011	No	n/a
Family	2,176.43	2,389.72	213.29	9.80	1/1/2011	No	n/a
Rochester							
Individual	715.48	785.60	70.12	9.80	1/1/2011	No	n/a
Family	1,788.66	1,963.95	175.29	9.80	1/1/2011	No	n/a
Buffalo							
Individual	770.50	846.01	75.51	9.80	1/1/2011	No	n/a
Family	1,926.26	2,115.03	188.77	9.80	1/1/2011	No	n/a

*These are the monthly rates based upon a quarterly bill. For those individuals who request a monthly bill, a \$4 expense cost will be included in the bill.

GROUP HEALTH INCORPORATED
Alliance Value - PLH-DPC-710, HCR-2010
Direct Pay Open Enrollment and Group Conversion

PRESENT AND PROPOSED SUBSCRIBER RATES*

	1 Present Monthly Rate @1/1/11	2 Proposed Monthly Rate @1/1/12	3 Rate Change Dollars (2) - (1)	4 Rate Change Percentage (3) / (1)	Last Rate Adjustment Date	Any Prior Rate Change Within Last 12 Months	Total % Change Within Last 12 Months
New York City							
Individual	527.82	579.55	51.73	9.80	1/1/2011	No	n/a
Family	1,319.57	1,448.89	129.32	9.80	1/1/2011	No	n/a
Mid-Hudson							
Individual	501.43	550.57	49.14	9.80	1/1/2011	No	n/a
Family	1,253.60	1,376.45	122.85	9.80	1/1/2011	No	n/a
Albany							
Individual	461.85	507.11	45.26	9.80	1/1/2011	No	n/a
Family	1,154.63	1,267.78	113.15	9.80	1/1/2011	No	n/a
Utica/Watertown							
Individual	440.74	483.93	43.19	9.80	1/1/2011	No	n/a
Family	1,101.83	1,209.81	107.98	9.80	1/1/2011	No	n/a
Syracuse							
Individual	459.19	504.19	45.00	9.80	1/1/2011	No	n/a
Family	1,148.03	1,260.54	112.51	9.80	1/1/2011	No	n/a
Rochester							
Individual	377.39	414.37	36.98	9.80	1/1/2011	No	n/a
Family	943.49	1,035.95	92.46	9.80	1/1/2011	No	n/a
Buffalo							
Individual	406.44	446.27	39.83	9.80	1/1/2011	No	n/a
Family	1,016.08	1,115.66	99.58	9.80	1/1/2011	No	n/a

*These are the monthly rates based upon a quarterly bill. For those individuals who request a monthly bill, a \$4 expense cost will be included in the bill.

GROUP HEALTH INCORPORATED
Prescription Drug Rider - PLH-DPC-411, HCR-2010
Available with Alliance Core - PLH-DPC-410
Direct Pay Group Conversion

PRESENT AND PROPOSED SUBSCRIBER RATES

	1 Present Monthly Rate @1/1/11	2 Proposed Monthly Rate @1/1/12	3 Rate Change Dollars (2) - (1)	4 Rate Change Percentage (3) / (1)	Last Rate Adjustment Date	Any Prior Rate Change Within Last 12 Months	Total % Change Within Last 12 Months
New York City							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Mid-Hudson							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Albany							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Utica/Watertown							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Syracuse							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Rochester							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Buffalo							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a

GROUP HEALTH INCORPORATED
Prescription Drug Rider - PLH-DPC-711, HCR-2010
Available with Alliance Value - PLH-DPC-710
Direct Pay Open Enrollment and Group Conversion

PRESENT AND PROPOSED SUBSCRIBER RATES

	1 Present Monthly Rate @1/1/11	2 Proposed Monthly Rate @1/1/12	3 Rate Change Dollars (2) - (1)	4 Rate Change Percentage (3) / (1)	Last Rate Adjustment Date	Any Prior Rate Change Within Last 12 Months	Total % Change Within Last 12 Months
New York City							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Mid-Hudson							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Albany							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Utica/Watertown							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Syracuse							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Rochester							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a
Buffalo							
Individual	167.51	183.93	16.42	9.80	1/1/2011	No	n/a
Family	427.03	468.88	41.85	9.80	1/1/2011	No	n/a