

SERFF Tracking Number: GRPH-127168464 State: New York
Filing Company: Group Health Incorporated State Tracking Number: 2011070099
Company Tracking Number:
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.003 Small Group Only
Expense
Product Name: Healthy New York EPO
Project Name/Number: Rate Increase - 2011 /

Filing at a Glance

Company: Group Health Incorporated
Product Name: Healthy New York EPO
TOI: H15G Group Health -
Hospital/Surgical/Medical Expense
Sub-TOI: H15G.003 Small Group Only
Filing Type: Rate Adjustment pursuant to
Section 4308(c)

SERFF Tr Num: GRPH-127168464 State: New York
SERFF Status: Closed-APPR State Tr Num: 2011070099
Approved
Co Tr Num: State Status:

Reviewer(s): [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Authors: [REDACTED] Disposition Date: 10/20/2011

[REDACTED]
[REDACTED]
[REDACTED]

Date Submitted: 07/15/2011

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

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

General Information

Project Name: Rate Increase - 2011
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.
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/27/2011
State Status Changed:

Deemer Date:
Submitted By: [REDACTED]

Created By: [REDACTED]
Corresponding Filing Tracking Number:

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PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

This filing contains the GHI Healthy New York 2012 rate increase application.

Company and Contact

Filing Contact Information

████████████████████
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]

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.): Yes. Healthy New York
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

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

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

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

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

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

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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: 19.800%
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	19.800%	19.800%	\$7,462,408	6,503	\$37,688,930	19.800%	19.800%
Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								15,000
Policy Holders:								6,503

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Rate Review Details

COMPANY:

Company Name: Group Health Incorporated
HHS Issuer Id: 88000
Product Names: HNY EPO
Trend Factors:

FORMS:

New Policy Forms:
Affected Forms:
Other Affected Forms: GHI-HNY-EPO

REQUESTED RATE CHANGE

INFORMATION:

Change Period: Annual
Member Months: 148,378
Benefit Change: None
Percent Change Requested: Min: 19.8 Max: 19.8 Avg: 19.8

PRIOR RATE:

Total Earned Premium: 50,198,462.27
Total Incurred Claims: 46,789,950.37
Annual \$: Min: 271.44 Max: 271.44 Avg: 271.44

REQUESTED RATE:

Projected Earned Premium: 74,332,976.00
Projected Incurred Claims: 61,371,074.00
Annual \$: Min: 348.06 Max: 348.06 Avg: 348.06

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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 HNY.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.

Attachments:

GHI_HNY_WEB_5488_2012 GHI HNY Rate Narr_Exhibit3.pdf
 GHI_HNY_Standard_Exhibits.pdf
 GHI_HNY_Standard_Exhibits.xls
 GHI_HNY_ActMemo_Appendix.pdf
 GHI_HNY_ActMemo_Appendix.xls

Item Status: **Status**
Date:

Satisfied - Item: Actuarial Memorandum

Comments:

The Actuarial memorandum is attached below.

Attachment:

GHI_HNY_ActMemo.pdf

Item Status: **Status**

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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:

GHI_HNY_2012_initial_notice_sample.pdf

GHI_HNY_2012_final_notice_sample.pdf

Item Status:

Status

Date:

Satisfied - Item: Rate Manual Pages

Comments:

The rate manual pages for these products are attached below.

Attachments:

Healthy NY EPO - Section One.pdf

Healthy NY HSA EPO - Section One.pdf

Healthy NY EPO Copay Rider - Section One.pdf

Item Status:

Status

Date:

Satisfied - Item: Benefit descriptions

Comments:

The benefit descriptions for the Healthy New York products are attached below..

Attachment:

HNYBftDescr.pdf

Item Status:

Status

Date:

Satisfied - Item: Commission schedule

Comments:

The GHI commission schedule is attached below.

Attachment:

CommissionSchedule.pdf

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Expense
Product Name: Healthy New York EPO
Project Name/Number: Rate Increase - 2011 /

Item Status:

**Status
Date:**

Satisfied - Item: Premium Rate change exhibits

Comments:

The premium rate change exhibits are attached below.

Attachments:

Healthy NY EPO - Section Four.pdf

Healthy NY HSA EPO - Section Four.pdf

Healthy NY EPO Copay Rider - Section Four.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

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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>	

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		<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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		<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>

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		<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>

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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>	

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		<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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<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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		<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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		<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>

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		<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>	

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		<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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		<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.

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	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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		<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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		<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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		<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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		<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.	

INFORMATION ABOUT YOUR GHI HEALTHY NEW YORK PLAN 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 15,000 GHI Healthy New York members.

The Components of Your Premium Rate

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

Administrative expenses include: costs for processing claims and appeals; maintenance and upgrading of systems needed to comply with HIPAA, federal health reform mandates and other legal requirements; costs for consumer education, wellness programs and programs for managing chronic and complex medical conditions; costs of maintaining our provider network; costs to operate Web-based information and services for members 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 Healthy New York business, which would become effective on your plan's 2012 policy renewal date. The reason for the requested rate increase is that health care costs have risen dramatically during the past year. The major factors driving 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 Healthy New York plans renewing during 2012.

The premium rate increase we are requesting is shown below.

Percent Increase from 2011 to 2012: 19.8%

Final Rate Increase

Your final renewal rate may be different from the proposed 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.

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-127168464</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>Healthy NY</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-127168464
Company submitting the rate adjustment request Company NAIC Code SERFF tracking number

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

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

We request that the actuarial memorandum accompanying this application signed by [REDACTED] 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-127168464

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_HNY_WEB_5488_2012 GHI HNY 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-127168464

 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: Healthy NY

Rating Region: All

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

Rolling Rate Product

Policy Form #	Product Name	Product Street Name	Effective Period of New Rolling Rate *	Proposed Rate Change (year/year)		
				Lowest	Highest	Weighted Avg
GHI-HNY-EPO	HNY EPO	HNY EPO	Jan.-Mar. 2012	19.8%	19.8%	19.8%
GHI-HNY-EPO	HNY EPO	HNY EPO	Apr.-Jun. 2012	19.8%	19.8%	19.8%
GHI-HNY-EPO	HNY EPO	HNY EPO	Jul.-Sep. 2012	19.8%	19.8%	19.8%
GHI-HNY-EPO	HNY EPO	HNY EPO	Oct.-Dec. 2012	19.8%	19.8%	19.8%

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

EXHIBIT 5: DISTRIBUTION OF CONTRACTS AFFECTED BY PROPOSED RATE ADJUSTMENTS

Company Name: GHI
 NAIC Code: 55239
 SERFF Tracking #: GRPH-127168464

- 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.

B. FOR A ROLLING RATE STRUCTURE - Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort

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

#	Market Segment	Rating Region	Product	Weighted Avg %	Total # of 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	
Q1	Healthy NY	All	HNY EPO	19.8%	4,784							4784					
Market Segment Total:					4,784							4784					

Effective Period of New Rolling Rate*: 04/01/2012 - 06/30/2012

#	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	
Q2	Healthy NY	All	HNY EPO	19.8%	2,995							2,995					
Market Segment Total:					2,995							2,995					

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

#	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	
Q3	Healthy NY	All	HNY EPO	19.8%	3,156							3,156					
Market Segment Total:					3,156							3,156					

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

#	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	
Q4	Healthy NY	All	HNY EPO	19.8%	4,065							4065					
Market Segment Total:					4,065							4065					

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

(* Indicate weighted average base used: Contracts or Members

EXHIBIT 6: SUMMARY OF POLICY FORM AND PRODUCT CHANGES

Company Name: GHI

NAIC Code: 55239

SERFF Number: GRPH-127168464

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-127168464

- A. Complete a separate response for each base medical policy form included in the rate adjustment filing.
 - Information requested applies to New York State business only.
 - Include riders that may be available with that policy form in each policy form response.
 - Submit a separate exhibit for each rating pool. Create additional tabs for each rating pool as needed.
 - Append additional columns to right of the existing columns (as needed) to include all base medical policy forms included in that rating pool. Add a rightmost column with the aggregate values for that entire rating pool.
- B. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Driven Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- C. The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- D. Note that many cells include a drop down list. Use the drop down list or enter applicable items.
- E. If members, covered lives or member months are not known, use reasonable estimates (note methodology used).
- F. This form must be submitted as an Excel file, even if a version is submitted as a PDF file.

Data Item for Specified Base Medical Policy Form	Response
1a. Base medical policy form number	GHI-HNY-EPO
1b. Product Name as in Rate Manual	HNY EPO
1c. Product Street Name as indicated to consumers	HNY EPO
2. Aggregated for rate development with these base medical policy form numbers	All Of The Above
3. Effective date of rate change (MM/DD/YYYY)	01/01/2012
4. Market Segment (large group, small group, individual, or sole proprietor) [drop down menu]	Small Group
5. Product type (see above for examples) [drop down menu]	EPO
6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	Yes
7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	No
8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	Open
9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.)	12
10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	19.8%
11. Number of policyholders affected by rate change. For group business this is number of groups.	6,503
12. Number of covered lives affected by rate change	15,000
13. Expected NY statewide loss ratio for base medical policy form including associated riders	82.5%

Data Item for Specified Base Medical Policy Form	Response
1a. Base medical policy form number	GHI-HNY-EPO
1b. Product Name as in Rate Manual	HNY EPO
1c. Product Street Name as indicated to consumers	HNY EPO
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
14.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2010
14.3 Member months for experience period	148,378
14.4 Earned premiums for experience period (\$)	37,688,930
14.5 Standardized earned premiums for experience period (\$)	43,109,217
14.6 Paid claims for experience period (\$)	29,169,401
14.7 Incurred claims for experience period (\$)	31,399,162
14.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	6,445,540
14.9 Earned premiums for experience period (\$pmpm)	254.01
14.10 Standardized premiums for experience period (\$pmpm)	290.54
14.11 Paid claims for experience period (\$pmpm)	196.59
14.12 Incurred claims for experience period (\$pmpm)	211.62
14.13 Administrative expenses for experience period (\$pmpm) (including commissions and premium taxes, but excluding federal and state income taxes)	43.44
14.14 Ratio: Incurred Claims / Earned Premiums	0.833
14.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.728
14.16 Ratio: Administration Expenses / Earned Premiums	0.171
14.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	1.004

Data Item for Specified Base Medical Policy Form	Response
1a. Base medical policy form number	GHI-HNY-EPO
1b. Product Name as in Rate Manual	HNY EPO
1c. Product Street Name as indicated to consumers	HNY EPO
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
15.2 Ending Date of the experience period (MM/DD/YYYY)	12/31/2009
15.3 Member months for experience period	113,010
15.4 Earned premiums for experience period (\$)	27,702,770
15.5 Standardized earned premiums for experience period (\$)	33,275,898
15.6 Paid claims for experience period (\$)	21,963,889
15.7 Incurred claims for experience period (\$)	22,010,537
15.8 Administrative expenses for experience period (\$) (including commissions and premium taxes, but excluding federal and state income taxes)	2,770,277
15.9 Earned premiums for experience period (\$mpm)	245.14
15.10 Standardized premiums for experience period (\$mpm)	294.45
15.11 Paid claims for experience period (\$mpm)	194.35
15.12 Incurred claims for experience period (\$mpm)	194.77
15.13 Administrative expenses for experience period (\$mpm) (including commissions and premium taxes, but excluding federal and state income taxes)	24.51
15.14 Ratio: Incurred Claims / Earned Premiums	0.795
15.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.661
15.16 Ratio: Administrative Expenses / Earned Premiums	0.100
15.17 Ratio: (Incurred Claims + Admin. Exp.) / Earned Prem.	0.895
Annualized Medical Trend Factors (%)	
16.1 All benefits combined, composite	15.8%
16.2 Due to utilization	3.8%
16.3 Due to unit cost	11.5%
Ratios: Most Recent Experience Period to Prior Period	
17.1 Member months	1.313
17.2 Earned premiums (\$mpm)	1.036
17.3 Standardized premiums (\$mpm)	0.987
17.4 Paid claims (\$mpm)	1.011
17.5 Incurred claims (\$mpm)	1.087
17.6 Administrative expenses (\$mpm) (including commissions and premium taxes, but excluding federal and state income taxes)	1.772
Ratio: Standard Premium to Earned Premium	
18.1 Most Recent Experience Period	1.144
18.2 Prior Experience Period	1.201

APPENDIX A Annual & Quarterly Rate Increases

BASE MEDICAL PLAN

Policy Form #	Product Name	Product Street Name	Annual Increase Period	Rate Change (year/year)			Quarterly Increase Period	Rate Change (quarter/quarter)		
				Lowest	Highest	Weighted Avg		Lowest	Highest	Weighted Avg
GHI-HNY-EPO	HNY EPO	HNY EPO	1Q10/1Q09	4.0%	4.0%	4.0%	1Q10/4Q09	4.0%	4.0%	4.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	2Q10/2Q09	4.0%	4.0%	4.0%	2Q10/1Q10	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	3Q10/3Q09	4.0%	4.0%	4.0%	3Q10/2Q10	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	4Q10/4Q09	6.7%	8.5%	7.8%	4Q10/3Q10	2.6%	4.3%	3.6%
GHI-HNY-EPO	HNY EPO	HNY EPO	1Q11/1Q10	15.5%	17.4%	16.6%	1Q11/4Q10	12.5%	12.6%	12.5%
GHI-HNY-EPO	HNY EPO	HNY EPO	2Q11/2Q10	15.5%	17.4%	16.6%	2Q11/1Q11	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	3Q11/3Q10	15.5%	17.4%	16.6%	3Q11/2Q11	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	4Q11/4Q10	12.5%	12.6%	12.5%	4Q11/3Q11	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	1Q12/1Q11	19.8%	19.8%	19.8%	1Q12/4Q11	19.8%	19.8%	19.8%
GHI-HNY-EPO	HNY EPO	HNY EPO	2Q12/2Q11	19.8%	19.8%	19.8%	2Q12/1Q12	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	3Q12/3Q11	19.8%	19.8%	19.8%	3Q12/2Q12	0.0%	0.0%	0.0%
GHI-HNY-EPO	HNY EPO	HNY EPO	4Q12/4Q11	19.8%	19.8%	19.8%	4Q12/3Q12	0.0%	0.0%	0.0%

**APPENDIX B-1
2009 Experience Period**

Product Type	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
HNY EPO	113,010	\$27,702,770	\$21,963,889	\$22,010,537	\$2,770,277	\$33,275,898	79.5%	66.1%	10.0%	89.5%	\$245.14	\$194.77	\$24.51	\$294.45

**APPENDIX B-2
2010 Experience Period**

Product Type	01	02	03	04	05	06					(05+04)	Earned	Incurred	Admin	Standardized
	Member Months	Earned Premium	Paid Claims	Incurred Claims	Administrative Expenses	Standardized Premium	04 / 02	04 / 06	05 / 02	/02	Premium PMPM	Claims PMPM	Expenses PMPM	Premium PMPM	
HNY EPO	148,378	\$37,688,930	\$29,169,401	\$31,399,162	\$6,445,540	\$43,109,217	83.3%	72.8%	17.1%	100.4%	\$254.01	\$211.62	\$43.44	\$290.54	

APPENDIX C
HNY EPO

Rate Ratio	
1Q 2009 Rate Ratio	1.170
2Q 2009 Rate Ratio	1.171
3Q 2009 Rate Ratio	1.171
4Q 2009 Rate Ratio	1.170
1Q 2010 Rate Ratio	1.126
2Q 2010 Rate Ratio	1.126
3Q 2010 Rate Ratio	1.125
4Q 2010 Rate Ratio	1.126

Renewal Distribution			
Renewal Month	Premium	Premium	Premium
	Before Renewal	After Renewal	Total
JAN	\$0	\$4,176,488	\$4,176,488
FEB	\$143,241	\$2,441,150	\$2,584,391
MAR	\$315,761	\$2,623,924	\$2,939,685
APR	\$586,266	\$2,670,320	\$3,256,586
MAY	\$704,714	\$2,181,138	\$2,885,852
JUN	\$917,567	\$2,048,518	\$2,966,085
JUL	\$989,591	\$1,514,030	\$2,503,621
AUG	\$1,250,527	\$1,260,400	\$2,510,927
SEP	\$1,836,371	\$1,430,853	\$3,267,224
OCT	\$2,510,749	\$889,534	\$3,400,283
NOV	\$2,285,934	\$654,045	\$2,939,979
DEC	\$3,799,877	\$457,932	\$4,257,809
Total			\$37,688,930

Average 2010 Rate by renewal month	
Jan	1.126
Feb	1.128
Mar	1.130
Apr	1.134
May	1.136
Jun	1.139
Jul	1.143
Aug	1.148
Sep	1.151
Oct	1.159
Nov	1.160
Dec	1.166
Average 2010 Rate Ratio	1.144

2010 Standardized Premium	
2010 Earned Premium PMPM	\$254.01
Average 2010 Rate Ratio	1.144
Standardized Premium PMPM	\$290.54

APPENDIX D
Source Data Exhibit / 2012 Projection Development

	2010	Standardized	2012		2012	1Q12 Cohort	2Q12 Cohort	3Q12 Cohort	4Q12 Cohort
Product	Member	Premium	Projected		Quarterly	Projected	Projected	Projected	Projected
Type	Months	PMPM	Member Months		Increases	Premium	Premium	Premium	Premium

HNY EPO	148,378	\$290.54	213,562		19.8%/0%/0%/0%	348.06	348.06	348.06	348.06
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	2010	Annualized	Projected	1Q12 Cohort	2Q12 Cohort	3Q12 Cohort	4Q12 Cohort
Product	Incurring Claims	Medical	Re-class	Projected	Projected	Projected	Projected
Type	PMPM	2011 Trend	2012 Trend	Expense PMPM	Clms PMPM	Clms PMPM	Clms PMPM

HNY EPO	\$211.62	15.7%	15.8%	\$0.21	287.28	298.02	309.16	320.73
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	1Q12	2Q12	3Q12	4Q12
Product	Expected	Expected	Expected	Expected
Type	MLR	MLR	MLR	MLR

HNY EPO	82.5%	85.6%	88.8%	92.1%
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*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 Healthy New York EPO Trends**

2010 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			Stop Loss Rec.			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
HNY EPO	4.0%	12.3%	16.8%	-3.4%	13.0%	9.1%	-3.7%	2.4%	-1.4%	3.2%	1.0%	4.2%	6.6%	-3.0%	3.4%	0.0%	-10.4%	-10.4%	0.0%	6.7%	6.7%	6.0%	
2011 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			Stop Loss Rec.			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
HNY EPO	3.0%	12.6%	16.0%	4.0%	10.8%	15.2%	3.0%	4.0%	7.2%	2.0%	4.0%	6.1%	3.0%	8.1%	11.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.6%	15.7%	
2012 Trends																							
Product	HospIP			HospOP			Medp			Medn			Drug			Covered Lives Asmt.			Stop Loss Rec.			Total	
	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total	Util	Cost	Total		
HNY EPO	3.0%	12.0%	15.4%	1.8%	11.8%	13.8%	3.0%	5.7%	8.9%	2.0%	5.7%	7.8%	3.0%	7.0%	10.2%	0.0%	0.0%	0.0%	0.0%	0.6%	0.6%	15.8%	

Professional Bank Account Summary by Line of Business

GHI LOB	IPA/PC	Unit Cost				CMS Impact		Total			
		Annual Spend*	Percent of Annual Spend 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
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
COMMERCIAL PPO TOTAL		\$443,718,170			\$447,742,519			\$703,304		\$4,727,653	

PROJECTED NEGOTIATED UNIT COST TREND INCREASE

PROJECTED CMS TREND INCREASE

PROJECTED TOTAL UNIT COST AND CMS TREND INCREASE

0.9%
0.2%
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.

GHI COMMERCIAL COMMUNITY RATED CY 2010 ACTUALS

Table 1	RETAIL						MAIL						TOTAL						2010/2009 Util %
	Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						Number of Scripts by Drug Category for 2010 per 1000 members						
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
													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					
Product Line	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	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
											Total CR					4.0%

Table 3	RETAIL				MAIL				TOTAL			
	Dispensing Fees for 2010				Dispensing Fees for 2010				Dispensing Fees for 2010			
Product Line	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
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Table 4	RETAIL				MAIL				TOTAL			
	Rebate % for 2010				Rebate % for 2010				Rebate % for 2010			
Product Line	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
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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%

GROUP HEALTH INCORPORATED

RATE FILING FOR COMMUNITY RATED HEALTHY NEW YORK EPO ACTUARIAL MEMORANDUM

GHI is submitting a prior approval rate filing for its Healthy New York EPO product. The proposed premium rates are based on a rolling rate structure with effective dates of January – March 2012 (1Q12), April – June 2012 (2Q12), July – September 2012 (3Q12), and October – December 2011 (4Q12).

The proposed represent a 19.8% increase for 1Q12 over 1Q11 rates, 2Q12 over 2Q11, 3Q12 over 3Q11, and 4Q12 over 4Q11. These increases apply 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 charged and the rolling rate increases for consecutive quarters starting with 1Q10 actual rates through proposed 4Q12 rates. Note that 4Q10 through 3Q11 rates include the approved rate adjustments for PPACA benefits averaging about 3.6%.

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 this product.

Aggregation of Policy Forms

We will aggregate our Healthy New York EPO 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 quarterly rate increase needed for 1st quarter 2012 Healthy New York EPO, we compared the projected 1Q12 cohort medical claims with our target loss ratio to the 4th quarter 2011 Standardized Premium. The following chart shows how we developed our needed rate increase.

2010 Medical PMPM	211.62
2011 Projected Trend	15.7%
2012 Projected Trend	15.8%
1Q12 Cohort Projected Medical PMPM	287.07
Projected Expense due to Re-class	0.21
Total 1Q12 Projected PMPM	287.28
Target Loss Ratio	82.0%
Required Premium PMPM	350.34
4Q11 Standardized Premium	290.54
Needed Rate Increase	20.6%
Proposed Rate Increase	19.8%

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 20.6% increase over 4Q11.

As mentioned above, we are proposing a 19.8% 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. Average 2009 rate ratios are developed at the product level to determine relationships between 2009 Earned Premium and December 2011 Standardized Premiums. These ratios are the 1Q08 through 4Q11 composite increases, and they exclude the PPACA increases since they were not effective until 4Q10 and a minimal portion of 2010 claims and premiums have been affected.
2. Quarterly rate ratios equaling the relationship between 1Q08 through 4Q09 rates and the 4Q11 Standardized rate were developed. The relationship between the quarterly rates and the 4Q11 rates reflects only pure rate increases and not increases due to contract language changes.
3. By renewal month, the rate ratios were weighted by the amount of premium received before and after renewal of rates to derive an average rate by renewal month. For instance, for February 2009 renewals, the average rate factor is the premium weighted average of the 1Q08 rate and the 1Q09 rate.

4. The average 2009 rate ratio is the composite of the rate factors by renewal month weighted by premium by renewal month.
5. This average 2009 rate ratio is then applied to the 2009 Earned premium PMPM to arrive at the Standardized Premium.
6. The calculation was similarly applied to derive the relationship between 2010 Earned Premium and December 2011 Standardized Premiums. An example which translates Healthy New York EPO 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 Healthy New York EPO.

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 Healthy New York EPO.

The buildup of projected 2012 claim PMPMs is shown in [Appendix D](#). 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 148,378 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 and claims, the expected Healthy New York EPO loss ratios for 1Q12, 2Q12, 3Q12, and 4Q12 are 82.5%, 85.6%, 88.8%, 92.1% respectively. All expected 2012 loss ratios are 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 runout. 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. Healthy New York consists of small groups and direct pay members, so do expect some level of adverse selection as typified by these markets. 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 Healthy New York.

[Appendix E-2](#) further summarizes the Healthy New York medical trends, adds the impact of covered lives assessment (CLA) and Stop Loss trend, and provides total composite trends by product. Note that the composite 2010/2009 medical, CLA, and Stop Loss PMPM trend for Healthy New York was 6.0%.

However, a significant portion of that was attributable to the favorable Stop Loss PMPM trend. Note that for 2012, in light of the reduced percentage of Stop Loss receivable received, we are assuming that the PMPM trend will be a nominal 0.6%. The table below shows the 2010 amount of Stop Loss receivable and the resultant amount projected to be paid in 2012 after adjustments for membership and product mix are reflected. Note that the \$16,993,242 expected Stop Loss receivable is the amount that is being built into the 2012 rate tables.

	Stop Loss Rec.	PMPM
2010 Pool (Receipt)	(\$11,670,413)	(\$78.65)
Change In Member Count (multiply)	1.44	
Change In Benefit Mix (multiply)	1.01	
2012 Pool (Receipt)	(\$16,993,242)	(\$79.57)

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

Composite medical trends were applied using the following formula to derive the claims PMPM projections:

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

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

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

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

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.

<u>2011 Admin</u>	<u>% of Prem</u>	<u>PMPM</u>
Regulatory authority fees	0.8%	\$2.23
Health care quality admin	0.2%	\$0.62
Commissions	3.0%	\$8.14
Premium Taxes	0.0%	\$0.00
Other Admin	9.5%	\$25.80
State income Taxes	0.0%	\$0.00
Federal income taxes	0.0%	\$0.00
Reduction for net investment income	0.0%	\$0.00
Net	13.6%	\$36.79

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.

<u>2012 Admin</u>	<u>% of Prem</u>	<u>PMPM</u>
Regulatory authority fees	0.9%	\$3.14
Health care quality admin	0.3%	\$0.89
Commissions	3.0%	\$10.44
Premium Taxes	0.0%	\$0.00
Other Admin	9.3%	\$32.54
Statutory contribution to surplus	1.0%	\$3.48
Risk charge	1.0%	\$3.48
After Tax UW margin	2.0%	\$6.96
State income Taxes	0.0%	\$0.00
Federal income taxes	0.0%	\$0.00
Reduction for net investment income	0.0%	\$0.00
Net	17.5%	\$60.94

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 19.8% for is required to make this product profitable. The resultant price of Healthy New York EPO 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



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 (“GHI”) Premium Rates

<<Date>>

<<Group Name>>
<<Contact First Name>> <<Contact Last Name>>
<<Street Add1>>
<<Street Add2>>
<<City,>> <<State>> <<Zip Code>>

<<Category Code>>

Group#: <<Base_Group_No>>

Dear <<Contact First Name>> <<Contact Last Name>>:

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

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

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

EmblemHealth

PremiumRateFilings@emblemhealth.com

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

New York State Insurance Department

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

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

www.ins.state.ny.us

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

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

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

Sincerely,



Vice President
Commercial Account Management

GHI_GR_HNY_EPO_LTR_5488



EmblemHealth®

GHI and HIP are EmblemHealth companies

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

<<Group Name>> <<Date>>
 <<Contact_First_Name>> <<Contact_Last_Name>>
 <<Street_Add1>>
 <<Street_Add2>>
 <<City,>> <<State>> <<Zip_Code>> **Group#: <Base_Group_No>>**

Notice of Premium Adjustment

Dear <<Contact_First_Name>> <<Contact_Last_Name>>:

We recently mailed you a recertification form that you need to complete and submit to us to certify your continued eligibility in the GHI Healthy New York plan. We are writing to you now to give you your group’s new premium rates, which will take effect <<Rate_Eff_Date>>.

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

<u>Coverage</u>	<u>Renewal Rate</u>
Individual	<<Tier_Id_1>>
Employee and Child or Children	<<Tier_Id_2>>
Employee and Spouse	<<Tier_Id_3>>
Employee, Spouse and Child or Children	<<Tier_Id_4>>

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

As a reminder, you are required to notify your covered employees about this rate increase and any additional premium contribution as soon possible after receiving this letter. 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 questions about your renewal or health coverage, please call our Account Services Department at **1-212-615-4037** in New York City, or **1-800-552-0103** outside New York City, Monday through Friday, 9 am to 5 pm.

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

Sincerely,

<<Client_Type_ID>>



Vice President
Commercial Account Management

GHI Group Healthy New York (Sample Final Notice)

GROUP HEALTH INCORPORATED
Healthy NY EPO Plan - GHI-HNY-EPO, HCR-2010
Public Program Plan
Rates for New York City Region

	Monthly Rates For Groups Entering/Renewing <u>1/1/12 - 3/31/12</u>	Monthly Rates For Groups Entering/Renewing <u>4/1/12 - 6/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>7/1/12 - 9/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>10/1/12 - 12/31/12</u>
Healthy NY EPO (with Drug) - Grandfathered Direct Pay				
Individual	417.48	417.48	417.48	417.48
Employee and Child(ren)	793.21	793.21	793.21	793.21
Employee and Spouse	918.43	918.43	918.43	918.43
Employee, Spouse and Child(ren)	1,231.54	1,231.54	1,231.54	1,231.54
Healthy NY EPO (with Drug) - Grandfathered Small Group				
Individual	424.40	424.40	424.40	424.40
Employee and Child(ren)	806.35	806.35	806.35	806.35
Employee and Spouse	933.65	933.65	933.65	933.65
Employee, Spouse and Child(ren)	1,251.96	1,251.96	1,251.96	1,251.96
Healthy NY EPO (with Drug) - PPACA compliant				
Individual	426.85	426.85	426.85	426.85
Employee and Child(ren)	810.99	810.99	810.99	810.99
Employee and Spouse	939.02	939.02	939.02	939.02
Employee, Spouse and Child(ren)	1,259.16	1,259.16	1,259.16	1,259.16
Healthy NY EPO (without Drug) - Grandfathered Direct Pay				
Individual	358.33	358.33	358.33	358.33
Employee and Child(ren)	680.81	680.81	680.81	680.81
Employee and Spouse	788.33	788.33	788.33	788.33
Employee, Spouse and Child(ren)	1,057.08	1,057.08	1,057.08	1,057.08
Healthy NY EPO (without Drug) - Grandfathered Small Group				
Individual	360.07	360.07	360.07	360.07
Employee and Child(ren)	684.13	684.13	684.13	684.13
Employee and Spouse	792.18	792.18	792.18	792.18
Employee, Spouse and Child(ren)	1,062.23	1,062.23	1,062.23	1,062.23
Healthy NY EPO (without Drug) - PPACA compliant				
Individual	362.17	362.17	362.17	362.17
Employee and Child(ren)	688.12	688.12	688.12	688.12
Employee and Spouse	796.79	796.79	796.79	796.79
Employee, Spouse and Child(ren)	1,068.41	1,068.41	1,068.41	1,068.41

GROUP HEALTH INCORPORATED

Healthy NY HSA Compatible EPO Plan - GHI-HNY-PLA-91 (Group & SP) / PLA-92 (DP), HCR-2010

Public Program Plan

Rates for New York City Region

	Monthly Rates For Groups Entering/Renewing <u>1/1/12 - 3/31/12</u>	Monthly Rates For Groups Entering/Renewing <u>4/1/12 - 6/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>7/1/12 - 9/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>10/1/12 - 12/31/12</u>
Healthy NY EPO (with Drug) - Grandfathered Direct Pay				
Individual	300.96	300.96	300.96	300.96
Employee and Child(ren)	571.82	571.82	571.82	571.82
Employee and Spouse	662.09	662.09	662.09	662.09
Employee, Spouse and Child(ren)	887.78	887.78	887.78	887.78
Healthy NY EPO (with Drug) - Grandfathered Small Group				
Individual	305.95	305.95	305.95	305.95
Employee and Child(ren)	581.29	581.29	581.29	581.29
Employee and Spouse	673.06	673.06	673.06	673.06
Employee, Spouse and Child(ren)	902.48	902.48	902.48	902.48
Healthy NY EPO (without Drug) - Grandfathered Direct Pay				
Individual	245.40	245.40	245.40	245.40
Employee and Child(ren)	466.26	466.26	466.26	466.26
Employee and Spouse	539.89	539.89	539.89	539.89
Employee, Spouse and Child(ren)	723.95	723.95	723.95	723.95
Healthy NY EPO (without Drug) - Grandfathered Small Group				
Individual	246.60	246.60	246.60	246.60
Employee and Child(ren)	468.54	468.54	468.54	468.54
Employee and Spouse	542.51	542.51	542.51	542.51
Employee, Spouse and Child(ren)	727.47	727.47	727.47	727.47
Healthy NY HSA EPO (with Drug) - PPACA compliant				
Individual	307.71	307.71	307.71	307.71
Employee and Child(ren)	584.64	584.64	584.64	584.64
Employee and Spouse	676.93	676.93	676.93	676.93
Employee, Spouse and Child(ren)	907.68	907.68	907.68	907.68
Healthy NY HSA EPO (without Drug) - PPACA compliant				
Individual	248.03	248.03	248.03	248.03
Employee and Child(ren)	471.26	471.26	471.26	471.26
Employee and Spouse	545.68	545.68	545.68	545.68
Employee, Spouse and Child(ren)	731.71	731.71	731.71	731.71

GROUP HEALTH INCORPORATED

Healthy NY EPO Plan Inpatient / Surgical Copay Adjustment Rider - GHI -BHW - CT2R, HCR-2010

Public Program Plan

Rates for New York City Region

	Monthly Rates For Groups Entering/Renewing <u>1/1/12 - 3/31/12</u>	Monthly Rates For Groups Entering/Renewing <u>4/1/12 - 6/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>7/1/12 - 9/30/12</u>	Monthly Rates For Groups Entering/Renewing <u>10/1/12 - 12/31/12</u>
Inpatient / Surgical Copay Adjustment Rider				
Individual	25.90	25.90	25.90	25.90
Employee and Child(ren)	49.18	49.18	49.18	49.18
Employee and Spouse	56.95	56.95	56.95	56.95
Employee, Spouse and Child(ren)	76.38	76.38	76.38	76.38



Healthy New York EPO

COPAYMENT SCHEDULE

Inpatient Hospital Services (Including Inpatient Maternity Care)	
Daily room & board General nursing care Special diets Miscellaneous hospital services & supplies	\$500 copayment per continuous confinement
Outpatient Hospital Services	
Diagnostic & treatment services Home Health Care Outpatient surgery	\$20 copayment per visit \$75 facility copayment
Physicians Services	
Diagnostic & treatment services Consultant & referral services Anesthesia services Second surgical opinion Second opinion for cancer Physical Therapy and Occupational Therapy Surgical services (including breast reconstruction following a mastectomy)	\$20 copayment per visit 20% or \$200, whichever is less
Pre-admission Testing	\$20 copayment
Maternity Care	
Prenatal care Postnatal care Delivery Home visit	\$10 copayment per visit (prenatal) \$10 copayment per visit (postnatal) 20% or \$200, whichever is less No copayment
Adult Preventive Health Care	
Mammography screening Cervical cytology screening Prostate Screening Periodic physical examinations Adult immunizations	\$20 copayment per visit
Child Preventive Health Services	
Preventive and Primary Care Immunization Scheduled Well-Care Visits	Covered in full Covered in full
Diabetic Equipment & Supplies and Self-Management Education	
	\$20 copayment per visit for self-education \$20 copayment per each item of equipment \$20 copayment per 34 day supply of insulin, hypoglycemics and supplies
Diagnostic X-Ray & Lab Services	\$20 copayment per visit
Emergency Services	\$50 copayment per visit (waived if hospital admission results from visit)
Therapeutic Services	
Radiological services Chemotherapy Renal Dialysis	\$20 copayment per visit
Blood and Blood Products	\$20 copayment per visit



COPAYMENT SCHEDULE (cont.)

Prescription Drugs (OPTIONAL)

Deductible:

\$100 per individual per calendar year

Copayment:

\$10 per generic drug per 34-day supply

\$20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34-day supply

Mail order program:

\$20 per generic drug per 90-day supply

\$40 per brand name drug per 90-day supply plus the difference in cost between the brand name drug and its generic equivalent

Benefit Maximum:

\$3,000 per individual per calendar year

NOT COVERED: Ambulance, Dental Care, Durable Medical Equipment, External Prosthetics, Ostomy Supplies, Mental Health Services, Advance Infertility Services, Chiropractic Care, Skilled Nursing Facility, Substance Abuse Diagnosis's and Treatment Detoxification, Rehabilitation.

This chart is intended to provide a general outline of GHI EPO Healthy New York benefits. Please refer to GHI EPO Healthy New York Subscriber Contract or Certificate of Coverage for complete benefit information.



Healthy New York EPO HDHP

COPAYMENT SCHEDULE

This is a high deductible health plan. With the exception of (1) well-baby and well-child care (up to the age of 19) including immunizations; and (2) adult preventive services (including a physical examination once every three years, mammography, pap smear, prostate screening exam and immunizations); and (3) pre-natal care, the deductible must be satisfied before GHI will provide coverage for covered services.

The individual deductible amount for 2010* is \$1,200; the family deductible amount for 2010 is \$2,400. Family coverage applies if the policy covers more than one person. The family deductible may be satisfied by one individual family member or by expenses incurred by various family members. However, the entire plan year deductible must be satisfied before services will be covered for any member of the family.

The Out-of-pocket maximum amount for an individual for 2010 is \$5,250; the out-of-pocket maximum amount for a family for 2010 is \$10,500. Family coverage applies if the policy covers more than one person. Out-of-pocket expenses include the deductible and copayments paid for Healthy New York benefits covered by this plan. Once the out-of-pocket maximum for the plan year is reached, no further copayments will apply and covered benefits will be covered in full. For more information about high deductible plans, please see your certificate.

Cost Sharing

Annual Plan Deductible	\$1,200 Individual for plan year 2010* \$2,400 Family for plan year 2010* *Treasury guidelines indicate that each year, the deductible amounts required for a high deductible health plan will be increased to reflect a cost-of-living adjustment. In order for this plan to continue to meet Healthy New York high deductible health plan requirements, and for this plan to continue to qualify as a high deductible health plan for use with a health savings account, the deductible amounts set forth above for plan years 2011 – 2021 will automatically increase to the new deductible amounts established in the Treasury guidelines.
Annual Out-of-Pocket Maximum	\$5,250 Individual \$10,500 Family

Inpatient Hospital Services (Including Inpatient Maternity Care)

Daily room & board General nursing care Special diets Miscellaneous hospital services & supplies	\$500 copayment per continuous confinement
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Outpatient Hospital Services

Diagnostic & treatment services Home Health Care Outpatient surgery	\$20 copayment per visit \$75 facility copayment
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Physicians Services	
Diagnostic & treatment services Consultant & referral services Anesthesia services Second surgical opinion Second opinion for cancer Physical Therapy and Occupational Therapy Surgical services (including breast reconstruction following a mastectomy)	\$20 copayment per visit 20% or \$200, whichever is less
Pre-admission Testing	\$20 copayment
Maternity Care	
Prenatal care Postnatal care Delivery Home visit	\$10 copayment per visit (prenatal) \$10 copayment per visit (postnatal) 20% or \$200, whichever is less No copayment
Adult Preventive Health Care	
Mammography screening Cervical cytology screening Prostate Screening Periodic physical examinations Adult immunizations	\$20 copayment per visit
Child Preventive Health Services	
Preventive and Primary Care Immunization Scheduled Well-Care Visits	Covered in full Covered in full
Diabetic Equipment & Supplies and Self-Management Education	
	\$20 copayment per visit for self-education \$20 copayment per each item of equipment \$20 copayment per 34 day supply of insulin, hypoglycemics and supplies
Diagnostic X-Ray & Lab Services	\$20 copayment per visit
Emergency Services	\$50 copayment per visit (waived if hospital admission results from visit)



COPAYMENT SCHEDULE (cont.)

Therapeutic Services	
Radiological services Chemotherapy Renal Dialysis	\$20 copayment per visit
Blood and Blood Products	\$20 copayment per visit
Prescription Drugs (OPTIONAL)	
Copayment:	<p>\$10 per generic drug per 34-day supply \$20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34-day supply</p> <p>Mail order program: \$20 per generic drug per 90-day supply \$40 per brand name drug per 90-day supply plus the difference in cost between the brand name drug and its generic equivalent</p> <p>Benefit Maximum: \$3,000 per individual per calendar year</p>

NOT COVERED: Ambulance, Dental Care, Durable Medical Equipment, External Prosthetics, Ostomy Supplies, Mental Health Services, Advance Infertility Services, Chiropractic Care, Skilled Nursing Facility, Substance Abuse Diagnosis's and Treatment Detoxification, Rehabilitation.

This chart is intended to provide a general outline of GHI EPO Healthy New York HDHP/HSA benefits. Please refer to GHI EPO Healthy New York HDHP Subscriber Contract or Certificate of Coverage for complete benefit information.

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
Healthy NY EPO Plan - GHI-HNY-EPO, HCR-2010
Public Program Plan

Rates for New York City Region

Rate Effective Date: 1/1/2012

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
Healthy NY EPO (with Drug) - Grandfathered Direct Pay							
Individual	348.48	417.48	69.00	19.80	10/1/2011	No	n/a
Employee and Child(ren)	662.11	793.21	131.10	19.80	10/1/2011	No	n/a
Employee and Spouse	766.64	918.43	151.79	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	1,028.00	1,231.54	203.54	19.80	10/1/2011	No	n/a
Healthy NY EPO (with Drug) - Grandfathered Small Group							
Individual	354.26	424.40	70.14	19.80	10/1/2011	No	n/a
Employee and Child(ren)	673.08	806.35	133.27	19.80	10/1/2011	No	n/a
Employee and Spouse	779.34	933.65	154.31	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	1,045.04	1,251.96	206.92	19.80	10/1/2011	No	n/a
Healthy NY EPO (with Drug) - PPACA compliant							
Individual	356.30	426.85	70.55	19.80	10/1/2011	No	n/a
Employee and Child(ren)	676.95	810.99	134.04	19.80	10/1/2011	No	n/a
Employee and Spouse	783.82	939.02	155.20	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	1,051.05	1,259.16	208.11	19.80	10/1/2011	No	n/a
Healthy NY EPO (without Drug) - Grandfathered Direct Pay							
Individual	299.11	358.33	59.22	19.80	10/1/2011	No	n/a
Employee and Child(ren)	568.29	680.81	112.52	19.80	10/1/2011	No	n/a
Employee and Spouse	658.04	788.33	130.29	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	882.37	1,057.08	174.71	19.80	10/1/2011	No	n/a
Healthy NY EPO (without Drug) - Grandfathered Small Gro							
Individual	300.56	360.07	59.51	19.80	10/1/2011	No	n/a
Employee and Child(ren)	571.06	684.13	113.07	19.80	10/1/2011	No	n/a
Employee and Spouse	661.25	792.18	130.93	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	886.67	1,062.23	175.56	19.80	10/1/2011	No	n/a
Healthy NY EPO (without Drug) - PPACA compliant							
Individual	302.31	362.17	59.86	19.80	10/1/2011	No	n/a
Employee and Child(ren)	574.39	688.12	113.73	19.80	10/1/2011	No	n/a
Employee and Spouse	665.10	796.79	131.69	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	891.83	1,068.41	176.58	19.80	10/1/2011	No	n/a

GROUP HEALTH INCORPORATED

Healthy NY HSA Compatible EPO Plan - GHI-HNY-PLA-91 (Group & SP) / PLA-92 (DP), HCR-2010
Public Program Plan

Rates for New York City Region

Rate Effective Date: 1/1/2012

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
Healthy NY EPO (with Drug) - Grandfathered Small Group							
Individual	255.38	305.95	50.57	19.80	10/1/2011	No	n/a
Employee and Child(ren)	485.22	581.29	96.07	19.80	10/1/2011	No	n/a
Employee and Spouse	561.82	673.06	111.24	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	753.32	902.48	149.16	19.80	10/1/2011	No	n/a
Healthy NY EPO (without Drug) - Grandfathered Small Group							
Individual	205.84	246.60	40.76	19.80	10/1/2011	No	n/a
Employee and Child(ren)	391.10	468.54	77.44	19.80	10/1/2011	No	n/a
Employee and Spouse	452.85	542.51	89.66	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	607.24	727.47	120.23	19.80	10/1/2011	No	n/a

GROUP HEALTH INCORPORATED

Healthy NY HSA Compatible EPO Plan - GHI-HNY-PLA-91 (Group & SP) / PLA-92 (DP), HCR-2010
Public Program Plan

Rates for New York City Region

Rate Effective Date: 1/1/2012

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
Healthy NY EPO (with Drug) - Grandfathered Direct Pay							
Individual	251.22	300.96	49.74	19.80	10/1/2011	No	n/a
Employee and Child(ren)	477.31	571.82	94.51	19.80	10/1/2011	No	n/a
Employee and Spouse	552.66	662.09	109.43	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	741.05	887.78	146.73	19.80	10/1/2011	No	n/a
Healthy NY EPO (without Drug) - Grandfathered Direct Pay							
Individual	204.84	245.40	40.56	19.80	10/1/2011	No	n/a
Employee and Child(ren)	389.20	466.26	77.06	19.80	10/1/2011	No	n/a
Employee and Spouse	450.66	539.89	89.23	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	604.30	723.95	119.65	19.80	10/1/2011	No	n/a
Healthy NY HSA EPO (with Drug) - PPACA compliant							
Individual	256.85	307.71	50.86	19.80	10/1/2011	No	n/a
Employee and Child(ren)	488.01	584.64	96.63	19.80	10/1/2011	No	n/a
Employee and Spouse	565.05	676.93	111.88	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	757.66	907.68	150.02	19.80	10/1/2011	No	n/a
Healthy NY HSA EPO (without Drug) - PPACA compliant							
Individual	207.04	248.03	40.99	19.80	10/1/2011	No	n/a
Employee and Child(ren)	393.37	471.26	77.89	19.80	10/1/2011	No	n/a
Employee and Spouse	455.49	545.68	90.19	19.80	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	610.78	731.71	120.93	19.80	10/1/2011	No	n/a

GROUP HEALTH INCORPORATED

Healthy NY EPO Plan Inpatient / Surgical Copay Adjustment Rider - GHI -BHW - CT2R, HCR-2010
Public Program Plan

Rates for New York City Region

Rate Effective Date: 1/1/2012

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
Inpatient / Surgical Copay Adjustment Rider							
Individual	21.62	25.90	4.28	19.80	10/1/2011	No	n/a
Employee and Child(ren)	41.05	49.18	8.13	19.81	10/1/2011	No	n/a
Employee and Spouse	47.54	56.95	9.41	19.79	10/1/2011	No	n/a
Employee, Spouse and Child(ren)	63.76	76.38	12.62	19.79	10/1/2011	No	n/a