Filing at a Glance

Company:	Managed Health, Inc.
Product Name:	MHI Small Group Rate Filing 2015
State:	New York
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.004F Small Group Only - HMO
Filing Type:	Prior Approval Off Exchange Form & Rate Filing
Date Submitted:	06/13/2014
SERFF Tr Num:	HLFT-129571793
SERFF Status:	Assigned
State Tr Num:	2014060264
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2015
Author(s):	[redacted]
Reviewer(s):	[redacted]
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *New York* **Filing Company:** *Managed Health, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*
Product Name: *MHI Small Group Rate Filing 2015*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 06/16/2014
State Status Changed:
Created By: [redacted]
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: [redacted]

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
Managed Health, Inc.'s initial submission of its 2015 small group rate filing.

The SERFF and State tracking numbers of the corresponding Prior Approval prefiling are HLFT-129571399 and 2014060080, respectively

The SERFF tracking number of the associated form filing is HLFT-129571789.

Company and Contact

Filing Contact Information

[redacted]

Filing Company Information

Managed Health, Inc.
100 Church Street
18th Floor
New York, NY 10007
[redacted]

CoCode: 95284
Group Code:
Group Name:
FEIN Number: 11-3029569

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): No
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is a group prefiling notification, out-of-state, or a report filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Form and Rate
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation).]: No
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
10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary and initial notification letter associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes. SERFF tracking number: HLFT-129571399. State tracking number: 2014060080.

6/13/14

«SubscirberFirstName» «SubscriberLastName»
«AddressLine1» «AddressLine2»
«CITY», «STATE» «ZipCode»

Re: Notice of Proposed Premium Rate Change
Healthfirst [Plan Name] - HIOS ID 83744NY001[XXXX]

Dear Healthfirst Member:

Managed Health, Inc.(Healthfirst) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your group premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Change
If approved, the percentage change to your premium is 0.3%.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features that your group policyholder selects on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change
Several market forces continue to drive health care costs higher and Healthfirst is requesting a higher rate in 2015. We continue to improve our care management and quality improvement programs. We also continue to strengthen our robust network. However, the demographic make-up of our current membership is different than was expected. Based on these factors, as well as our projections, the membership's average demand for medical services may go up in 2015. This is why we are applying for a rate increase to account for marketplace trends and to reflect these changing factors.

30-day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Healthfirst for additional information at:

Healthfirst
100 Church Street
New York, NY
1-888-250-2220
www.healthfirst.org

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincrease@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Managed Health, Inc.
2. The name of your plan, which is Healthfirst [Plan Name]
3. Indicate you have Small Group coverage
4. Your HIOS identification number, which is 83744NY001[XXXX]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Healthfirst website: www.healthfirst.org/priorapproval
DFS website: http://www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,

Nemesio Ortiz
Vice President, Sales
Healthfirst

SAMPLE

6/13/14

«SubscirberFirstName» «SubscriberLastName»
«AddressLine1» «AddressLine2»
«CITY», «STATE» «ZipCode»

Re: Notice of Proposed Premium Rate Change
Healthfirst [Plan Name] - HIOS ID 83744NY001[XXXX]

Dear Group Benefit Administrator:

Managed Health, Inc. (Healthfirst) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Change
If approved, the percentage change to your premium is 0.3%.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change
Several market forces continue to drive health care costs higher and Healthfirst is requesting a higher rate in 2015. We continue to improve our care management and quality improvement programs to bring you and your employees greater value. We also continue to strengthen our robust network. However, the demographic make-up of our current membership is different than was expected. Based on these factors, as well as our projections, the membership's average demand for medical services may go up in 2015. This is why we are applying for a rate increase to account for marketplace trends and to reflect these changing factors.

30-day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Healthfirst for additional information at:

Healthfirst PHSP, Inc.
100 Church Street
New York, NY
1-888-250-2220
www.healthfirst.org

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincrease@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Managed Health, Inc.
2. The name of your plan, which is Healthfirst [Plan Name]
3. Indicate you have Small Group coverage
4. Your HIOS identification number, which is 83744NY001[XXXX]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

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Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,

Nemesio Ortiz
Vice President, Sales
Healthfirst

SAMPLE

State: *New York* **Filing Company:** *Managed Health, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*
Product Name: *MHI Small Group Rate Filing 2015*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Managed Health, Inc.	Increase	%	%				%	%

State: New York **Filing Company:** Managed Health, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: MHI Small Group Rate Filing 2015
Project Name/Number: /

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		MHI Small Group HMO Rate Manual		New		MHI_Rate Manual_Small Group HMO B_2015.pdf,

healthfirst

June 13, 2014

Health Bureau
New York State Department of Financial Services
One State Street
New York, NY 10004

RE: Managed Health, Inc. – Small Group HMO
Submission Effective January 1, 2015
Rates and Forms Application Under New York Insurance Law Section 3231(d)

Dear

Managed Health, Inc. (MHI) is pleased to submit its premium rates and forms for products with an effective date of January 1, 2015. The products listed herein are being filed pursuant to section 4308(c) of the NY Insurance Law.

Enclosed please find the rate manual for this submission. These rates and forms are for participation in New York, Richmond, Kings, Queens, Bronx, Nassau, and Suffolk Counties.

If you have any questions regarding this rates and forms submission please feel free to contact respectively. Thank you for your time and consideration.

MANAGED HEALTH, INC.

Rate Manual Pursuant to New York Insurance Law Section 4308(c)

Small Group HMO Rates and Forms Submission

Effective January 1, 2015

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SECTION I –
Off-Exchange Small Group HMO
Premium Rates

Section I.A – Rate Pages

MANAGED HEALTH, INC.
OFF-EXCHANGE SMALL GROUP HMO
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES (WITH FAMILY PLANNING)

January – December, 2015

Plan Name: HMO B	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
Single	$618.74	$20.63	$0
Single + spouse	$1,237.49	$41.26	$0
Single + child(ren)	$1,051.86	$35.07	$0
Single + spouse + child(ren)	$1,763.42	$58.79	$0

Form Numbers of policies to which these rates apply:

HMO B
MHI-SG-15-OFF
MHI-SG-SoB-15-OFF
MHI-DPR-15
MHI-A29R-15

MANAGED HEALTH, INC.
OFF-EXCHANGE SMALL GROUP HMO
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES (WITHOUT FAMILY PLANNING)

January – December, 2015

HMO B	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
Single	$614.15	$20.48	$0
Single + spouse	$1,228.31	$40.95	$0
Single + child(ren)	$1,044.06	$34.81	$0
Single + spouse + child(ren)	$1,750.34	$58.36	$0

Form Numbers of policies to which these rates apply:

HMO B
MHI-SG-15-OFF
MHI-SG-SoB-15-OFF
MHI-DPR-15
MHI-A29R-15
MHI-FPR-15

Section I.B – Description of Rating Classes, Factors, & Premium Discounts

Managed Health, Inc.'s rates have been developed in accordance with New York State's community rating laws. Premiums for every member covered under the same policy are the same regardless of age, sex, health status or occupation. The risk for on-Exchange and off-Exchange plans, pursuant to the Patient Protection and Affordable Care Act of 2010 and its associated regulations, is pooled into a single risk pool. As illustrated below, these rates within the community rated pool vary based on only several factors: dependent age limit, the inclusion of a pediatric dental benefit, the inclusion of family planning benefits, and family/census tier.

Family/Census Tier

Census Tiers	Cost Factor
Single	**1.000**
Single + Spouse	**2.000**
Single + Child(ren)	**1.700**
Single + Spouse + Child(ren)	**2.850**

Rating Region

Rating Region	Counties Included	Area Factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Family Planning Benefits

Family Planning Rider	Cost Factor
Included	**1.000**
Not Included	**0.993**

Dependent Age Limit

Dependent Age Limit	Cost Factor
26	1.000
29	1.033

Domestic Partner Coverage

Domestic Partner	Cost Factor
Covered	1.000
Not Covered	1.000

Section I.C – Rate Calculation Examples

The entirety of premium rates for Managed Health, Inc.'s Small Group plans is listed above in the rate tables in section I.A (pages 56of this rate manual). An example of how to look up a particular premium rate is below.

EXAMPLE:

Consumer Profile: A married employee (subscriber), of a Queens County-based employer, who is electing to cover his spouse and two children as dependents, is choosing the Small Group HMO B product with pediatric dental benefits and family planning benefits, and not choosing the Age 29 Rider.

Rate Look-Up Solution: There are no differences in premium rates for the two different rating regions included in this product (Regions 4 and 8), therefore the subscriber is advised to proceed to page 5 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans (with Family Planning)." Next, the consumer would refer to the column labeled, "Healthfirst HMO B Small Group" and cross-reference the row labeled, "Single + Spouse + Child(ren)." The rate for this plan is $1,763.42 per month.

Section I.D – Expected Loss Ratios

For the plans listed in this rate manual, the projected loss ratio using the Federally prescribed medical loss ratio (MLR) methodology is 84.5%. The expected loss ratio under New York State's MLR methodology is 82.4%. These projected loss ratios are greater than the Federally prescribed 80% minimum for Individual products, as well as the 82% minimum prescribed by New York State for Individual products.

SECTION II –

Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, & Renewal Conditions

Section II.A – Off-Exchange Small Group HMO Gold Benefit Description (with Family Planning)

Managed Health, Inc. HMO B Small Group (with Family Planning)		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$40 Copayment after deductible**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**

Screening for Prostate Cancer	**$40 Copayment after deductible**	**Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.**
Family Planning Services for Women	**Covered in full**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		

Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	

Habilitation Services **(Physical Therapy, Occupational Therapy or Speech Therapy)**	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies**
Home Health Care	**$25 Copayment after deductible**	**40 Visits per Plan Year**
Infertility Services	**Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Home Infusion Therapy	**$25 Copayment after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**

Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies** **Speech and Physical Therapy are only Covered following a Hospital stay or surgery.**
Second Opinions on the Diagnosis of Cancer, Surgery and Other	**$40 Copayment after deductible**	**One second surgical opinion on the need for surgery** **For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer**

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	$100 Copayment	No limit
Inpatient Hospital Surgery	$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
Elective Termination of Pregnancy	$100 Copayment	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	$25 Copayment after deductible	No limit

Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	$10 Copayment	No limit
Tier 2	$35 Copayment	No limit
Tier 3	$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	$30 Copayment	No limit
Tier 2	$105 Copayment	No limit
Tier 3	$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	$25 Copayment	No limit

Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits**
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.A – Off-Exchange Small Group HMO Gold Benefit Description (with Family Planning)

Managed Health, Inc. HMO B Small Group (without Family Planning)		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**

Screening for Prostate Cancer	**$40 Copayment after deductible**	**Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**

Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	
Habilitation Services	**$30 Copayment after deductible**	**60 visits per condition, per**

(Physical Therapy, Occupational Therapy or Speech Therapy)		lifetime combined therapies
Home Health Care	$25 Copayment after deductible	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Home Infusion Therapy	$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit
Inpatient Hospital Services and Birthing Center	$1,000 Copayment per admission after deductible	No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Physician Midwife Services for Delivery	$100 Copayment after deductible	No limit
Breast Pump	Covered in full	Covered for duration of breast feeding

Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies** **Speech and Physical Therapy are only Covered following a Hospital stay or surgery.**
Second Opinions on the Diagnosis of Cancer, Surgery and Other	**$40 Copayment after deductible**	**One second surgical opinion on the need for surgery** **For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer**

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	$100 Copayment	No limit
Inpatient Hospital Surgery	$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	$25 Copayment after deductible	No limit
Diabetic Education	$25 Copayment after deductible	No limit

Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER	**Participating Provider Member Responsibility for Cost-Sharing**	

SERVICES		
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	$10 Copayment	No limit
Tier 2	$35 Copayment	No limit
Tier 3	$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	$30 Copayment	No limit
Tier 2	$105 Copayment	No limit
Tier 3	$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	$25 Copayment	No limit
Tier 2	$88 Copayment	No limit

Tier 3	$175 Copayment	No limit
Enteral Formulas	20% Coinsurance after deductible	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pediatric Dental Care		
Preventive Dental Care	$25 Copayment after deductible	One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals
Routine Dental Care	$25 Copayment after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	$25 Copayment after deductible	
Orthodontics	$25 Copayment after deductible	
Pediatric Vision Care		
Exams	$25 Copayment after deductible	One Exam Per 12-Month Period
Lenses and Frames	20% Coinsurance after deductible	One Prescribed Lenses & Frames in a 12-Month Period
Contact Lenses	20% Coinsurance after deductible	

SECTION III – Underwriting Guidelines

HEALTHFIRST PARTICIPATION AND ELIGIBILITY GUIDELINES

New York Small Groups (1 – 50 Employees)

Off-Exchange Products

The following participation and eligibility guidelines apply to employer groups enrolling in or renewing coverage in Healthfirst Small Group Off-Exchange products.

Section 1: Small Group Eligibility

A. The employer must actively operate a business with a street address in a county where Healthfirst offers small group products (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties).

B. If the employer does not offer group health coverage to all eligible employees, group size will be calculated based on the number of eligible employees in Healthfirst's service area.

C. A minimum of 60% of all eligible employees after valid waivers must be enrolled. The 60% threshold will be determined by multiplying the number of eligible employees by 0.60 and rounding fractions down to the nearest whole number. Valid waivers include:

a. Spousal coverage
b. Medicare coverage
c. Medicaid coverage
d. VA coverage
e. TriCare coverage
f. ACA-compliant plan coverage

This requirement does not apply to HMO plans.

D. If the group offers retiree coverage, a minimum of 60% of all eligible employees after valid waivers and all eligible former retired employees must be enrolled. (Additional documentation may be required on audit to confirm retirees' eligibility for coverage).

This requirement does not apply to HMO plans.

E. **Valid Employer Class(es)**: An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic status of employment, earnings, method of compensation, hours and occupational duties. (**Example**: Employer may elect to offer coverage only to employees who work at least 30 hours per week.)

F. **Out-of-Area**: Out-of-area enrollment is not allowed on Healthfirst small group plans. Eligible employees who neither work nor reside in HF's service area (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties) may not be covered on Healthfirst small group products.

G. Two Life Group: A two life group consisting of a husband and wife is considered to be a sole proprietor per Federal guidelines, and is not eligible for small group coverage

H. Minimum Participation – Calculation (for plans other than HMOs):
Pursuant to federal regulations, Healthfirst will have an open enrollment period from November 15th through December 15th for all small groups that do not meet minimum participation requirements. The coverage effective date for small groups enrolling during this period will be January 1st.

Section 2: Employee Eligibility

A. Eligible employees, and if the group offers retiree benefits, all eligible retired former employees, can be enrolled in Healthfirst small group products if they:

a. Live in the Healthfirst service area.

b. Are active full-time employees of the employer, and of all subsidiaries and affiliates of a corporate employer, that work at least 20 hours or more per week. The employer must have at least two such employees to remain active.

B. Eligible dependents are defined as: a legally married spouse or domestic partner, and a legally dependent child up to the age of 26. Additional options for age 29 are also available. Domestic partners will be required to submit a domestic partner eligibility attestation. Marriage and birth certificates may be required to prove family eligibility. A copy of a filed Federal Form 1040 may be required for married couples or dependents with a different last name than the employee.

C. The following are **not** counted as eligible employees when determining group size and are excluded from eligibility and coverage:

a. COBRA-only former employees
b. Consultants and independent contractors (1099 employees)
c. Directors and officers who do not qualify as owners, partners or employees
d. Foreign employees covered by their country's government health insurance
e. Leased employees are ineligible for coverage
f. Part-time, temporary and seasonal workers that are not hired to work a full year

Section 3: Employee Required Information

A. The following information on enrolled employees and their dependents is required before processing:

a. Social security number for each subscriber
b. Date(s) of birth for all subscribers and dependents
c. Complete street address
d. Date of marriage (if applicable)
e. Employment effective (start) date
f. Employer and employee signatures

Section 4: Employer Tax Documentation

A. The most recent NYS-45 (NYS Quarterly Combined Withholding and Wage Report). If not required to file the NYS-45, then one of the following is required:

B. If a "C" corporation: Articles of incorporation, Form 1120 (line 13 is wages) and payroll documents

C. If a Church: Form 941 (line 2 is wages) and payroll documents

D. If a LLC: LLC agreement and the appropriate documentation noted above

E. If a Partnership: K-1 or Form 1065 (line 9 is wages) and payroll documents and business license

F. If an "S" corporation: Articles of incorporation, Form 1120S (line 8 is wages) and payroll documents

G. Newly formed business: If the business has been in existence less than one year and has not yet filed a Quarterly Wage and Tax Statement, HF will accept Corporation or Partnership papers and payroll documents

H. A federal TIN or additional documentation may be required upon audit.

Section 5: Required Documentation for Effectuation

A. All paperwork for new business must be received 30 days in advance of the requested effectuation date. New business will have an effective date of the 1st of the month.

B. All paperwork for renewing business must be received 30 days in advance of the requested renewal date.

C. Paperwork required:

a. Signed group application
b. Fully completed original employee enrollment forms and waiver forms (if applicable)
c. Check for the first month's premium from the employer's business account

Section 6: Submit Application & Payment

A. New business must be submitted at least 30 days before the effective date.

B. Incomplete application packages may delay a group's effective date.

Mailing address:
Healthfirst
Enrollment Intake Department
100 Church Street
New York, NY 10007

C. Please fill out application completely and include member and dependent information.

- New groups should submit the first month's premium on a company check.
- Payment may be remitted via bank check or money order. (Please be sure the name of the company or organization is clearly written when sending in bank check or money orders so that payment can be properly applied.)

Section 7: Enrollment and Waiting Periods

A. Open enrollment will be held once a year on the group's anniversary or renewal date.

B. Employee waiting periods for coverage effectiveness cannot exceed 90 days.

C. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period. A copy of the employee's W-4 or recent payroll check stub must be supplied to qualify for provisional enrollment in the event that the new employee is not yet listed on filed tax documentation. The payroll date cannot be more than 30 days prior to the date of application. The employer must produce tax documents within 90 days after the effective date of coverage to substantiate a new hire's eligibility.

D. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.

E. Eligible employees who decline coverage and subsequently wish to enroll without a qualifying event will only be eligible to enroll during the next annual open enrollment period. A qualifying event is an unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is the loss of coverage through a spouse who's losing a job.

Section 8: Rates and Rating Tiers

A. Only 4-tier rates are available.

B. Premium rates for Healthfirst Small Group products are based on employer location.

C. Changes in group eligibility, rate structure, and benefits may be made upon the group's renewal. Should an employer cease to qualify as a small group of between 1- 50 eligible employees, the group is required to promptly notify Healthfirst of this change pursuant to the group contract.

Section 9: Ongoing Small Group Verification

Healthfirst or a Healthfirst designated administrator may take periodic surveys of enrolled small groups to ensure that the group is actively operating its business and is still qualified to be enrolled in a community-rated product. The survey can include, but not be limited to, any or all of the following to verify continued eligibility:

1. The employer's most recently filed NYS-45 or NYS-ATT
2. Tax documentation as requested by HF and/or HF's designated administrators
3. Payroll information as requested by HF and/or HF's designated administrators

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum/Actuarial Certification
Comments:	
Attachment(s):	Actuarial Memorandum - MHI SG - to DFS.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Actuarial Memorandum - MHI SG - to HHS.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	AV MHI.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	Exhibit 13 Numerical Summary MHI SG 2015_FINAL.pdf Exhibit 13 Numerical Summary MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 14B-Sm Grp Requested Percentage Changes
Comments:	
Attachment(s):	Exhibit 14B MHI SG 2015_FINAL.pdf Exhibit 14B MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 15B-Sm Grp Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	Exhibit 15B MHI SG 2015_FINAL.pdf Exhibit 15B MHI SG 2015_FINAL.xlsx

State: New York **Filing Company:** Managed Health, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: MHI Small Group Rate Filing 2015
Project Name/Number: /

Item Status:	
Status Date:	

Bypassed - Item:	Exhibit 16-Summary of Policy Form & Product Changes
Bypass Reason:	No changes to this products' rates or benefits have been made/submitted since the initial submission in 2013.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 17-Claims Experience for 2011-13 (Sm Grps)
Comments:	
Attachment(s):	Exhibit 17 MHI SG 2015_FINAL.pdf Exhibit 17 MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	Exhibit 18 MHI SG 2015_FINAL.pdf Exhibit 18 MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 19-Claim Trend, Admin Expenses & Profit
Comments:	
Attachment(s):	Exhibit 19 MHI SG 2015_FINAL.pdf Exhibit 19 MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	Exhibit 20 - MHI HMO B Small Group OffExchange 2015.pdf Exhibit 20 - MHI HMO B Small Group OffExchange 2015.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates
Comments:	

State: New York **Filing Company:** Managed Health, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: MHI Small Group Rate Filing 2015
Project Name/Number: /

Attachment(s):	Exhibit 23 MHI SG 2015_FINAL.pdf Exhibit 23 MHI SG 2015_FINAL.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	Initial rate adjustment notice (Group Certificate Holder - MHI) for submission.pdf Initial rate adjustment notice (Group Policyholder - MHI) for submission.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redacted Documents for Web Posting
Comments:	
Attachment(s):	Actuarial Memorandum - MHI SG - to DFS_Redacted.pdf Actuarial Memorandum - MHI SG - to HHS_Redacted.pdf MHI_Rate Manual_Small Group HMO B_2015_Redacted.pdf MHI SG Readability Certification Letter_FINAL 2015_Redacted.pdf MHI SG Readability Form FINAL v2_Redacted.pdf Exhibit 11 - MHI SG 2015_FINAL_REDACTED v2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	MHI SG URRT FINAL 2015.pdf MHI SG URRT FINAL 2015.xlsm
Item Status:	
Status Date:	

Attachment Exhibit 13 Numerical Summary MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 14B MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 15B MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 17 MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 18 MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 19 MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 20 - MHI HMO B Small Group OffExchange 2015.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit 23 MHI SG 2015_FINAL.xlsx is not a PDF document and cannot be reproduced here.

Attachment MHI SG URRT FINAL 2015.xlsm is not a PDF document and cannot be reproduced here.

healthfirst

June 13, 2014

[redacted]
New York State Department of Financial Services
One State Street
New York, NY 10014

RE: Managed Health, Inc. – Small Group Off-Exchange Plans

Dear [redacted]:

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law, for Small Group Off-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties. Please note that the proposed rates are not rolling rates.

If you have any questions concerning this submission, please feel free to contact me at [redacted]. We look forward to continue working with the Department.

Sincerely,

[redacted]

Confidential and Proprietary

Managed Health, Inc.

Part III Actuarial Memorandum

Small Group Rate Filing

Effective January 1, 2015

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1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Managed Health, Inc. (MHI) rate filing for the Small Group block of business. The rates are effective for calendar year 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of MHI's Small Group rate filing. The memorandum contains information that is confidential and proprietary to MHI; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Managed Health, Inc.
- State: New York
- HIOS Issuer ID: 83744
- Market: Small Group
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

MHI is proposing an overall 0.3% rate increase for their existing plans. The rate increase varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

The following shows the list of Small Group Off-Exchange plans that will be offered in 2015.

Benefit Design	HIOS Plan ID
Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	83744NY0010025
Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	83744NY0010026
Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	83744NY0010027
Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	83744NY0010028
Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	83744NY0010029
Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	83744NY0010030
Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	83744NY0010031
Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning	83744NY0010032

Reason for Rate Changes

The rate changes are net results from expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

MHI currently have approximately 20 small group Healthy New York members and no Small Group commercial members. With approximately 1,186 member months in Healthy New York Small Group products in 2013, we do not have any credible experience for rate development. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

The "Experience Period Data" section in Worksheet 1 Section I and the "Experience Period on Actual Experience Allowed" in Worksheet 1 Section II of the Unified Rate Review Template contains our Healthy New York Small Group experience. However, as this data is not credible, it was not used in rate development.

Premiums (net of MLR Rebate) in Experience Period

The corresponding premiums for the 1,186 member months were reported.

Allowed and Paid Claims Incurred During the Experience Period

Claims experience for the 1,186 member months were reported as described above.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

The base year experience reported was not credible for rate development. Hence, no projection factors were provided. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development

Source and Appropriateness of Data Used

The New York Small Group experience for the incurred period 1/1/2013 to 12/31/2013 was used as the basis for the manual rate. The experience was obtained from the "New York Risk Adjustment Simulation" Small Group Report published by Deloitte on April 18, 2014. The New York City and Long Island average claims experience were blended based on our assumption that 84% of projected MHI membership will be in New York City. The blended claims cost PMPM was adjusted by 1.042 to account for claims incurred in 2013 but unpaid as of 1/31/2014.

The New York blended Small Group experience was projected to the CY 2015 rating period, and adjusted to reflect changes in provider reimbursement, benefits, and benefit richness. The adjustments are discussed in detail below.

Adjustments Made to the Data

The following adjustments were made to the starting data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.837, as published in the Deloitte report. The starting data was adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.837. The induced utilization factor is 1.106, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 0.926 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of 2.1% over the 2013 average Small Group benefits.

- Provider Network and Reimbursement (*Line 14*) – We believe that our provider network is slightly smaller than the average market-wide Small Group network. We used an overall adjustment of 0.950 to reflect our estimate that our provider contracts are approximately 5% below market.

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – We assumed that the impact of the utilization management, quality improvement and cost containment initiatives for our QHP programs is comparable to the impact that is implicit in the starting data. Hence, no adjustment was made to the starting data.

- Federal Risk Adjustment (Line 21) – Since the starting data was based on market-wide Small Group experience, we assumed that there would be no risk transfer payments.

- Federal Transitional Reinsurance Program Recovery (Line 22) – No adjustment is needed as the federal reinsurance program does not apply to the Small Group market.

- Trend (*Line 24*) – An annual trend of 8.6% was assumed. The trend was based on projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.179 represents trend for a 24 month period between the 2013 base period and the 2015 rating period.

- Covered Lives Assessment (*Line 25*) – The projected claims cost is increased to include the Covered Lives Assessment. The factor is based on the following:

  - The 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City annual assessments of $197.69 per Individual contract and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 84% of our contracts would be in New York City.
  - Using a tier distribution (that will be described in Section 17.B. "Conversion Factor"), the per-contract per year assessment was determined to be $372.40, or a $15.34 PMPM. This equates to an adjustment factor of 1.038.

- HCRA Surcharge (*Line 26*). The starting data does not include the HCRA surcharge. We increased the starting data by 4.3% to include the HCRA surcharge.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

We assigned 100% credibility to the manual rate, as we have no credible experience in the Small Group market. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

All of the plans provide Gold level coverage. The average paid-to-allowed ratio is 0.7905. The ratio was developed using the HHS Actuarial Value Calculator.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

As it was our assumption that we anticipate an average risk profile in the Small Group market, we did not adjust for any risk transfer paid (received) amount. The risk adjustment user fee of $0.08 PMPM was used for all plans, and was included in our administrative expenses.

Projected ACA Reinsurance Recoveries

This is not applicable to the Small Group market. The transitional reinsurance program fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

MHI utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at 12% of premium for all the administrative activities of the MHI QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.
- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The same percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 3.5% was included in all plans. This is consistent with our current ROI for other products. MHI recognizes the need to have positive margins on our programs. We believe that our 3.5% operating margin would provide necessary capital to invest in the company's infra-structure, provide adequate capital to meet reserve requirements for MHI, and provide high quality care to our members. The margin set on MHI is slightly higher than our margin for our QHP business. With the few members that we serve, we still need to maintain the network as well as other operational responsibility such as claims system setup and payment, etc.

The ROI for MHI's investment portfolio in calendar year 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.40%
2012	1.40%
2011	0.70%
2010	1.46%
2009	1.96%

The average ROI for the last five years was 1.18% for MHI.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. MHI is exempt in 2015 since
    i. It is incorporated as a non-profit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any political campaign on behalf of or in opposition to any candidate for public office, and
    iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.
- As a non-profit organization, MHI does not pay any other State or Federal taxes or assessments.

- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 82.4%, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 84.5%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as MHI is a new company without any prior experience.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State in 2015. The following table shows the calculation of MHI's Market Adjusted Index Rate:

	Market Adjusted Index Rate
Index Rate	$523.78
Net Risk Adjustment	$0.08
Net Transitional Reinsurance	$3.67
Exchange Fee	$0.00
Market Adjusted Index Rate	$527.53

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Since MHI had minimal enrollment (about 100 members) in 2013, the experience was not used in the rate development. Exhibit 18 shows the starting experience used in the manual rate development in the experience section of Exhibit 18. As discussed in Section 6 above, the starting experience is market-wide Small Group experience, as published by Deloitte.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting Small Group net paid PMPM.
  - Lines 11 – 12: The net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market-wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced demand
    - Administrative expenses
    - Profit
    - Age 29 Adjustment: An adjustment was made for applicable plans.
    - Family Planning Exclusion Adjustment: An adjustment was made for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate from Exhibit 18, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

MHI participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products in affiliated companies including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for all plans for Employee Only, Employee and Spouse, Employee and Child(ren), and Employee/Spouse/Child(ren) are based on the following census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850

We do not have a credible distribution of members and contracts by census tier during the experience period. Hence, we used information from Milliman for the contract distribution and the average number of members per contract for employer groups, as shown below. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	51.5%	1.000	1.000	1.221
Single + Spouse	15.2%	2.000	2.000	2.442
Single + Child(ren)	9.7%	1.700	2.629	2.076
Single + Spouse + Child(ren)	23.6%	2.850	4.019	3.480

Total	100.0%	**1.657**	**2.023**	**2.023**

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

Currently we have no small group products other than Healthy New York small groups, where we have 20 members. We expect the enrollment to remain low in 2015. Membership by plan is shown on Worksheet 2 of the URRT.

21. Terminated Products

MHI is terminating products in 2014 listed below. Please note that the terminated products on Worksheet 2 of the URRT represent the Healthy New York small group products offered prior to 1/1/2014.

Benefit Design	HIOS Plan ID
Dependent Age 26, Dental & Family Planning	83744NY0010017
Dependent Age 29, Dental & Family Planning	83744NY0010018
Dependent Age 26, No Dental & Family Planning	83744NY0010019
Dependent Age 29, No Dental & Family Planning	83744NY0010020
Dependent Age 26, No Dental & No Family Planning	83744NY0010021
Dependent Age 29, No Dental & No Family Planning	83744NY0010022
Dependent Age 26, Dental & No Family Planning	83744NY0010023
Dependent Age 29, Dental & No Family Planning	83744NY0010024

22. Plan Type

The Plan types listed in the URRT accurately describe MHI's plans.

23. Warning Alerts

There are no validation warning alerts.

24. DFS Exhibits

Please note that due to the minimal small group membership in MHI's Small Group New York in the past three years, we have asked DFS' permission to not fill out the following exhibits that are applicable to Small Group plans.

21A	Hospital Inpatient - Unit Costs [Based on Small Groups]
21B	Hospital Outpatient - Unit Costs [Based on Small Groups]
22	Utilization Information [Based on Small Groups]

25. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not included in the starting base period experience.
- Milliman age/gender factors, distribution of contracts by contract type, and average members per contract by contract type
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

26. Actuarial Certification

I, [redacted] am a Member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by MHI to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted] June 12,2014

Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	0.926
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network	0.950
15	Market wide adjustment for fee schedule changes	1.000
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.179
25	Covered Lives Assessment	1.038
26	HCRA Surcharge	1.043
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.

2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.
3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach

that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance

are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;

- Providing tips, brochures, and other information to help live a healthier life
- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)

- Intercultural Business Etiquette (Second Edition)
- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning
8	HIOS Plan ID*	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032
9	Exchange Plan?*	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate								
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	4,965,488,464							
10B	Member-Months for Latest Experience Period	13,574,523							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	365.79							
11	Average Pricing Actuarial Value reflected in experience period	0.926							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network **	0.950
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
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SERFF Number: HLFT-129571793
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Separate column for each plan design (on or off Exchange)

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1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.179							
25	Other 1 - Covered Lives Assessment	1.038							
26	Other 2 - HCRA Surcharge	1.043							
27	Other 3 (specify)	1.000							
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
29	Pricing actuarial value (without induced demand factor) #	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080	1.080	1.080	1.080	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170
37	Profit/Contribution to surplus margins	1.036	1.036	1.036	1.036	1.036	1.036	1.036	1.036
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Other 1 - Age 29	1.000	1.033	1.000	1.033	1.000	1.033	1.000	1.033
42	Other 2 - Family Planning	1.000	1.000	1.000	1.000	0.993	0.993	0.993	0.993
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.036**	**1.070**	**1.036**	**1.070**	**1.028**	**1.062**	**1.028**	**1.062**

Changes that affect an entire standard population as cost sharing

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

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2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852

changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**506.69**	**523.58**	**506.69**	**523.58**	**502.93**	**519.70**	**502.93**	**519.70**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

healthfirst

June 13, 2014

[redacted]
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Managed Health, Inc. – Small Group Off-Exchange Plans

Dear [redacted]

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law, for Small Group Off-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties. Please note that the proposed rates are not rolling rates.

If you have any questions concerning this submission, please feel free to contact me at [redacted]
We look forward to continue working with the Department.

Sincerely,

[redacted]

cc: [redacted]

Confidential and Proprietary

Managed Health, Inc.

Part III Actuarial Memorandum

Small Group Rate Filing

Effective January 1, 2015

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1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Managed Health, Inc. (MHI) rate filing for the Small Group block of business. The rates are effective for calendar year 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of MHI's Small Group rate filing. The memorandum contains information that is confidential and proprietary to MHI; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Managed Health, Inc.
- State: New York
- HIOS Issuer ID: 83744
- Market: Small Group
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

MHI is proposing an overall 0.3% rate increase for their existing plans. The rate increase varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

The following shows the list of Small Group Off-Exchange plans that will be offered in 2015.

Benefit Design	HIOS Plan ID
Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	83744NY0010025
Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	83744NY0010026
Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	83744NY0010027
Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	83744NY0010028
Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	83744NY0010029
Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	83744NY0010030
Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	83744NY0010031
Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning	83744NY0010032

Reason for Rate Changes

The rate changes are net results from expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

MHI currently have approximately 20 small group Healthy New York members and no Small Group commercial members. With approximately 1,186 member months in Healthy New York Small Group products in 2013, we do not have any credible experience for rate development. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

The "Experience Period Data" section in Worksheet 1 Section I and the "Experience Period on Actual Experience Allowed" in Worksheet 1 Section II of the Unified Rate Review Template contains our Healthy New York Small Group experience. However, as this data is not credible, it was not used in rate development.

Premiums (net of MLR Rebate) in Experience Period

The corresponding premiums for the 1,186 member months were reported.

Allowed and Paid Claims Incurred During the Experience Period

Claims experience for the 1,186 member months were reported as described above.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

The base year experience reported was not credible for rate development. Hence, no projection factors were provided. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development

Source and Appropriateness of Data Used

The New York Small Group experience for the incurred period 1/1/2013 to 12/31/2013 was used as the basis for the manual rate. The experience was obtained from the "New York Risk Adjustment Simulation" Small Group Report published by Deloitte on April 18, 2014. The New York City and Long Island average claims experience were blended based on our assumption that 84% of projected MHI membership will be in New York City. The blended claims cost PMPM was adjusted by 1.042 to account for claims incurred in 2013 but unpaid as of 1/31/2014.

The New York blended Small Group experience was projected to the CY 2015 rating period, and adjusted to reflect changes in provider reimbursement, benefits, and benefit richness. The adjustments are discussed in detail below.

Adjustments Made to the Data

The following adjustments were made to the starting data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.837, as published in the Deloitte report. The starting data was adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.837. The induced utilization factor is 1.106, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 0.926 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of 2.1% over the 2013 average Small Group benefits.

- Provider Network and Reimbursement (*Line 14*) – We believe that our provider network is slightly smaller than the average market-wide Small Group network. We used an overall adjustment of 0.950 to reflect our estimate that our provider contracts are approximately 5% below market.

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – We assumed that the impact of the utilization management, quality improvement and cost containment initiatives for our QHP programs is comparable to the impact that is implicit in the starting data. Hence, no adjustment was made to the starting data.

- Federal Risk Adjustment (Line 21) – Since the starting data was based on market-wide Small Group experience, we assumed that there would be no risk transfer payments.

- Federal Transitional Reinsurance Program Recovery (Line 22) – No adjustment is needed as the federal reinsurance program does not apply to the Small Group market.

- Trend (*Line 24*) – An annual trend of 8.6% was assumed. The trend was based on projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.179 represents trend for a 24 month period between the 2013 base period and the 2015 rating period.

- Covered Lives Assessment (*Line 25*) – The projected claims cost is increased to include the Covered Lives Assessment. The factor is based on the following:

  - The 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City annual assessments of $197.69 per Individual contract and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 84% of our contracts would be in New York City.
  - Using a tier distribution (that will be described in Section 17.B. "Conversion Factor"), the per-contract per year assessment was determined to be $372.40, or a $15.34 PMPM. This equates to an adjustment factor of 1.038.

- HCRA Surcharge (*Line 26*). The starting data does not include the HCRA surcharge. We increased the starting data by 4.3% to include the HCRA surcharge.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

We assigned 100% credibility to the manual rate, as we have no credible experience in the Small Group market. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

All of the plans provide Gold level coverage. The average paid-to-allowed ratio is 0.7905. The ratio was developed using the HHS Actuarial Value Calculator.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

As it was our assumption that we anticipate an average risk profile in the Small Group market, we did not adjust for any risk transfer paid (received) amount. The risk adjustment user fee of $0.08 PMPM was used for all plans, and was included in our administrative expenses.

Projected ACA Reinsurance Recoveries

This is not applicable to the Small Group market. The transitional reinsurance program fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

MHI utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at 12% of premium for all the administrative activities of the MHI QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.
- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The same percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 3.5% was included in all plans. This is consistent with our current ROI for other products. MHI recognizes the need to have positive margins on our programs. We believe that our 3.5% operating margin would provide necessary capital to invest in the company's infra-structure, provide adequate capital to meet reserve requirements for MHI, and provide high quality care to our members. The margin set on MHI is slightly higher than our margin for our QHP business. With the few members that we serve, we still need to maintain the network as well as other operational responsibility such as claims system setup and payment, etc.

The ROI for MHI's investment portfolio in calendar year 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.40%
2012	1.40%
2011	0.70%
2010	1.46%
2009	1.96%

The average ROI for the last five years was 1.18% for MHI.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. MHI is exempt in 2015 since
    i. It is incorporated as a non-profit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any political campaign on behalf of or in opposition to any candidate for public office, and
    iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.
- As a non-profit organization, MHI does not pay any other State or Federal taxes or assessments.

- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 82.4%, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 84.5%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as MHI is a new company without any prior experience.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State in 2015. The following table shows the calculation of MHI's Market Adjusted Index Rate:

	Market Adjusted Index Rate
Index Rate	$523.78
Net Risk Adjustment	$0.08
Net Transitional Reinsurance	$3.67
Exchange Fee	$0.00
Market Adjusted Index Rate	$527.53

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Since MHI had minimal enrollment (about 100 members) in 2013, the experience was not used in the rate development. Exhibit 18 shows the starting experience used in the manual rate development in the experience section of Exhibit 18. As discussed in Section 6 above, the starting experience is market-wide Small Group experience, as published by Deloitte.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting Small Group net paid PMPM.
  - Lines 11 – 12: The net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market-wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced demand
    - Administrative expenses
    - Profit
    - Age 29 Adjustment: An adjustment was made for applicable plans.
    - Family Planning Exclusion Adjustment: An adjustment was made for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate from Exhibit 18, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

MHI participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products in affiliated companies including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for all plans for Employee Only, Employee and Spouse, Employee and Child(ren), and Employee/Spouse/Child(ren) are based on the following census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850

We do not have a credible distribution of members and contracts by census tier during the experience period. Hence, we used information from Milliman for the contract distribution and the average number of members per contract for employer groups, as shown below. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	51.5%	1.000	1.000	1.221
Single + Spouse	15.2%	2.000	2.000	2.442
Single + Child(ren)	9.7%	1.700	2.629	2.076
Single + Spouse + Child(ren)	23.6%	2.850	4.019	3.480

Total	100.0%	**1.657**	**2.023**	**2.023**

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

Currently we have no small group products other than Healthy New York small groups, where we have 20 members. We expect the enrollment to remain low in 2015. Membership by plan is shown on Worksheet 2 of the URRT.

21. Terminated Products

MHI is terminating products in 2014 listed below. Please note that the terminated products on Worksheet 2 of the URRT represent the Healthy New York small group products offered prior to 1/1/2014.

Benefit Design	HIOS Plan ID
Dependent Age 26, Dental & Family Planning	83744NY0010017
Dependent Age 29, Dental & Family Planning	83744NY0010018
Dependent Age 26, No Dental & Family Planning	83744NY0010019
Dependent Age 29, No Dental & Family Planning	83744NY0010020
Dependent Age 26, No Dental & No Family Planning	83744NY0010021
Dependent Age 29, No Dental & No Family Planning	83744NY0010022
Dependent Age 26, Dental & No Family Planning	83744NY0010023
Dependent Age 29, Dental & No Family Planning	83744NY0010024

22. Plan Type

The Plan types listed in the URRT accurately describe MHI's plans.

23. Warning Alerts

There are no validation warning alerts.

24. DFS Exhibits

Please note that due to the minimal small group membership in MHI's Small Group New York in the past three years, we have asked DFS' permission to not fill out the following exhibits that are applicable to Small Group plans.

21A	Hospital Inpatient - Unit Costs [Based on Small Groups]
21B	Hospital Outpatient - Unit Costs [Based on Small Groups]
22	Utilization Information [Based on Small Groups]

25. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not included in the starting base period experience.
- Milliman age/gender factors, distribution of contracts by contract type, and average members per contract by contract type
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

26. Actuarial Certification

I, [redacted]), am a Member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by MHI to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted] June 12,2014

Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	0.926
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network	0.950
15	Market wide adjustment for fee schedule changes	1.000
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.179
25	Covered Lives Assessment	1.038
26	HCRA Surcharge	1.043
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.

2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.
3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach

that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance

are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;

- Providing tips, brochures, and other information to help live a healthier life
- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)

- Intercultural Business Etiquette (Second Edition)
- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning
8	HIOS Plan ID*	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032
9	Exchange Plan?*	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate								
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	4,965,488,464							
10B	Member-Months for Latest Experience Period	13,574,523							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	365.79							
11	Average Pricing Actuarial Value reflected in experience period	0.926							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network **	0.950
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.179							
25	Other 1 - Covered Lives Assessment	1.038							
26	Other 2 - HCRA Surcharge	1.043							
27	Other 3 (specify)	1.000							
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
29	Pricing actuarial value (without induced demand factor) #	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080	1.080	1.080	1.080	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170
37	Profit/Contribution to surplus margins	1.036	1.036	1.036	1.036	1.036	1.036	1.036	1.036
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Other 1 - Age 29	1.000	1.033	1.000	1.033	1.000	1.033	1.000	1.033
42	Other 2 - Family Planning	1.000	1.000	1.000	1.000	0.993	0.993	0.993	0.993
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.036**	**1.070**	**1.036**	**1.070**	**1.028**	**1.062**	**1.028**	**1.062**

Changes that affect an entire standard population as cost sharing

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852

changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**506.69**	**523.58**	**506.69**	**523.58**	**502.93**	**519.70**	**502.93**	**519.70**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

healthfirst

NARRATIVE SUMMARY

Community-Rated Small Group Commercial Comprehensive Premium Rate Filings
Plan Year 2015

Managed Health, Inc. (MHI) has submitted to the New York Department of Financial Services (DFS) an application to adjust premium rates for small group health insurance coverage effective in 2015. MHI has requested an increase in premium rates for plans offered in 2015. The Department of Financial Services is reviewing MHI's requested premium rate increase and will determine if the rates are appropriate based on the available evidence.

The requested rate adjustments will affect all currently enrolled small group market subscribers renewing coverage in the 2015 calendar year as well as new small group contracts issued during the 2015 calendar year. Final rate adjustments approved by DFS will be effective January 1, 2015. The rates are guaranteed for a 12-month period ending December 31, 2015 and are subject to New York's community rating and guarantee issue laws. Subscribers' rates will vary according to the census/family tier they select.

As of the date of the submission of this Narrative Summary, zero covered lives (i.e., subscribers and their covered dependents) are affected by the rate adjustment.

A Description of Your Premium Rate

Health insurance premium rates have two main components. One is the costs of paying for medical care and the other is MHI's administrative costs.

1. **Medical care costs.** The largest portion of health insurance premium rates goes toward paying for the costs of the medical claims submitted by you and other members enrolled in MHI's small group market plans. Under New York law, at least 82 percent of the premium MHI's members pay must be put toward paying for the costs of medical claims. More than 82 percent of MHI's premium dollars is used for paying medical expenses.

2. **Administrative costs.** Administrative expenses include a wide range of services and functions, such as processing claims and upgrading technology to keep pace with the rapidly changing health care sector. It also accounts for an array of member-centric expenses such as conducting medical necessity reviews, managing members' complex and chronic conditions, maintaining a robust provider network, and partnering with the community on health education initiatives.

MHI takes a meaningful and evidence-based approach to determining how much of a rate adjustment to request from DFS.

Your Rate Adjustment Explained

MHI is applying for a rate adjustment to account for marketplace trends and to reflect actual and anticipated claims costs. While several market forces continue to drive health care costs higher more generally, MHI continues to strengthen the effectiveness of its care management and quality improvement programs and robust network.

This requested rate change is based primarily only on preliminary data and information related to what the medical utilization, cost trends, and other data elements will be at year's end. The demographic make-up of MHI's commercial membership, for instance, is currently different than was expected. Based on these factors, information provided by New York State, and MHI's projections, the membership's average demand for medical services may change in 2015. MHI's premium rates must therefore be adjusted to accurately reflect these changing factors.

The premium rate increase MHI is requesting is summarized in the table below.

Plan Name	Requested Increase
HMO B	0.3%

Final Rate Adjustment

The final rate adjustment that MHI members experience may differ than what DFS eventually approves. MHI will notify its currently enrolled members approximately 60 days prior to the new rate taking effect.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company Managed Health, Inc.
NAIC Code: 95284
SERFF Trac HLFT-129571793
Market Segment: Small Groups Off Exchange

1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
6) The company should submit the these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
9) Links should be provided on key pages of the company's website so that the information may be easily located.
10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
11) This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2014 and 2015 Premium Rates:

1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	NA	$637.08	NA	NA	NA
2015 Premium Rates	NA	$639.37	NA	NA	NA

B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]*:

	2014 to 2015
Requested Rate Adjustment	0.3%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	0.0%	0.0%	5.5%

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

	2011	2012	2013
MLR	NA	NA	NA

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	NA	11.0%	8.6%
Expense Ratios	NA	14.0%	14.1%
Pre Tax Profit Ratios	NA	2.0%	3.5%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company Managed Health, Inc.
NAIC Code: 95284
SERFF Trac HLFT-129571793
Market Segment: Small Groups Off Exchange

1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
6) The company should submit the these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
9) Links should be provided on key pages of the company's website so that the information may be easily located.
10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
11) This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2014 and 2015 Premium Rates:

1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	NA	$637.08	NA	NA	NA
2015 Premium Rates	NA	$639.37	NA	NA	NA

B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]*:

	2014 to 2015
Requested Rate Adjustment	0.3%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	0.0%	0.0%	5.5%

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

	2011	2012	2013
MLR	NA	NA	NA

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	NA	11.0%	8.6%
Expense Ratios	NA	14.0%	14.1%
Pre Tax Profit Ratios	NA	2.0%	3.5%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.

EXHIBIT 14 - PART B: SUMMARY OF REQUESTED PERCENTAGE CHANGES TO EXISTING RATES

-- for Small Group Medical Plans

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Tracking #: HLFT-129571793
Market Segment: Small Groups Off Exchange

1) Use this Exhibit for Small Group Medical Plans.
2) The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
3) Market segment refers to the Small Group Plans.
4) The requested percentage rate change reflects the expected change in premium rates that would apply to the contract holder on that contract holder's next rate change date for each contract holder within the indicated combination of rating period, metal level, rating region and product name.
5) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/metal level when communicating with the DFS). A separate row is to be used for each combination of rating period, metal level, rating region and product name.
6) The effective date is the earliest date that the proposed new rate would become effective if approved. Effective Dates for Small Groups are 1/1/15, 4/1/15, 7/1/15 and 10/1/15.
7) If the percentage change (lowest and highest and weighted average) are identical for all the rating regions, then separate rows by rating region need not be used, and "All Regions" can be shown in the Rating Region column. If the rate change range information differs by rating region, then separate rows need to be used for each rating region the insurer uses. Rating region names used on this exhibit are to use the standard rating region names developed by DFS (e.g., Albany Area, Buffalo Area, etc.).
8) The "requested rate change" includes the impact of any riders (such as: age 29, domestic partner, family planning, pediatric dental, etc.).
9) Lowest should be the smallest percentage change that could affect any contract holder due to the submitted rate filing with that that rating period, metal level and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
10) Highest should be the largest percentage change that could affect any contract holder due to the submitted rate filing with that rating period, metal level and rating region, including any applicable riders. This includes benefit designs included in this rate filing which have no actual members.
11) The weighted average percentage should be developed based on annualized premium volume or membership for that rating period, metal level and rating region, including any applicable riders.
12) This exhibit must be submitted as an Excel file and as a PDF file.

Small Group Medical Products

Market Segment	Effective Date of New Rate	Metal Level	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Small Group	1/1/2015	Gold	99 - All Regions	HMO B	HMO B	-0.1%	0.4%	0.3%
Small Group								
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EXHIBIT 14B

Small Group Medical Products

Market Segment	Effective Date of New Rate	Metal Level	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Small Group								
Small Group								
Small Group								
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EXHIBIT 15 - PART B: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR SMALL GROUP PRODUCTS

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Tracking #: HLFT-129571793
Market Segment: Small Groups Off Exchange

Instructions:

1) The percentage rate change reflects the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
2) The effective date is the earliest date that the proposed new rate would become effective if approved. Effective Dates for Small Group are 1/1/15, 4/1/15, 7/1/15 and 10/1/15.
3) The distribution is by number of members or number of contracts . The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
4) The Weighted Average Percentage change should be developed based on the distribution of annualized premiums for that Market Segment/Rating Period/Metal Level and for the market segment in total.
5) Market segment refers to Small Group market segment.
6) Rating region refers to the standard rating regions applicable to this filing. If the percentage change for each plan design does not vary by region, then "All Regions" can be used in the rating region column; otherwise indicate the applicable rating region.
7) Under each market segment, the table should provide the distribution by metal level (platinum, gold, silver, bronze).
8) Provide distribution information by quarter of renewal.
9) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
10) After each effective period/market segment combination there should be a market segment total row. Enter the effective period in the applicable column, the sum of the counts in the various columns, and the market segment weighted avg change %.
11) This exhibit must be submitted as an Excel file and a PDF file.

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of (*) with Requested Percentage Rate Change at Renewal										
					6/1/2014			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
Small Group	1/1/2015	Gold	99 - All Regions	0.3%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Small Group	1/0/1900																	
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	Market Segment Total:				0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment: Small Groups Off Exchange

1) Complete a separate ROW for each base medical policy form included in the rate adjustment filing.
- Information requested applies to New York State business only and for all rating regions combined.
- Include riders that may be available with that policy form in each policy form response. Discontinued policy forms and products are to be included in the Exhibit.
- Insert additional rows as needed to include all base medical policy forms included in a particular market segment for Small Groups, Small Group Sole Proprietors and Small Group HNY Business.
- Add a row with the aggregate values for that entire market segment (including any Small Group Healthy NY and enter an appropriate identifier in column 1b (such as TOTAL).

2) **In Column 4, market segment refers to Small Group, Small Group Sole Proprietors and Small Group Healthy NY Business.**

3) Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, and Consumer Health Plans. Indicate appropriate designation for policy form, etc.

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 DFS.

5) Paid claims in Columns 14.6, 15.6 and 16.6 are all claims paid during experience period regardless of incurred dates.

6) Note that many cells include a drop down list. Use the drop down list for entries.

7) If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).

8) This exhibit must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form												Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)										
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identification	3. Effective date of rate change (mm/dd/yy)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change		14.1 Beginning Date of the experience period (mm/dd/y)	14.2 Ending Date of the experience period (mm/dd/yy)	14.3 Member months for experience period	14.4 Earned premiums for experience period ($)	14.5 Standardized earned premiums for experience period ($)	14.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	14.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	14.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
MHI-HNY-SG	Healthy New	Healthy New	HNY	01/01/15	HNY-SG	HMO	No	Open	8	20	XX	01/01/13	12/31/13	1,186	472,137	472,137	466,510	494,021	(62,881)	0	69,404	XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX
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EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

	First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)											Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										
	15.1 Beginning date of the experience period (mm/dd/yy)	15.2 Ending Date of the experience period (mm/dd/yy)	15.3 Member months for experience period	15.4 Earned premiums for experience period ($)	15.5 Standardized earned premiums for experience period ($)	15.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	15.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	15.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)		16.1 Beginning date of the experience period (mm/dd/yy)	16.2 Ending Date of the experience period (mm/dd/yy)	16.3 Member months for experience period	16.4 Earned premiums for experience period ($)	16.5 Standardized earned premiums for experience period ($)	16.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	16.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool ($)	16.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) ($)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts as a negative value and payments to the pool as a positive value) ($)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) ($)	
XX	01/01/12	12/31/12	649	307,812	307,812	351,368	322,339	(59,109)	0	45,248	XX	01/01/11	12/31/11	551	203,509	203,509	236,240	256,835	-82,822	0	20,360	XX
XX											XX											XX
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Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning
8	HIOS Plan ID*	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032
9	Exchange Plan?*	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate								
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	4,965,488,464							
10B	Member-Months for Latest Experience Period	13,574,523							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	365.79							
11	Average Pricing Actuarial Value reflected in experience period	0.926							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network **	0.950
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000							
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.179							
25	Other 1 - Covered Lives Assessment	1.038							
26	Other 2 - HCRA Surcharge	1.043							
27	Other 3 (specify)	1.000							
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
29	Pricing actuarial value (without induced demand factor) #	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080	1.080	1.080	1.080	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170
37	Profit/Contribution to surplus margins	1.036	1.036	1.036	1.036	1.036	1.036	1.036	1.036
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Other 1 - Age 29	1.000	1.033	1.000	1.033	1.000	1.033	1.000	1.033
42	Other 2 - Family Planning	1.000	1.000	1.000	1.000	0.993	0.993	0.993	0.993
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.036**	**1.070**	**1.036**	**1.070**	**1.028**	**1.062**	**1.028**	**1.062**

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**506.69**	**523.58**	**506.69**	**523.58**	**502.93**	**519.70**	**502.93**	**519.70**

EXHIBIT 19 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment: Small Groups Off Exchange

1) Complete a separate ROW for Metal Level/Product
- Information should be for all the benefits included in that plan design including any riders (medical, drugs, etc).
- Enter in column 1 the Metal Tier level. Use the drop down menu.
- Enter in column 2 the plan designation as to On/Off Plan and Std/Non Standard Plan. Use the drop down menu.
- Enter in column 3 the Estimated Membership as of a recent date mm/dd/yyy; enter the date in column heading.
- Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.

2) The average claim trend is the average annualized claim trend that is used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).

3) Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the requested rates and the average annual claim trend assumed.

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

5) **ACA Fees** are to be entered in columns 6.5 and 16.5.

6) This exhibit must be submitted as an Excel file and as a PDF file.

				For the rate period included in this rate adjustment filing											For the rate period included in this rate adjustment filing						
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of 6/1/2014		4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	
Gold	Off Std	0	XX	01/01/15	12/31/15	8.6%	1.75%	0.62%	0.00%	0.00%	0.77%	11.88%	15.02%	3.50%	0.00%	0.00%	0.00%	0.00%	0.00%	18.52%	XX
		313	XX										0.00%							0.00%	XX
		5781	XX										0.00%							0.00%	XX
		878	XX										0.00%							0.00%	XX
		6	XX										0.00%							0.00%	XX
		NA	XX										0.00%							0.00%	XX
		NA	XX										0.00%							0.00%	XX
		NA	XX										0.00%							0.00%	XX
			XX										0.00%							0.00%	XX
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			XX										0.00%							0.00%	XX

EXHIBIT 19: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES

				For the rate period included in the prior rate and form filing																	For the rate period included in the prior rate and form filing
1. Metal Level [drop down menu]	2. On/Off Exchange Designation **and** Standard/Non Std [drop down menu]	3. Estimated Membership as of 6/1/2014		14.1 Period assumed - beginning date (mm/dd/yy)	14.2 Period assumed - ending date (mm/dd/yy)	15. Average annual claim trend assumed	16.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	16.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	16.3 Commissions and broker fees - as a % of gross premium	16.4 Premium Taxes - as a % of gross premium	16.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	16.6 Other administrative expenses - as a % of gross premium	16.7 Subtotal columns 20.1 through 20.6	17 After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	18 State income tax component - as a % of gross premium	18.1 State income tax rate assumed (eg 3%)	19 Federal income tax component - as a % of gross premium	19.1 Federal income tax rate assumed (eg 30%)	20 Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	21 Subtotal columns 16.7 + 17 + 18 + 19 +20
Gold	Off Std	0	XX	01/01/14	12/31/14	11.00%	0.86%	0.74%	0.00%	0.00%	1.07%	11.35%	14.02%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.02%
		313	XX										0.00%							0.00%
		5781	XX										0.00%							0.00%
		878	XX										0.00%							0.00%
		6	XX										0.00%							0.00%
		NA	XX										0.00%							0.00%
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EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: Managed Health, Inc.
NAIC Code: 95284
SERFF Number: HLFT-129571793
Market Segment: Small Groups Off Exchange

1) This exhibit is to help DFS reconcile the 14 digit HIOS IDs used to the different plan designs and to reconcile the rate manual to the binder rate template.
2) The HIOS IDs should be without the variants after the hyphen.
3) Column 3: Enter Metal Level. Use drop down menu.
4) Column 4: Enter On/Off Plan Designation. Use drop down menu.
5) Column 5: Enter Standard/Non Standard Plan Designation. Use drop down menu.
6) Column 6: Enter coverage of children to 26th birthday (26) or to 30th birthday. Use drop down menu.
7) Column 7: Enter Yes/No for coverage of Domestic Partner. Use drop down menu.
8) Column 8: Enter Yes/No for coverage of Family Planning. Use drop down menu.
9) Column 9: Enter Yes/No for coverage of Embedded Pediatric Dental. Use drop down menu.
10) Column 10: Enter Yes/No for coverage of Out of Network Benefits [PPO or POS]. Use drop down menu.
11) Column 11: Indicate if the plan design includes benefits in addition to the EHB benefits (yes) or (no). Use drop down menu.
12) This exhibit must be submitted as an Excel and as PDF file.

1 HIOS ID	2 Rate Manual Plan Name	3 Metal Level	4 Exchange Plan? (on, off, both)	5 Standard Plan Design? (yes, no)	6 Limiting Child Age? (26 or 30)	7 Domestic Partner Coverage Included? (yes, no)	8 Family Planning Coverage? (included, excluded)	9 Pediatric Dental Coverage Included? (yes, no)	10. Out of Network Benefits? (yes, no)	11 Include Benefits in Addition to EHB? (yes, no)
83744NY0010025	Healthfirst HMO B Small Group	Gold	OFF	YES	26	YES	INCLUDED	YES	NO	NO
83744NY0010026	Healthfirst HMO B Small Group	Gold	OFF	YES	29	YES	INCLUDED	YES	NO	NO
83744NY0010027	Healthfirst HMO B Small Group	Gold	OFF	YES	26	NO	INCLUDED	YES	NO	NO
83744NY0010028	Healthfirst HMO B Small Group	Gold	OFF	YES	29	NO	INCLUDED	YES	NO	NO
83744NY0010029	Healthfirst HMO B Small Group	Gold	OFF	YES	26	NO	EXCLUDED	YES	NO	NO
83744NY0010030	Healthfirst HMO B Small Group	Gold	OFF	YES	29	NO	EXCLUDED	YES	NO	NO
83744NY0010031	Healthfirst HMO B Small Group	Gold	OFF	YES	26	YES	EXCLUDED	YES	NO	NO
83744NY0010032	Healthfirst HMO B Small Group	Gold	OFF	YES	29	YES	EXCLUDED	YES	NO	NO

EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: Managed Health, Inc.
NAIC Code: 61405
SERFF Number: HLFT-129571793
Market Segment: Groups Off Exchange

1) Purpose of this Exhibit is to summarize all Premium Rates for all Metal Levels and for all Regions.
2) Premium rates are Calendar Year 2015 premium rates for Individual Only on Individual Plans and First Quarter 2015 premium rates for Employee Only on Small Group Plans.
3) Premium rates are only for plans with the following benefit provisions:
   (a) Through Age 29; **and**
   (b) With Domestic Partner; **and**
   (c) With Family Planning.
4) This exhibit must be submitted as an Excel and as a PDF file.

SUMMARY OF REQUESTED 2015 PREMIUM RATES													
						Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
1. HIOS ID PLAN (14 Digits)	2. Metal Level or Catastrophic	3. Exchange [Ind/Sml Grp]	4. On/Off Exchange	5. Plan Type [Std or Non Std]	6. Pediatric Dental [Yes/No]	Albany	Buffalo	Mid-Hudson	New York	Rochester	Syracuse	Utica	Long Island
83744NY0010026	Gold	SG	Off	Non-Standard	Yes	$0.00	$0.00	$0.00	$639.37	$0.00	$0.00	$0.00	$639.37

healthfirst

6/13/14

«SubscirberFirstName» «SubscriberLastName»
«AddressLine1» «AddressLine2»
«CITY», «STATE» «ZipCode»

Re: Notice of Proposed Premium Rate Change
Healthfirst [Plan Name] - HIOS ID 83744NY001[XXXX]

Dear Healthfirst Member:

Managed Health, Inc.(Healthfirst) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your group premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Change
If approved, the percentage change to your premium is 0.3%.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features that your group policyholder selects on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change
Several market forces continue to drive health care costs higher and Healthfirst is requesting a higher rate in 2015. We continue to improve our care management and quality improvement programs. We also continue to strengthen our robust network. However, the demographic make-up of our current membership is different than was expected. Based on these factors, as well as our projections, the membership's average demand for medical services may go up in 2015. This is why we are applying for a rate increase to account for marketplace trends and to reflect these changing factors.

30-day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Healthfirst for additional information at:

Healthfirst
100 Church Street
New York, NY
1-888-250-2220
www.healthfirst.org

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincrease@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Managed Health, Inc.
2. The name of your plan, which is Healthfirst [Plan Name]
3. Indicate you have Small Group coverage
4. Your HIOS identification number, which is 83744NY001[XXXX]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Healthfirst website: www.healthfirst.org/priorapproval
DFS website: http://www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,

Nemesio Ortiz
Vice President, Sales
Healthfirst

SAMPLE

healthfirst

6/13/14

«SubscirberFirstName» «SubscriberLastName»
«AddressLine1» «AddressLine2»
«CITY», «STATE» «ZipCode»

Re: Notice of Proposed Premium Rate Change
Healthfirst [Plan Name] - HIOS ID 83744NY001[XXXX]

Dear Group Benefit Administrator:

Managed Health, Inc. (Healthfirst) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Change
If approved, the percentage change to your premium is 0.3%.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change
Several market forces continue to drive health care costs higher and Healthfirst is requesting a higher rate in 2015. We continue to improve our care management and quality improvement programs to bring you and your employees greater value. We also continue to strengthen our robust network. However, the demographic make-up of our current membership is different than was expected. Based on these factors, as well as our projections, the membership's average demand for medical services may go up in 2015. This is why we are applying for a rate increase to account for marketplace trends and to reflect these changing factors.

30-day Comment Period
You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact Healthfirst for additional information at:

Healthfirst PHSP, Inc.
100 Church Street
New York, NY
1-888-250-2220
www.healthfirst.org

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincrease@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer, which is Managed Health, Inc.
2. The name of your plan, which is Healthfirst [Plan Name]
3. Indicate you have Small Group coverage
4. Your HIOS identification number, which is 83744NY001[XXXX]

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change
We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Healthfirst website: www.healthfirst.org/priorapproval
DFS website: http://www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate
After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,

Nemesio Ortiz
Vice President, Sales
Healthfirst

SAMPLE

healthfirst

June 13, 2014

RE: Managed Health, Inc. – Small Group Off-Exchange Plans

Dear

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law, for Small Group Off-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties. Please note that the proposed rates are not rolling rates.

If you have any questions concerning this submission, please feel free to contact me at . We look forward to continue working with the Department.

Sincerely,

Confidential and Proprietary

Managed Health, Inc.

Part III Actuarial Memorandum

Small Group Rate Filing

Effective January 1, 2015

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1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Managed Health, Inc. (MHI) rate filing for the Small Group block of business. The rates are effective for calendar year 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of MHI's Small Group rate filing. The memorandum contains information that is confidential and proprietary to MHI; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Managed Health, Inc.
- State: New York
- HIOS Issuer ID: [redacted]
- Market: Small Group
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

MHI is proposing an overall 0.3% rate increase for their existing plans. The rate increase varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

The following shows the list of Small Group Off-Exchange plans that will be offered in 2015.

Benefit Design	HIOS Plan ID
Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	83744NY0010025
Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	83744NY0010026
Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	83744NY0010027
Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	83744NY0010028
Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	83744NY0010029
Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	83744NY0010030
Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	83744NY0010031
Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning	83744NY0010032

Reason for Rate Changes

The rate changes are net results from expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

MHI currently have approximately 20 small group Healthy New York members and no Small Group commercial members. With approximately 1,186 member months in Healthy New York Small Group products in 2013, we do not have any credible experience for rate development. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

The "Experience Period Data" section in Worksheet 1 Section I and the "Experience Period on Actual Experience Allowed" in Worksheet 1 Section II of the Unified Rate Review Template contains our Healthy New York Small Group experience. However, as this data is not credible, it was not used in rate development.

Premiums (net of MLR Rebate) in Experience Period

The corresponding premiums for the 1,186 member months were reported.

Allowed and Paid Claims Incurred During the Experience Period

Claims experience for the 1,186 member months were reported as described above.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

The base year experience reported was not credible for rate development. Hence, no projection factors were provided. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development

Source and Appropriateness of Data Used

The New York Small Group experience for the incurred period 1/1/2013 to 12/31/2013 was used as the basis for the manual rate. The experience was obtained from the "New York Risk Adjustment Simulation" Small Group Report published by Deloitte on April 18, 2014. The New York City and Long Island average claims experience were blended based on our assumption that 84% of projected MHI membership will be in New York City. The blended claims cost PMPM was adjusted by 1.042 to account for claims incurred in 2013 but unpaid as of 1/31/2014.

The New York blended Small Group experience was projected to the CY 2015 rating period, and adjusted to reflect changes in provider reimbursement, benefits, and benefit richness. The adjustments are discussed in detail below.

Adjustments Made to the Data

The following adjustments were made to the starting data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.837, as published in the Deloitte report. The starting data was adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.837. The induced utilization factor is 1.106, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 0.926 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of 2.1% over the 2013 average Small Group benefits.

- Provider Network and Reimbursement (*Line 14*) – We believe that our provider network is slightly smaller than the average market-wide Small Group network. We used an overall adjustment of [redacted] to reflect our estimate that our provider contracts are approximately [redacted]

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – We assumed that the impact of the utilization management, quality improvement and cost containment initiatives for our QHP programs is comparable to the impact that is implicit in the starting data. Hence, no adjustment was made to the starting data.

- Federal Risk Adjustment (Line 21) – Since the starting data was based on market-wide Small Group experience, we assumed that there would be no risk transfer payments.

- Federal Transitional Reinsurance Program Recovery (Line 22) – No adjustment is needed as the federal reinsurance program does not apply to the Small Group market.

- Trend (*Line 24*) – An annual trend of 8.6% was assumed. The trend was based on projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.179 represents trend for a 24 month period between the 2013 base period and the 2015 rating period.

- Covered Lives Assessment (*Line 25*) – The projected claims cost is increased to include the Covered Lives Assessment. The factor is based on the following:

  - The 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City annual assessments of $197.69 per Individual contract and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 84% of our contracts would be in New York City.
  - Using a tier distribution (that will be described in Section 17.B. "Conversion Factor"), the per-contract per year assessment was determined to be $372.40, or a $15.34 PMPM. This equates to an adjustment factor of 1.038.

- HCRA Surcharge (*Line 26*). The starting data does not include the HCRA surcharge. We increased the starting data by 4.3% to include the HCRA surcharge.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

We assigned 100% credibility to the manual rate, as we have no credible experience in the Small Group market. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

All of the plans provide Gold level coverage. The average paid-to-allowed ratio is 0.7905. The ratio was developed using the HHS Actuarial Value Calculator.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

As it was our assumption that we anticipate an average risk profile in the Small Group market, we did not adjust for any risk transfer paid (received) amount. The risk adjustment user fee of $0.08 PMPM was used for all plans, and was included in our administrative expenses.

Projected ACA Reinsurance Recoveries

This is not applicable to the Small Group market. The transitional reinsurance program fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

MHI utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at 12% of premium for all the administrative activities of the MHI QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.
- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The same percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 3.5% was included in all plans. This is consistent with our current ROI for other products. MHI recognizes the need to have positive margins on our programs. We believe that our 3.5% operating margin would provide necessary capital to invest in the company's infra-structure, provide adequate capital to meet reserve requirements for MHI, and provide high quality care to our members. The margin set on MHI is slightly higher than our margin for our QHP business. With the few members that we serve, we still need to maintain the network as well as other operational responsibility such as claims system setup and payment, etc.

The ROI for MHI's investment portfolio in calendar year 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.40%
2012	1.40%
2011	0.70%
2010	1.46%
2009	1.96%

The average ROI for the last five years was 1.18% for MHI.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. MHI is exempt in 2015 since
    i. It is incorporated as a non-profit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any political campaign on behalf of or in opposition to any candidate for public office, and
    iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.
- As a non-profit organization, MHI does not pay any other State or Federal taxes or assessments.

- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 82.4%, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 84.5%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as MHI is a new company without any prior experience.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State in 2015. The following table shows the calculation of MHI's Market Adjusted Index Rate:

	Market Adjusted Index Rate
Index Rate	$523.78
Net Risk Adjustment	$0.08
Net Transitional Reinsurance	$3.67
Exchange Fee	$0.00
Market Adjusted Index Rate	$527.53

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Since MHI had minimal enrollment (about 100 members) in 2013, the experience was not used in the rate development. Exhibit 18 shows the starting experience used in the manual rate development in the experience section of Exhibit 18. As discussed in Section 6 above, the starting experience is market-wide Small Group experience, as published by Deloitte.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting Small Group net paid PMPM.
  - Lines 11 – 12: The net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market-wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced demand
    - Administrative expenses
    - Profit
    - Age 29 Adjustment: An adjustment was made for applicable plans.
    - Family Planning Exclusion Adjustment: An adjustment was made for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate from Exhibit 18, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

MHI participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products in affiliated companies including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for all plans for Employee Only, Employee and Spouse, Employee and Child(ren), and Employee/Spouse/Child(ren) are based on the following census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850

We do not have a credible distribution of members and contracts by census tier during the experience period. Hence, we used information from Milliman for the contract distribution and the average number of members per contract for employer groups, as shown below. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	51.5%	1.000	1.000	1.221
Single + Spouse	15.2%	2.000	2.000	2.442
Single + Child(ren)	9.7%	1.700	2.629	2.076
Single + Spouse + Child(ren)	23.6%	2.850	4.019	3.480

Total	100.0%	**1.657**	**2.023**	**2.023**

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

Currently we have no small group products other than Healthy New York small groups, where we have 20 members. We expect the enrollment to remain low in 2015. Membership by plan is shown on Worksheet 2 of the URRT.

21. Terminated Products

MHI is terminating products in 2014 listed below. Please note that the terminated products on Worksheet 2 of the URRT represent the Healthy New York small group products offered prior to 1/1/2014.

Benefit Design	HIOS Plan ID
Dependent Age 26, Dental & Family Planning	83744NY0010017
Dependent Age 29, Dental & Family Planning	83744NY0010018
Dependent Age 26, No Dental & Family Planning	83744NY0010019
Dependent Age 29, No Dental & Family Planning	83744NY0010020
Dependent Age 26, No Dental & No Family Planning	83744NY0010021
Dependent Age 29, No Dental & No Family Planning	83744NY0010022
Dependent Age 26, Dental & No Family Planning	83744NY0010023
Dependent Age 29, Dental & No Family Planning	83744NY0010024

22. Plan Type

The Plan types listed in the URRT accurately describe MHI's plans.

23. Warning Alerts

There are no validation warning alerts.

24. DFS Exhibits

Please note that due to the minimal small group membership in MHI's Small Group New York in the past three years, we have asked DFS' permission to not fill out the following exhibits that are applicable to Small Group plans.

21A	Hospital Inpatient - Unit Costs [Based on Small Groups]
21B	Hospital Outpatient - Unit Costs [Based on Small Groups]
22	Utilization Information [Based on Small Groups]

25. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not included in the starting base period experience.
- Milliman age/gender factors, distribution of contracts by contract type, and average members per contract by contract type
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

26. Actuarial Certification

I, [redacted] am a Member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by MHI to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted] June 12,2014

Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	0.926
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network	0.950
15	Market wide adjustment for fee schedule changes	1.000
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.179
25	Covered Lives Assessment	1.038
26	HCRA Surcharge	1.043
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.

2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.
3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach

that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance

are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;

- Providing tips, brochures, and other information to help live a healthier life
- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)

- Intercultural Business Etiquette (Second Edition)
- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning
8	HIOS Plan ID*	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032
9	Exchange Plan?*	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate								
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	4,965,488,464							
10B	Member-Months for Latest Experience Period	13,574,523							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	365.79							
11	Average Pricing Actuarial Value reflected in experience period	0.926							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network **	0.950
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.179							
25	Other 1 - Covered Lives Assessment	1.038							
26	Other 2 - HCRA Surcharge	1.043							
27	Other 3 (specify)	1.000							
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
29	Pricing actuarial value (without induced demand factor) #	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080	1.080	1.080	1.080	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170
37	Profit/Contribution to surplus margins	1.036	1.036	1.036	1.036	1.036	1.036	1.036	1.036
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Other 1 - Age 29	1.000	1.033	1.000	1.033	1.000	1.033	1.000	1.033
42	Other 2 - Family Planning	1.000	1.000	1.000	1.000	0.993	0.993	0.993	0.993
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.036**	**1.070**	**1.036**	**1.070**	**1.028**	**1.062**	**1.028**	**1.062**

Changes that affect an entire standard population as cost sharing

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

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3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852

changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**506.69**	**523.58**	**506.69**	**523.58**	**502.93**	**519.70**	**502.93**	**519.70**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

healthfirst

June 13, 2014

[redacted]

RE: Managed Health, Inc. – Small Group Off-Exchange Plans

Dear [redacted]

We have prepared the enclosed submission, pursuant to section 4308(c) of the New York Insurance Law, for Small Group Off-Exchange rates to be effective on January 1, 2015. The rates are for the New York City region which includes Bronx, Kings, New York, Queens, and Richmond Counties; and the Long Island region which includes Nassau and Suffolk Counties. Please note that the proposed rates are not rolling rates.

If you have any questions concerning this submission, please feel free to contact me at [redacted]. We look forward to continue working with the Department.

Sincerely,

[redacted]

cc: [redacted]

Confidential and Proprietary

Managed Health, Inc.

Part III Actuarial Memorandum

Small Group Rate Filing

Effective January 1, 2015

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1. General Information

Document Overview

This document contains the Part III Actuarial Memorandum for Managed Health, Inc. (MHI) rate filing for the Small Group block of business. The rates are effective for calendar year 2015. This actuarial memorandum is submitted in conjunction with the Part I Unified Rate Review Template (URRT).

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the URRT, which supports compliance with the market rating rules and reasonableness of applicable rate increases. This information may not be appropriate for other purposes.

This memorandum is intended for use by the New York Department of Financial Services (DFS), the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of MHI's Small Group rate filing. The memorandum contains information that is confidential and proprietary to MHI; therefore, the memorandum should not be distributed to any other parties unless required by law.

The results are actuarial projections. Actual experience is likely to differ for a number of reasons including population changes, claims experience, and other deviations from assumptions.

Company Identifying Information

- Company Legal Name: Managed Health, Inc.
- State: New York
- HIOS Issuer ID: [redacted]
- Market: Small Group
- Effective Date: January 1, 2015

Company Contact Information

- Primary Contact Name: [redacted]
- Primary Contact Telephone Number: [redacted]
- Primary Contact Email Address: [redacted]

2. Proposed Rate Increase(s)

MHI is proposing an overall 0.3% rate increase for their existing plans. The rate increase varies by plan as shown in Worksheet 2 of the URRT. The proposed rates are effective January 1, 2015.

The following shows the list of Small Group Off-Exchange plans that will be offered in 2015.

Benefit Design	HIOS Plan ID
Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	83744NY0010025
Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	83744NY0010026
Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	83744NY0010027
Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	83744NY0010028
Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	83744NY0010029
Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	83744NY0010030
Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	83744NY0010031
Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning	83744NY0010032

Reason for Rate Changes

The rate changes are net results from expected claim trend, changes in network utilization, changes in benefits, changes in expected enrollment demographics, and changes in the reinsurance fees, all of which are discussed in more detail throughout this filing.

3. Experience Period Premium and Claims

Paid through Date

MHI currently have approximately 20 small group Healthy New York members and no Small Group commercial members. With approximately 1,186 member months in Healthy New York Small Group products in 2013, we do not have any credible experience for rate development. The rates were developed based upon 100% manual rates, as described below in the Credibility Manual Rate Development section.

The "Experience Period Data" section in Worksheet 1 Section I and the "Experience Period on Actual Experience Allowed" in Worksheet 1 Section II of the Unified Rate Review Template contains our Healthy New York Small Group experience. However, as this data is not credible, it was not used in rate development.

Premiums (net of MLR Rebate) in Experience Period

The corresponding premiums for the 1,186 member months were reported.

Allowed and Paid Claims Incurred During the Experience Period

Claims experience for the 1,186 member months were reported as described above.

4. Benefit Categories

The services included in each benefit category of the URRT are consistent with the definitions of the benefit categories included in the URRT instructions. The "Other Medical" category includes home health care, ambulance, DME/ prosthetics, glasses/contacts, and pediatric dental services.

5. Projection Factors

The base year experience reported was not credible for rate development. Hence, no projection factors were provided. See the Credibility Manual Rate Development section, just below, for a discussion of the projection factors.

6. Credibility Manual Rate Development

Source and Appropriateness of Data Used

The New York Small Group experience for the incurred period 1/1/2013 to 12/31/2013 was used as the basis for the manual rate. The experience was obtained from the "New York Risk Adjustment Simulation" Small Group Report published by Deloitte on April 18, 2014. The New York City and Long Island average claims experience were blended based on our assumption that 84% of projected MHI membership will be in New York City. The blended claims cost PMPM was adjusted by 1.042 to account for claims incurred in 2013 but unpaid as of 1/31/2014.

The New York blended Small Group experience was projected to the CY 2015 rating period, and adjusted to reflect changes in provider reimbursement, benefits, and benefit richness. The adjustments are discussed in detail below.

Adjustments Made to the Data

The following adjustments were made to the starting data discussed above. Each one of these factors is included in Exhibit 18 required by New York State. For your review, we have included market-wide adjustments from Exhibit 18 in **Appendix A** and have identified the line numbers from Exhibit 18 that reference the adjustments discussed below.

- Paid-to-Allowed and Induced Utilization (*Line 11*) – The starting data is on a paid basis, and was adjusted to an allowed PMPM using a paid-to-allowed ratio of 0.837, as published in the Deloitte report. The starting data was adjusted to remove the induced utilization that corresponds to experience with a paid-to-allowed ratio of 0.837. The induced utilization factor is 1.106, and was based on the HHS induced utilization factors. The combination of these factors produces the AV Pricing Value of 0.926 on Line 11.

- Benefits (*Line 13*) – It was assumed that the additional Essential Health Benefits (EHBs) covered under ACA would represent a cost increase of 2.1% over the 2013 average Small Group benefits.

- Provider Network and Reimbursement (*Line 14*) – We believe that our provider network is slightly smaller than the average market-wide Small Group network. We used an overall adjustment of [redacted] to reflect our estimate that our provider contracts are approximately [redacted]

- Utilization Management; Quality Improvement and Cost Containment Adjustment (*Lines 16 and 17*) – We assumed that the impact of the utilization management, quality improvement and cost containment initiatives for our QHP programs is comparable to the impact that is implicit in the starting data. Hence, no adjustment was made to the starting data.

- Federal Risk Adjustment (Line 21) – Since the starting data was based on market-wide Small Group experience, we assumed that there would be no risk transfer payments.

- Federal Transitional Reinsurance Program Recovery (Line 22) – No adjustment is needed as the federal reinsurance program does not apply to the Small Group market.

- Trend (*Line 24*) – An annual trend of 8.6% was assumed. The trend was based on projected industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state. The factor of 1.179 represents trend for a 24 month period between the 2013 base period and the 2015 rating period.

- Covered Lives Assessment (*Line 25*) – The projected claims cost is increased to include the Covered Lives Assessment. The factor is based on the following:

  - The 2014 Covered Lives Assessments were used since they are the latest published assessments. New York City annual assessments of $197.69 per Individual contract and $652.39 per Family contract were used; Long island assessments of $61.96 per Individual contract and $204.48 per Family contract were used.
  - An estimated 84% of our contracts would be in New York City.
  - Using a tier distribution (that will be described in Section 17.B. "Conversion Factor"), the per-contract per year assessment was determined to be $372.40, or a $15.34 PMPM. This equates to an adjustment factor of 1.038.

- HCRA Surcharge (*Line 26*). The starting data does not include the HCRA surcharge. We increased the starting data by 4.3% to include the HCRA surcharge.

Inclusion of Capitation Payments

No capitated arrangements were included in the manual rate development.

7. Credibility of Experience

We assigned 100% credibility to the manual rate, as we have no credible experience in the Small Group market. The experience section of the URRT was populated with 1's and 0's to allow for finalization.

8. Paid to Allowed Ratio

All of the plans provide Gold level coverage. The average paid-to-allowed ratio is 0.7905. The ratio was developed using the HHS Actuarial Value Calculator.

9. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

As it was our assumption that we anticipate an average risk profile in the Small Group market, we did not adjust for any risk transfer paid (received) amount. The risk adjustment user fee of $0.08 PMPM was used for all plans, and was included in our administrative expenses.

Projected ACA Reinsurance Recoveries

This is not applicable to the Small Group market. The transitional reinsurance program fee of $3.67 PMPM was used for all plans, and was included in our administrative expenses.

10. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

MHI utilized an allocation methodology that distributes departmental costs using driver-based allocation, for example, membership, number of claims, number of calls, premium revenue, etc. We also distinguish departments between "fixed and variable" depending on the impact of membership growth on staffing levels. For example, Claims is considered a variable department since claims volume varies proportionately by membership. On the other hand, Finance Corporate, for example, is a department unaffected by membership growth for the most part.

Exchange administrative projections were driven by two main components – Projected 2015 membership, premium revenue and medical costs under our Exchange products were used to drive cost allocations for "variable" departments while a "current run-rate" PMPM was used to drive "fixed" departments, with nominal inflation.

Our administrative costs for all our Exchange QHP line of business include the following:

- Healthfirst Management Services, LLC (HFMS) will be contracted at 12% of premium for all the administrative activities of the MHI QHP products. This will include, but not limited to, marketing and sales, enrollment, claims administration, medical management, member services, network management, product management, clinical and quality performance management, compliance, legal, regulatory, finance and actuarial. This fee will not include the taxes and fees described below.
- This includes the quality improvement/cost containment programs that impact the health plans, estimated at 0.62% of premium. Please refer to **Appendix B** for a description of all quality improvement/cost containment programs that impact the health plans included in the risk pool. This should tie in with the activities that improve health care quality, as specified in Exhibit 19 (DFS), the HHS MLR report and the Supplemental Health Care Exhibit.

The same percentage load was applied to all plans.

Profit (or Contribution to Surplus) & Risk Margin

Profit or Contribution to Surplus margin of 3.5% was included in all plans. This is consistent with our current ROI for other products. MHI recognizes the need to have positive margins on our programs. We believe that our 3.5% operating margin would provide necessary capital to invest in the company's infra-structure, provide adequate capital to meet reserve requirements for MHI, and provide high quality care to our members. The margin set on MHI is slightly higher than our margin for our QHP business. With the few members that we serve, we still need to maintain the network as well as other operational responsibility such as claims system setup and payment, etc.

The ROI for MHI's investment portfolio in calendar year 2009 through 2013 are as follows:

Year	Total Rate of Return
2013	0.40%
2012	1.40%
2011	0.70%
2010	1.46%
2009	1.96%

The average ROI for the last five years was 1.18% for MHI.

Taxes and Fees

The following taxes and fees are included in the premium rates:

- Patient-Centered Outcomes Research (PCORI) Tax of $2.00 per member per year;
- Transitional Reinsurance Program Fee of $3.67 PMPM;
- Risk Adjustment User Fee of $0.08 PMPM;
- New York State 332 Assessment estimated to be approximately 0.78% of premium;
- Health Insurance Excise Tax (ACA Premium Tax) is not included. MHI is exempt in 2015 since
    i. It is incorporated as a non-profit corporation under state law;
    ii. No part of the entity's profits inure to any private shareholder or individual, no substantial part of its activities include carrying on propaganda or otherwise attempting to influence legislation, and does not participate in or intervene in any political campaign on behalf of or in opposition to any candidate for public office, and
    iii. More than 80% of the entity's gross revenues are received from government programs that target low income, disabled or elderly populations.
- As a non-profit organization, MHI does not pay any other State or Federal taxes or assessments.

- Since New York has determined that there will be no Exchange user fee for 2015, no adjustment was incorporated in our 2015 rates.

11. Projected Loss Ratio

Two loss ratios are calculated, one consistent with the New York State prescribed Medical Loss Ratio (MLR) methodology and one based on the Federal definition. The anticipated New York MLR is 82.4%, which exceeds the minimum allowable MLR of 82%. The anticipated Federal MLR is 84.5%, prior to credibility, which exceeds the Federal minimum MLR of 80%.

12. Single Risk Pool

Premium rates were not developed from historical experience as MHI is a new company without any prior experience.

13. Index Rate

The index rate was developed using the manual rate projection that was described in Section 6. The index rate is shown in Worksheet 1 of the URRT. The index rate reflects the estimated allowed claims cost PMPM for EHBs, prior to any adjustments for risk transfer or reinsurance.

14. Market Adjusted Index Rates

The Market Adjusted Index rate is calculated as the Index Rate adjusted for allowable market-wide adjustments. The market-wide adjustments are the net risk adjustment, the net federal reinsurance program costs, and the Exchange user fee, which are discussed in Sections 9 and 10 above. The Exchange user fee is $0.00 in New York State in 2015. The following table shows the calculation of MHI's Market Adjusted Index Rate:

	Market Adjusted Index Rate
Index Rate	$523.78
Net Risk Adjustment	$0.08
Net Transitional Reinsurance	$3.67
Exchange Fee	$0.00
Market Adjusted Index Rate	$527.53

15. Plan Adjusted Index Rates

The Plan Adjusted Index Rates are calculated in Exhibit 18 (**Appendix C**). Below is a description of the development. Since MHI had minimal enrollment (about 100 members) in 2013, the experience was not used in the rate development. Exhibit 18 shows the starting experience used in the manual rate development in the experience section of Exhibit 18. As discussed in Section 6 above, the starting experience is market-wide Small Group experience, as published by Deloitte.

- Lines 10A – 12: Experience Period
  - Lines 10A – 10C: Shows the starting Small Group net paid PMPM.
  - Lines 11 – 12: The net paid PMPM is adjusted to an allowed PMPM level and adjusted to remove the induced utilization that is included in the starting experience, as discussed in Section 6 above.
- Lines 13 - 28: Market-wide Adjustments as discussed in detail in Section 6 above.
- Lines 29 – 43: Plan Level Adjustments
  - The rate is adjusted for plan specific adjustments, as listed below and described earlier:
    - Pricing actuarial value
    - Induced demand
    - Administrative expenses
    - Profit
    - Age 29 Adjustment: An adjustment was made for applicable plans.
    - Family Planning Exclusion Adjustment: An adjustment was made for applicable plans.
- Line 44: Plan adjusted index rate.

16. Calibration

No rate calibration was needed.

17. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is developed based on the plan adjusted index rate from Exhibit 18, which is on a PMPM basis, adjusted to reflect the required rate for each contract type. It is the final premium rate per contract, and the same rates are used for both the New York City and Long Island rating areas.

A. Standard Rating Regions

MHI participates in two of the eight standardized rating regions in New York State:

- New York – Our service area includes Bronx, Kings, New York, Queens and Richmond.
- Long Island – Our service area includes Nassau and Suffolk.

The area factors to be used for 2015 are as follows:

Region	Counties included	Area factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Please note that these area factors are to be applied to the Index Rates shown for each QHP plan.

We determined that the area factors for these two regions are the same, which is consistent with our rating approach for our other products in affiliated companies including Individual HMO, Healthy New York products, as well as Child Health Plus products.

B. Conversion Factor

The final premium rates for all plans for Employee Only, Employee and Spouse, Employee and Child(ren), and Employee/Spouse/Child(ren) are based on the following census factors prescribed by DFS:

Census Tiers	Relativity
Single	1.000
Single + Spouse	2.000
Single + Child(ren)	1.700
Single + Spouse + Child(ren)	2.850

We do not have a credible distribution of members and contracts by census tier during the experience period. Hence, we used information from Milliman for the contract distribution and the average number of members per contract for employer groups, as shown below. The development of the conversion factor is shown in the table below:

Census Tiers	Contract Distribution	Cost Per Contract	Number Of Members Per Contract	Loading Factor
Single	51.5%	1.000	1.000	1.221
Single + Spouse	15.2%	2.000	2.000	2.442
Single + Child(ren)	9.7%	1.700	2.629	2.076
Single + Spouse + Child(ren)	23.6%	2.850	4.019	3.480

Total	100.0%	**1.657**	**2.023**	**2.023**

18. AV Metal Values

The AV Metal Values included in Worksheet 2 of the URRT were based entirely on the Federal AV Calculator. No adjustments were needed for any benefits from those values produced by the AV calculator.

19. AV Pricing Values

The AV Pricing Value includes the impact of cost sharing, the utilization impact of the cost sharing, and other allowable plan specific adjustments to the index rate. Each of the plan specific adjustments can be seen in Exhibit 18. The utilization adjustments due to cost sharing are based on the HHS induced utilization factors, and do not include health status adjustments.

20. Membership Projections

Currently we have no small group products other than Healthy New York small groups, where we have 20 members. We expect the enrollment to remain low in 2015. Membership by plan is shown on Worksheet 2 of the URRT.

21. Terminated Products

MHI is terminating products in 2014 listed below. Please note that the terminated products on Worksheet 2 of the URRT represent the Healthy New York small group products offered prior to 1/1/2014.

Benefit Design	HIOS Plan ID
Dependent Age 26, Dental & Family Planning	83744NY0010017
Dependent Age 29, Dental & Family Planning	83744NY0010018
Dependent Age 26, No Dental & Family Planning	83744NY0010019
Dependent Age 29, No Dental & Family Planning	83744NY0010020
Dependent Age 26, No Dental & No Family Planning	83744NY0010021
Dependent Age 29, No Dental & No Family Planning	83744NY0010022
Dependent Age 26, Dental & No Family Planning	83744NY0010023
Dependent Age 29, Dental & No Family Planning	83744NY0010024

22. Plan Type

The Plan types listed in the URRT accurately describe MHI's plans.

23. Warning Alerts

There are no validation warning alerts.

24. DFS Exhibits

Please note that due to the minimal small group membership in MHI's Small Group New York in the past three years, we have asked DFS' permission to not fill out the following exhibits that are applicable to Small Group plans.

21A	Hospital Inpatient - Unit Costs [Based on Small Groups]
21B	Hospital Outpatient - Unit Costs [Based on Small Groups]
22	Utilization Information [Based on Small Groups]

25. Reliance

In the preparation of this filing, I relied upon data provided by Milliman including the following items:

- Pricing of EHB benefits not included in the starting base period experience.
- Milliman age/gender factors, distribution of contracts by contract type, and average members per contract by contract type
- Industry trends for New York commercial business based upon the S&P Healthcare Claims Indices, which track healthcare trends by state

I performed general reasonableness checks, but I have not audited the data and have relied upon its accuracy. To the extent that the underlying data is inaccurate, this filing may also be inaccurate. Actual results will certainly vary from those projected in the filing. This is due to random fluctuations, unexpected large claims, changes in population and other such factors.

26. Actuarial Certification

I, [redacted] am a Member of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.

I certify that:

(1) The submission is in compliance with all applicable laws and regulations of the State of New York, as well as Federal Statutes and Regulations (45 CFR 156.80(d)(1));

(2) The projected index rate is:
   a. Developed in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
      - ASOP No. 5, Incurred Health and Disability Claims
      - ASOP No. 8, Regulatory Filings for Health Plan Entities
      - ASOP No. 12, Risk Classification
      - ASOP No. 23, Data Quality
      - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
      - ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
      - ASOP No. 41, Actuarial Communications
   b. Reasonable in relation to the benefits provided and the population anticipated to be covered
   c. Neither excessive nor deficient

(3) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;

(4) The rates are not unfairly discriminatory.

(5) The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(6) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

(7) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

Please note that the Part I Unified Rate Review Template does not demonstrate the process used by MHI to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

[redacted] June 12,2014

[redacted] Date

Appendix A

Market-wide Index Rate Adjustments

Line	Adjustments	Adjustment Factor
11	Average Pricing Actuarial Value reflected in experience period	0.926
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network	0.950
15	Market wide adjustment for fee schedule changes	1.000
16	Market wide adjustment for utilization management changes	1.000
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives	1.000
18	Impact on risk pool of changes in expected covered membership risk characteristics	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by the standard rating regions	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery, more than 1.00 to reflect a payment to the pool)	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000
24	Claim trend projection factor (midpoint of experience period to mid-point of rate applicability period)	1.179
25	Covered Lives Assessment	1.038
26	HCRA Surcharge	1.043
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**

Appendix B

Quality and Cost Containment Strategy for Healthfirst Individual On and Off Exchange Plans

A. Improving Health Outcomes

Healthfirst implements health promotion and care management programs to contribute in a meaningful way to improved health outcomes for our members. The objective of these programs is to increase member access to and engagement with preventive health services, especially the patient-centered medical home, to promote appropriate utilization of services for acute and chronic care and to optimize member capability for self-management and collaboration with the provider's care and treatment strategies.

Preventive Health: Member Access and Engagement

Upon enrollment, Healthfirst offers information and support in establishing primary care as well as the opportunity for incoming members to complete a health risk assessment (HRA). Based on the member's self-reported information, the member's evidence based prevention needs, and feedback from the member's primary care and other providers, Healthfirst provides members with targeted health information, health promotion and care management outreach, education and case management programs. For example, at the Healthfirst Healthy Living website, members have access to information that can help them understand how they can best fulfill prevention needs like mammography and colon cancer screening.

Central to the initial engagement of members is the assistance that Healthfirst provides to members to schedule an appointment with their primary care provider as soon as possible following enrollment. Healthfirst Member Services is available to assist the member in contacting their primary care provider and making the first appointment.

Chronic Care Management: Promoting Self-Management and Adherence to Care / Care Compliance

Healthfirst works collaboratively with primary care, mental health and substance abuse and specialty practices to promote the delivery of evidence based care to our members living with chronic conditions using a three-pronged approach:

1) Promoting Health Knowledge and Self-Management: using a variety of approaches, Healthfirst reaches out to members to close gaps in knowledge about their conditions and critical adherence and self-management strategies. Members are educated on the importance of adhering to medications and recognizing potential adverse effects associated with their therapeutic regimens. Efforts are made to identify and manage potential barriers to therapy to minimize the potential of medication non-compliance. Materials are produced based on the needs of members identified through quality and utilization reports, as well as feedback from our members and providers. Examples include printed brochures, newsletters, targeted member letter and reminder campaigns.

2) Care Management: Based on the profile of disease prevalence and utilization patterns of our members, Healthfirst implements disease management programs and initiatives. Conditions that may be addressed by our Spectrum case managers include: diabetes, asthma, schizophrenia and sickle cell anemia.
3) Patient centered medical home: Healthfirst supports physicians and clinicians in the medical home by providing opportunities to refer members with complex needs to case management, and by sharing care plans with the patient's key providers when there is a change in health status or as requested.

Provider Partnership and Collaboration

Healthfirst works closely and collaboratively with its primary care practices to meet the health needs of our members. Many of our primary care practices have met NCQA criteria for designation as a "patient centered medical home," or PCMH. Health outcome targets are defined no less than annually and shared with the Healthfirst provider network to create a shared agenda to improve health outcomes for our members. Tools to support providers in caring for and serving our members include:

- Provider clinical bulletins detailing pragmatic ways to promote evidenced based care and improved outcomes
- Provider Symposia, which allows Healthfirst providers to highlight and share their best practices
- Provider Partnership Practice meetings for Healthfirst care management, quality and network staff to provide interim reports with feedback on utilization and quality, as well as satisfaction and medication utilization and adherence

Monitoring and Performance Improvement

No less than quarterly, Healthfirst administrative and clinical teams as well as providers and member representatives meet to review care management and quality activity and outcomes. At these quality meetings, thresholds and targets for quality performance are approved, trends in health outcomes and plan performance are reviewed, recommendations are made and work plans are monitored. Clinical Performance and Care Management programs are initiated to close gaps in targeted health outcomes and to improve strategies for identifying and minimizing medication barriers, thus improving compliance and therapeutic outcomes.

B. Preventing Hospital Readmissions

Healthfirst members at high risk for poor health outcomes and / or challenges in navigating the health care delivery system are identified based on patterns of utilization, such as fewer than expected primary care visits, frequent inpatient admissions, readmissions within 30 days in a defined time period or presence of a condition that places them at high risk for readmission such as congestive heart failure. These members are enrolled in complex case management. They receive intensive outreach

that includes a detailed assessment which forms the foundation for a comprehensive care plan to address the areas of need. Once outreach and assessment are complete, the case manager will offer community based services to support high risk members, such as home visits, medication reconciliation and post discharge coaching and reminders. Whenever possible, Healthfirst case managers work closely with hospital discharge planners to ensure a safe hospital discharge. Healthfirst also collaborates with providers and community based organizations to identify regional strategies to address difficult psychosocial issues such as homelessness, mental health and substance abuse community programs and innovative strategies to address navigation and cultural barriers to effective health care.

Healthfirst offers primary care provider practices real time notice that their assigned members have been hospitalized to promote the implementation of practice care coordination, including early appointments for members post discharge. The Healthfirst primary care practices receive feedback about the types of emergency department visits, preventable admissions and readmissions that their population of members has experienced in the previous quarter and year.

C. Improving Patient Safety

Healthfirst has implemented three major approaches to improving the safety of our patients.

Medication Management

Healthfirst supports and promotes the use of electronic prescribing and medication reconciliation to reduce polypharmacy and improved communication between the patient, the pharmacist and the prescriber. Through our pharmacy benefit manager, Healthfirst utilizes all point of sale edits available to improve the likelihood that members receive an optimized medication regimen. Pharmacy alerts for recalls and other prescriber concerns are distributed via multiple modalities which may include the Healthfirst portal, mail and email. Patients are educated through our newsletter about safe use of pharmaceuticals.

Reducing Antibiotic Resistance

Healthfirst actively educates and monitors non evidence based use of antibiotics in primary care and other practices to reduce the likelihood of the development of antibiotic resistance in the communities that we serve. These efforts include a provider bulletin with patient education material and quality reports that monitor the use of antibiotics for patients with uncomplicated acute bronchitis and viral upper respiratory infections. Pharmacy data is also available to support these efforts. Healthfirst offers provider workshops to consider alternatives to antibiotic prescriptions as appropriate.

Quality Assurance Reviews

The Healthfirst Medical Management Department and medical directors investigate potential quality assurance issues as reported by members, providers or Healthfirst staff to determine specific areas of risk for poor health outcomes for our members. Trends in provider, practice or network performance

are discussed, and when necessary Healthfirst requires corrective action plans to avoid recurrence of confirmed quality of care events.

D. Wellness and Health Promotion Activities

Healthfirst has a number of wellness and health promotion programs that seek to meaningfully improve health outcomes for our members by increasing member access to preventive health services, promoting appropriate utilization of services for acute and chronic care, and optimizing member health status.

Spectrum of Health

The Spectrum of Health program promotes health and wellness in collaboration with each member's primary care provider as well as a provider network comprised of clinical specialists and subspecialists that support the health goals of each target population of members. The Spectrum of Health process begins with an assessment of health risk and key determinants of member wellness, matching member needs with available resources and providing targeted education, alerts, reminders and assistance to facilitate members in navigating the health care delivery system.

The Spectrum of Health Program is outcomes focused, seeking to:

- Promote access to age and gender appropriate primary, secondary and tertiary prevention services
- Ensure that age and gender appropriate preventive milestones are met
- Facilitate control of chronic illness
- Optimize the functional status of members in the community

Spectrum of Health meets the targeted needs of beneficiaries by utilizing the following strategies:

- Population based education tools such as newsletters and web based information
- Targeted education, reminders and alerts based on the needs of subpopulations of members
- Provider based outreach, education, and support
- Community based outreach and education in collaboration with community based organizations with shared health promotion goals

Healthfirst continually evaluates and improves health promotion programming by collecting and analyzing performance data.

Provider Collaboration & Reporting

Healthfirst regularly collaborates with providers with the objective of meaningfully improving health outcomes for members. Communication occurs via telephone, on-site visits, relevant articles in newsletters and the web portal, provider clinical bulletins, and targeted mailings.

Key components of Healthfirst's provider reporting efforts include:

- Quality Report Cards: provider quality reports are posted on the Healthfirst provider web portal for concurrent review of status for QARR measures in comparison with HF targets
- Non-compliant Member Lists: lists of providers' measure-specific non-compliant members in their panel are posted to the provider web portal. Providers are encouraged to outreach members needing services (e.g., preventive screenings, recommended lab tests, communications on medication adherence) and schedule appointments to close gaps in care

Member Health Risk Assessment

Healthfirst seeks to engage members in their health by providing access to a member health risk assessment (HRA). Results of member HRAs are used to:

- Generate member care plans
- Identify members who qualify for Healthfirst wellness campaigns and care management programs
- Inform provider outreach and education campaigns

E. Reducing Health and Health Care Disparities

Healthfirst is a community-based health plan with established processes and programs to reduce health and healthcare disparities among its members.

Language Services

Healthfirst's member-facing staff is reflective of its diverse membership. Member Services representatives are available to speak to members in English, Spanish, Mandarin, Cantonese, Russian, and Korean. To serve members with other language preferences, Healthfirst uses a language line. Healthfirst continually evaluates use and performance of the language line to identify opportunities for improvement as well as emerging language needs.

Community Outreach

Healthfirst has seven community offices that are each fully staffed with representatives to answer questions. In addition to these community offices, Healthfirst also has mobile vans and tables set up in local hospitals, clinics, and other locations to serve members. Representatives are fluent in the languages commonly spoken in the surrounding communities and provide the following services for members:

- Renewing or re-certifying health insurance
- Providing information about the health services and benefits offered by Healthfirst
- Addressing general member questions or needs, such as changing Primary Doctor (PCP), changing address or other personal information, or requesting a new member ID card;

- Providing tips, brochures, and other information to help live a healthier life
- Linking members to other helpful community organizations

Healthfirst hosts and/or supports over 600 community events per year. Examples of events that Healthfirst has supported in the last year include:

- Health Literacy Events
- Health Fairs / Street Fairs
- Nutrition Workshop / Healthy Cooking Contest
- Breast Cancer / HIV / Blood Pressure / A1C Screenings
- Diabetes Prevention & Health Awareness Days
- Infant Immunization Events
- Men's Health Awareness Events
- Healthy Heart Day Events
- Healthy Kids & Baby Showers
- Chronic Care Workshops
- Physical Wellness and Exercise Workshops
- Brown Bag Workshops (Pharmacist review medications with attendees)
- World Health Day Events
- Gospel Health Fairs & Gospel Concerts
- Community Running Events
- Holiday celebrations (e.g., Lunar Chinese New Year, Three Kings Day, Dominican Heritage, Black History Month, Women's History Month, Veterans Day, Vaisakhi South Asian Festival).
- Family Day Events (NYCHA)

Cultural Competency Trainings

Healthfirst has a comprehensive cultural competency training program. The objective of this program is to support the organization in its aims to (1) deliver the highest-quality service to every member regardless of race, ethnicity, culture, or language proficiency and (2) eliminate racial/ethnic disparities in health care.

Healthfirst's Member Services department serves as the front line staff for member questions and concerns. All member services representatives participate in an interactive, instructor-led cultural sensitivity training when they are hired. In subsequent years, Member Services representatives are required to take an annual refresher course on cultural sensitivity.

In addition, all Healthfirst employees have access to several online training courses that focus on cultural competency. These courses include:

- Diversity Awareness (Second Edition)
- Diversity for Managers (Second Edition)

- Intercultural Business Etiquette (Second Edition)
- Communicating Across Cultures (Includes Simulation)
- Writing for a Global Audience

F. Behavioral Health Services

The behavioral health program provides a full continuum of care, utilizing acute inpatient services, partial hospitalization and intensive outpatient programs along with ambulatory outpatient care. The program is designed to assist members in finding the appropriate provider to meet their needs and to facilitate timely access to treatments and services including emergency, urgent and routine office care. Healthfirst is ready to work with members to determine a specific provider and, where necessary and desired, assist the member in obtaining an appointment.

The program includes diagnostic-specific programs such as intensive outpatient programs that target substance use and eating disorders. Healthfirst is exploring the potential use of services that make access easier for members such as the use of tele-mental health as a vehicle for those who have difficulty attending appointments in offices to receive care closer to or in their homes.

Members who have been hospitalized not only receive an agreed upon specific discharge plan but Healthfirst also provides support within the community during the initial post-hospital period to improve the potential success of connection to the next treatment component. These activities serve to increase the likelihood of the member maintaining and enhancing progress made in the hospital and also to decrease the risks of readmission.

Healthfirst recognizes that many of those suffering from a mental illness or substance use disorder also have significant physical illnesses and psychosocial issues such as homelessness, poverty and illiteracy. Through its care management program, Healthfirst provides case management, care coordination and navigation assistance to reduce gaps in care and disparity in outcomes by facilitating access to preventive care, treatment and support services. Healthfirst care managers with medical and behavioral health expertise work closely with members, families, providers, social service agencies and community based organizations to provide a unique, member-centric, integrated and holistic approach to care.

Appendix C

Exhibit 18 (DFS)

Appendix D

AV Calculator – Screen Shots

Appendix C

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
6	Plan Type*	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
7	Plan Name*	Small Group Gold Dependent Age 26, Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & Family Planning	Small Group Gold Dependent Age 26, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, No Domestic Partner & No Family Planning	Small Group Gold Dependent Age 26, Domestic Partner & No Family Planning	Small Group Gold Dependent Age 29, Domestic Partner & No Family Planning
8	HIOS Plan ID*	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032
9	Exchange Plan?*	No	No	No	No	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

	Experience Period Index Rate								
10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	4,965,488,464							
10B	Member-Months for Latest Experience Period	13,574,523							
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	365.79							
11	Average Pricing Actuarial Value reflected in experience period	0.926							
12	**AV Adjusted Experience Period Index Rate PMPM (L10C / L11)**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**	**394.94**

	Market Wide Adjustments to the AV Adjusted Experience Period Index Rate	
13	Impact of adjusting experience period data to EHB benefit level	1.021
14	Market wide adjustment for changes in provider network **	0.950
15	Market wide adjustment for fee schedule changes **	1.000
16	Market wide adjustment for utilization management changes **	1.000
17	Market wide adustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000
18	**Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics ** **	1.000
19	**Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]**	**1.000**
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery,	1.000
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	1.000

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000							
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.179							
25	Other 1 - Covered Lives Assessment	1.038							
26	Other 2 - HCRA Surcharge	1.043							
27	Other 3 (specify)	1.000							
28	**Impact of Market Wide Adjustments (product L13 through L27)**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**	**1.239**

** Not Included in Claim Trend Adjustment

	Plan Level Adjustments								
29	Pricing actuarial value (without induced demand factor) #	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791
30	Pricing actuarial value (only the induced demand factor) #	1.080	1.080	1.080	1.080	1.080	1.080	1.080	1.080
31	Impact of provider network characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.170	1.170	1.170	1.170	1.170	1.170	1.170	1.170
37	Profit/Contribution to surplus margins	1.036	1.036	1.036	1.036	1.036	1.036	1.036	1.036
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
41	Other 1 - Age 29	1.000	1.033	1.000	1.033	1.000	1.033	1.000	1.033
42	Other 2 - Family Planning	1.000	1.000	1.000	1.000	0.993	0.993	0.993	0.993
43	**Impact of Plan Level Adjustments (product L29 through L42)**	**1.036**	**1.070**	**1.036**	**1.070**	**1.028**	**1.062**	**1.028**	**1.062**

Changes that affect an entire standard population as cost sharing

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Managed Health, Inc.
NAIC Code: [redacted]
SERFF Number: [redacted]
Market Segment : Small Groups Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General								
1	Product*	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group HNY	MHI HMO Small Group	MHI HMO Small Group
2	Product ID*	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001	83744NY001
3	Metal Level (or catastrophic)*	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold
4	AV Metal Value (HHS Calculator)*	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905	0.7905
5	AV Pricing Value (total, risk pool experience based)*	0.9605	0.9925	0.9605	0.9925	0.9534	0.9852	0.9534	0.9852

changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	**TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)**	**506.69**	**523.58**	**506.69**	**523.58**	**502.93**	**519.70**	**502.93**	**519.70**

Appendix D

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%				
OOP Maximum ($)	$4,000.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$1,000.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$25.00	☑	☑		
Specialist Visit	☑	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$25.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$40.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$30.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$30.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		
Skilled Nursing Facility	☑	☐		$1,000.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	96.12%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	93.22%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☐	☐		$70.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☐	☐		$70.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	79.05%
Metal Tier:	Gold

healthfirst

June 13, 2014

[redacted]

RE: Managed Health, Inc. – Small Group HMO
Submission Effective January 1, 2015
Rates and Forms Application Under New York Insurance Law Section 3231(d)

Dear [redacted]:

Managed Health, Inc. (MHI) is pleased to submit its premium rates and forms for products with an effective date of January 1, 2015. The products listed herein are being filed pursuant to section 4308(c) of the NY Insurance Law.

Enclosed please find the rate manual for this submission. These rates and forms are for participation in New York, Richmond, Kings, Queens, Bronx, Nassau, and Suffolk Counties.

If you have any questions regarding this rates and forms submission please feel free to contact [redacted] or me at [redacted] respectively. Thank you for your time and consideration.

[redacted]

[redacted]

MANAGED HEALTH, INC.

Rate Manual Pursuant to New York Insurance Law Section 4308(c)

Small Group HMO Rates and Forms Submission

Effective January 1, 2015

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SECTION I –
Off-Exchange Small Group HMO
Premium Rates

Section I.A – Rate Pages

MANAGED HEALTH, INC.
OFF-EXCHANGE SMALL GROUP HMO
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES (WITH FAMILY PLANNING)

January – December, 2015

Plan Name: HMO B	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
Single	$618.74	$20.63	$0
Single + spouse	$1,237.49	$41.26	$0
Single + child(ren)	$1,051.86	$35.07	$0
Single + spouse + child(ren)	$1,763.42	$58.79	$0

Form Numbers of policies to which these rates apply:

HMO B
MHI-SG-15-OFF
MHI-SG-SoB-15-OFF
MHI-DPR-15
MHI-A29R-15

MANAGED HEALTH, INC.
OFF-EXCHANGE SMALL GROUP HMO
RATE PAGES - EFFECTIVE JANUARY 1, 2015
AREAS: NEW YORK, KINGS, QUEENS, RICHMOND, BRONX, NASSAU, AND SUFFOLK COUNTIES

PROPOSED HMO PREMIUM RATES (WITHOUT FAMILY PLANNING)

January – December, 2015

HMO B	Monthly Premium	Added Cost of Age 29 Rider	Added Cost of Domestic Partner Rider
Single	$614.15	$20.48	$0
Single + spouse	$1,228.31	$40.95	$0
Single + child(ren)	$1,044.06	$34.81	$0
Single + spouse + child(ren)	$1,750.34	$58.36	$0

Form Numbers of policies to which these rates apply:

HMO B
MHI-SG-15-OFF
MHI-SG-SoB-15-OFF
MHI-DPR-15
MHI-A29R-15
MHI-FPR-15

Section I.B – Description of Rating Classes, Factors, & Premium Discounts

Managed Health, Inc.'s rates have been developed in accordance with New York State's community rating laws. Premiums for every member covered under the same policy are the same regardless of age, sex, health status or occupation. The risk for on-Exchange and off-Exchange plans, pursuant to the Patient Protection and Affordable Care Act of 2010 and its associated regulations, is pooled into a single risk pool. As illustrated below, these rates within the community rated pool vary based on only several factors: dependent age limit, the inclusion of a pediatric dental benefit, the inclusion of family planning benefits, and family/census tier.

Family/Census Tier

Census Tiers	Cost Factor
Single	**1.000**
Single + Spouse	**2.000**
Single + Child(ren)	**1.700**
Single + Spouse + Child(ren)	**2.850**

Rating Region

Rating Region	Counties Included	Area Factor
New York City	Bronx, Kings, New York, Queens, Richmond	1.000
Long Island	Nassau, Suffolk	1.000

Family Planning Benefits

Family Planning Rider	Cost Factor
Included	**1.000**
Not Included	**0.993**

Dependent Age Limit

Dependent Age Limit	Cost Factor
26	1.000
29	1.033

Domestic Partner Coverage

Domestic Partner	Cost Factor
Covered	1.000
Not Covered	1.000

Section I.C – Rate Calculation Examples

The entirety of premium rates for Managed Health, Inc.'s Small Group plans is listed above in the rate tables in section I.A (pages 56of this rate manual). An example of how to look up a particular premium rate is below.

EXAMPLE:

Consumer Profile: A married employee (subscriber), of a Queens County-based employer, who is electing to cover his spouse and two children as dependents, is choosing the Small Group HMO B product with pediatric dental benefits and family planning benefits, and not choosing the Age 29 Rider.

Rate Look-Up Solution: There are no differences in premium rates for the two different rating regions included in this product (Regions 4 and 8), therefore the subscriber is advised to proceed to page 5 and refer to the first table under the heading "Proposed HMO Premium Rates – Standard Plans (with Family Planning)." Next, the consumer would refer to the column labeled, "Healthfirst HMO B Small Group" and cross-reference the row labeled, "Single + Spouse + Child(ren)." The rate for this plan is $1,763.42 per month.

Section I.D – Expected Loss Ratios

For the plans listed in this rate manual, the projected loss ratio using the Federally prescribed medical loss ratio (MLR) methodology is 84.5%. The expected loss ratio under New York State's MLR methodology is 82.4%. These projected loss ratios are greater than the Federally prescribed 80% minimum for Individual products, as well as the 82% minimum prescribed by New York State for Individual products.

SECTION II –

Description of Benefits, Types of Coverage, Limitations, Exclusions, Issue Limits, & Renewal Conditions

Section II.A – Off-Exchange Small Group HMO Gold Benefit Description (with Family Planning)

Managed Health, Inc. HMO B Small Group (with Family Planning)		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Sterilization Procedures for Women*	**Covered in full**	**No limit**
Vasectomy	**$40 Copayment after deductible**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**

Screening for Prostate Cancer	**$40 Copayment after deductible**	**Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.**
Family Planning Services for Women	**Covered in full**	**No limit**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		

Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	

Habilitation Services **(Physical Therapy, Occupational Therapy or Speech Therapy)**	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies**
Home Health Care	**$25 Copayment after deductible**	**40 Visits per Plan Year**
Infertility Services	**Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)**	**• Member must be between ages of 21 and 44** **• Advanced infertility not covered**
Infusion Therapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Home Infusion Therapy	**$25 Copayment after deductible**	**Home Infusion counts towards Home Health Care Visit Limits**
Inpatient Medical Visits	**Covered in full**	**No limit**
Laboratory Procedures		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Laboratory Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Maternity and Newborn Care		
Prenatal Care	**Covered in full**	**No limit**
Inpatient Hospital Services and Birthing Center	**$1,000 Copayment per admission after deductible**	**No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early**
Physician Midwife Services for Delivery	**$100 Copayment after deductible**	**No limit**

Breast Pump	**Covered in full**	**Covered for duration of breast feeding**
Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies** **Speech and Physical Therapy are only Covered following a Hospital stay or surgery.**
Second Opinions on the Diagnosis of Cancer, Surgery and Other	**$40 Copayment after deductible**	**One second surgical opinion on the need for surgery** **For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer**

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	$100 Copayment	No limit
Inpatient Hospital Surgery	$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
Elective Termination of Pregnancy	$100 Copayment	1 Treatment per Year; Therapeutic termination of pregnancy unlimited
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	$25 Copayment after deductible	No limit

Diabetic Education	**$25 Copayment after deductible**	**No limit**
Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible** **Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	$10 Copayment	No limit
Tier 2	$35 Copayment	No limit
Tier 3	$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	$30 Copayment	No limit
Tier 2	$105 Copayment	No limit
Tier 3	$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	$25 Copayment	No limit

Tier 2	**$88 Copayment**	**No limit**
Tier 3	**$175 Copayment**	**No limit**
Enteral Formulas	**20% Coinsurance after deductible**	**No limit**
Off Label Cancer Drugs	**Use appropriate prescription drug tier cost-sharing**	**30 day supply per month**
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	**Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse**	**• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits**
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pediatric Dental Care		
Preventive Dental Care	**$25 Copayment after deductible**	**One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals**
Routine Dental Care	**$25 Copayment after deductible**	
Major Dental (Endodontics, Periodontics and Prosthodontics)	**$25 Copayment after deductible**	
Orthodontics	**$25 Copayment after deductible**	
Pediatric Vision Care		
Exams	**$25 Copayment after deductible**	**One Exam Per 12-Month Period**
Lenses and Frames	**20% Coinsurance after deductible**	**One Prescribed Lenses & Frames in a 12-Month Period**
Contact Lenses	**20% Coinsurance after deductible**	

Section II.A – Off-Exchange Small Group HMO Gold Benefit Description (with Family Planning)

Managed Health, Inc. HMO B Small Group (without Family Planning)		
COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Deductible		
Individual	**$600**	
Family	**$1,200**	
Out-of-Pocket Limit		
Individual	**$4,000**	
Family	**$8,000**	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	
Primary Care Office Visits (or home visits)	**$25 Copayment**	**No limit**
Specialist Office Visits (or home visits)	**$40 Copayment**	**No limit**
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Well Child Visits and Immunizations	**Covered in full**	**No limit**
Adult Annual Physical Examinations	**Covered in full**	**No limit**
Adult Immunizations	**Covered in full**	**No limit**
Routine Gynecological Services/Well Woman Exams	**Covered in full**	**No limit**
Mammography Screenings	**Covered in full**	**No limit**
Bone Density Testing*	**Covered in full**	**No limit**

Screening for Prostate Cancer	**$40 Copayment after deductible**	**Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.**
All other preventive services required by USPSTF and HRSA.	**Covered in full**	**No limit**
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	**$150 Copayment after deductible**	**No limit**
Emergency Department	**$150 Copayment after deductible**	**No limit**
	Copayment / Coinsurance waived if Hospital admission	**No limit**
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	
Advanced Imaging Services		
Performed in a Freestanding Radiology Facility or Office Setting	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Allergy Testing and Treatment		
Performed in a PCP Office	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	**No limit**
Performed in a Specialist Office		
Ambulatory Surgical Center Facility Fee	**$100 Copayment after deductible**	**No limit**
Anesthesia Services (all settings)	**Covered in full**	**No limit**
Cardiac and Pulmonary Rehabilitation		
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**

Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Performed as Inpatient Hospital Services	**Included as part of inpatient hospital cost sharing**	**No limit**
Chemotherapy		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Chiropractic Services	**$40 Copayment after deductible**	**No limit**
Clinical Trials	**Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)**	
Diagnostic Testing		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Dialysis		**Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year**
Performed in a PCP Office	**$25 Copayment after deductible**	
Performed in a Freestanding Center or Specialist Office Setting	**$25 Copayment after deductible**	
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	
Habilitation Services	**$30 Copayment after deductible**	**60 visits per condition, per**

(Physical Therapy, Occupational Therapy or Speech Therapy)		lifetime combined therapies
Home Health Care	$25 Copayment after deductible	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	• Member must be between ages of 21 and 44 • Advanced infertility not covered
Infusion Therapy		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in Specialist Office	$25 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$25 Copayment after deductible	No limit
Home Infusion Therapy	$25 Copayment after deductible	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	Covered in full	No limit
Laboratory Procedures		
Performed in a PCP Office	$25 Copayment after deductible	No limit
Performed in a Freestanding Laboratory Facility or Specialist Office	$40 Copayment after deductible	No limit
Performed as Outpatient Hospital Services	$40 Copayment after deductible	No limit
Maternity and Newborn Care		
Prenatal Care	Covered in full	No limit
Inpatient Hospital Services and Birthing Center	$1,000 Copayment per admission after deductible	No limit; 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Physician Midwife Services for Delivery	$100 Copayment after deductible	No limit
Breast Pump	Covered in full	Covered for duration of breast feeding

Postnatal Care	**Covered in full**	**No limit**
Outpatient Hospital Surgery Facility Charge	**$100 Copayment after deductible**	**No limit**
Diagnostic Radiology Services		
Performed in a PCP Office	**$25 Copayment after deductible**	**No limit**
Performed in a Freestanding Radiology Facility or Specialist Office	**$40 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$40 Copayment after deductible**	**No limit**
Therapeutic Radiology Services		
Performed in a Freestanding Radiology Facility or Specialist Office	**$25 Copayment after deductible**	**No limit**
Performed as Outpatient Hospital Services	**$25 Copayment after deductible**	**No limit**
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	**$30 Copayment after deductible**	**60 visits per condition, per lifetime combined therapies** **Speech and Physical Therapy are only Covered following a Hospital stay or surgery.**
Second Opinions on the Diagnosis of Cancer, Surgery and Other	**$40 Copayment after deductible**	**One second surgical opinion on the need for surgery** **For cancer specialist – second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer**

Surgical Services		No limit Transplants – Solely for transplants for surgeries determined to be non-experimental and non-investigational. Oral Surgery due to injury is limited to sound and natural teeth only.
(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)	$100 Copayment	No limit
Inpatient Hospital Surgery	$100 Copayment after deductible	No limit
Outpatient Hospital Surgery	$100 Copayment after deductible	No limit
Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after deductible	No limit
Office Surgery	Cost sharing determined by provider type, whether PCP or SPC	No limit
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder	$25 Copayment after deductible	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment after deductible	Limited to dedicated devices
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)	$25 Copayment after deductible	No limit
Diabetic Education	$25 Copayment after deductible	No limit

Durable Medical Equipment and Braces	**20% Coinsurance after deductible**	**Coverage for standard equipment only.**
External Hearing Aids	**20% Coinsurance after deductible**	**Single Purchase Once Every 3 Years**
Cochlear Implants	**20% Coinsurance after deductible**	**One Per Ear Per Time Covered**
Hospice Care		
Inpatient	**$1,000 Copayment per admission after deductible**	**210 Days per Plan Year**
Outpatient	**$25 Copayment after deductible**	**5 Visits for Family Bereavement Counseling**
Medical Supplies	**20% Coinsurance after deductible**	
Prosthetic Devices		
External	**20% Coinsurance after deductible**	**One prosthetic device, per limb, per lifetime**
Internal	**20% Coinsurance after deductible**	**No limit**
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.**	**No limit**
Observation Stay	**$150 Copayment after deductible**	**No limit**
Bariatric Surgery	**$100 Copayment per admission after deductible**	**No limit**
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	**$1,000 Copayment per admission after deductible**	**200 Days Per Plan Year**
Inpatient Rehabilitation Services (Physcial, Speech and Occupational therapy)	**$1,000 Copayment per admission after deductible**	**60 Consecutive Days Per Condition, Per Lifetime**
MENTAL HEALTH and SUBSTANCE USE DISORDER	**Participating Provider Member Responsibility for Cost-Sharing**	

SERVICES		
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$25 Copayment after deductible	No limit
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1,000 Copayment per admission after deductible Preauthorization is Not Required for Emergency Admissions.	No limit
Outpatient Substance Use Services	$25 Copayment after deductible	No limit; Up to 20 Visits a Plan Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	
Retail Pharmacy		
30-day supply		
Tier 1	$10 Copayment	No limit
Tier 2	$35 Copayment	No limit
Tier 3	$70 Copayment	No limit
Up to a 90-day supply for Maintenance Drugs		
Tier 1	$30 Copayment	No limit
Tier 2	$105 Copayment	No limit
Tier 3	$210 Copayment	No limit
Mail Order Pharmacy		
Up to a 90-day supply		
Tier 1	$25 Copayment	No limit
Tier 2	$88 Copayment	No limit

Tier 3	$175 Copayment	No limit
Enteral Formulas	20% Coinsurance after deductible	No limit
Off Label Cancer Drugs	Use appropriate prescription drug tier cost-sharing	30 day supply per month
WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse	• Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse • Partial reimbursement for facility fees every 6 months if member attains at least 50 visits
PEDIATRIC DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	
Pediatric Dental Care		
Preventive Dental Care	$25 Copayment after deductible	One dental exam and cleaning per 6-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals
Routine Dental Care	$25 Copayment after deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	$25 Copayment after deductible	
Orthodontics	$25 Copayment after deductible	
Pediatric Vision Care		
Exams	$25 Copayment after deductible	One Exam Per 12-Month Period
Lenses and Frames	20% Coinsurance after deductible	One Prescribed Lenses & Frames in a 12-Month Period
Contact Lenses	20% Coinsurance after deductible	

SECTION III – Underwriting Guidelines

HEALTHFIRST PARTICIPATION AND ELIGIBILITY GUIDELINES

New York Small Groups (1 – 50 Employees)

Off-Exchange Products

The following participation and eligibility guidelines apply to employer groups enrolling in or renewing coverage in Healthfirst Small Group Off-Exchange products.

Section 1: Small Group Eligibility

A. The employer must actively operate a business with a street address in a county where Healthfirst offers small group products (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties).

B. If the employer does not offer group health coverage to all eligible employees, group size will be calculated based on the number of eligible employees in Healthfirst's service area.

C. A minimum of 60% of all eligible employees after valid waivers must be enrolled. The 60% threshold will be determined by multiplying the number of eligible employees by 0.60 and rounding fractions down to the nearest whole number. Valid waivers include:

a. Spousal coverage
b. Medicare coverage
c. Medicaid coverage
d. VA coverage
e. TriCare coverage
f. ACA-compliant plan coverage

This requirement does not apply to HMO plans.

D. If the group offers retiree coverage, a minimum of 60% of all eligible employees after valid waivers and all eligible former retired employees must be enrolled. (Additional documentation may be required on audit to confirm retirees' eligibility for coverage).

This requirement does not apply to HMO plans.

E. **Valid Employer Class(es)**: An employer may elect to offer coverage to a class of employees based on conditions pertaining to employment: geographic status of employment, earnings, method of compensation, hours and occupational duties. (**Example**: Employer may elect to offer coverage only to employees who work at least 30 hours per week.)

F. **Out-of-Area**: Out-of-area enrollment is not allowed on Healthfirst small group plans. Eligible employees who neither work nor reside in HF's service area (Bronx, Kings, Nassau, New York, Queens, Richmond, and Suffolk counties) may not be covered on Healthfirst small group products.

G. Two Life Group: A two life group consisting of a husband and wife is considered to be a sole proprietor per Federal guidelines, and is not eligible for small group coverage

H. Minimum Participation – Calculation (for plans other than HMOs):
Pursuant to federal regulations, Healthfirst will have an open enrollment period from November 15th through December 15th for all small groups that do not meet minimum participation requirements. The coverage effective date for small groups enrolling during this period will be January 1st.

Section 2: Employee Eligibility

A. Eligible employees, and if the group offers retiree benefits, all eligible retired former employees, can be enrolled in Healthfirst small group products if they:

a. Live in the Healthfirst service area.

b. Are active full-time employees of the employer, and of all subsidiaries and affiliates of a corporate employer, that work at least 20 hours or more per week. The employer must have at least two such employees to remain active.

B. Eligible dependents are defined as: a legally married spouse or domestic partner, and a legally dependent child up to the age of 26. Additional options for age 29 are also available. Domestic partners will be required to submit a domestic partner eligibility attestation. Marriage and birth certificates may be required to prove family eligibility. A copy of a filed Federal Form 1040 may be required for married couples or dependents with a different last name than the employee.

C. The following are **not** counted as eligible employees when determining group size and are excluded from eligibility and coverage:

a. COBRA-only former employees
b. Consultants and independent contractors (1099 employees)
c. Directors and officers who do not qualify as owners, partners or employees
d. Foreign employees covered by their country's government health insurance
e. Leased employees are ineligible for coverage
f. Part-time, temporary and seasonal workers that are not hired to work a full year

Section 3: Employee Required Information

A. The following information on enrolled employees and their dependents is required before processing:

a. Social security number for each subscriber
b. Date(s) of birth for all subscribers and dependents
c. Complete street address
d. Date of marriage (if applicable)
e. Employment effective (start) date
f. Employer and employee signatures

Section 4: Employer Tax Documentation

A. The most recent NYS-45 (NYS Quarterly Combined Withholding and Wage Report). If not required to file the NYS-45, then one of the following is required:

B. If a "C" corporation: Articles of incorporation, Form 1120 (line 13 is wages) and payroll documents

C. If a Church: Form 941 (line 2 is wages) and payroll documents

D. If a LLC: LLC agreement and the appropriate documentation noted above

E. If a Partnership: K-1 or Form 1065 (line 9 is wages) and payroll documents and business license

F. If an "S" corporation: Articles of incorporation, Form 1120S (line 8 is wages) and payroll documents

G. Newly formed business: If the business has been in existence less than one year and has not yet filed a Quarterly Wage and Tax Statement, HF will accept Corporation or Partnership papers and payroll documents

H. A federal TIN or additional documentation may be required upon audit.

Section 5: Required Documentation for Effectuation

A. All paperwork for new business must be received 30 days in advance of the requested effectuation date. New business will have an effective date of the 1st of the month.

B. All paperwork for renewing business must be received 30 days in advance of the requested renewal date.

C. Paperwork required:

a. Signed group application
b. Fully completed original employee enrollment forms and waiver forms (if applicable)
c. Check for the first month's premium from the employer's business account

Section 6: Submit Application & Payment

A. New business must be submitted at least 30 days before the effective date.

B. Incomplete application packages may delay a group's effective date.

Mailing address:
Healthfirst
Enrollment Intake Department
100 Church Street
New York, NY 10007

C. Please fill out application completely and include member and dependent information.

- New groups should submit the first month's premium on a company check.
- Payment may be remitted via bank check or money order. (Please be sure the name of the company or organization is clearly written when sending in bank check or money orders so that payment can be properly applied.)

Section 7: Enrollment and Waiting Periods

A. Open enrollment will be held once a year on the group's anniversary or renewal date.

B. Employee waiting periods for coverage effectiveness cannot exceed 90 days.

C. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period. A copy of the employee's W-4 or recent payroll check stub must be supplied to qualify for provisional enrollment in the event that the new employee is not yet listed on filed tax documentation. The payroll date cannot be more than 30 days prior to the date of application. The employer must produce tax documents within 90 days after the effective date of coverage to substantiate a new hire's eligibility.

D. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.

E. Eligible employees who decline coverage and subsequently wish to enroll without a qualifying event will only be eligible to enroll during the next annual open enrollment period. A qualifying event is an unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is the loss of coverage through a spouse who's losing a job.

Section 8: Rates and Rating Tiers

A. Only 4-tier rates are available.

B. Premium rates for Healthfirst Small Group products are based on employer location.

C. Changes in group eligibility, rate structure, and benefits may be made upon the group's renewal. Should an employer cease to qualify as a small group of between 1- 50 eligible employees, the group is required to promptly notify Healthfirst of this change pursuant to the group contract.

Section 9: Ongoing Small Group Verification

Healthfirst or a Healthfirst designated administrator may take periodic surveys of enrolled small groups to ensure that the group is actively operating its business and is still qualified to be enrolled in a community-rated product. The survey can include, but not be limited to, any or all of the following to verify continued eligibility:

1. The employer's most recently filed NYS-45 or NYS-ATT
2. Tax documentation as requested by HF and/or HF's designated administrators
3. Payroll information as requested by HF and/or HF's designated administrators

healthfirst

June 13, 2014

[redacted]

RE: Form Readability Certification
Managed Health, Inc. – Small Group HMO Plans
Submission Effective January 1, 2015
Rates and Forms Application Under New York Insurance Law Section 4308(c)

Dear [redacted]

As part of Managed Health, Inc.'s premium rates and forms submission for plans with an effective date of January 1, 2015, and pursuant to the Major Medical and Other Similar-Type Comprehensive Health Insurance Checklist for Small Groups Checklist, dated April 15, 2014, we have included a policy and form Readability Certification.

Although the forms filed as part of this submission use Model Language the Flesch reading ease test score does not meet the minimum score of 45. The Readability Certification we have submitted indicates that this standard has not been met, while also noting the actual Flesch reading ease score of each policy/form we are submitting in this filing.

If you have any questions regarding this matter please feel free to contact [redacted]. Thank you for your time and consideration. We look forward to continue working with you and New York State of Health.

[redacted]

New York Readability Certification

This is to certify that the forms listed below are in compliance with New York's Insurance Policy Readability Law.

A. Scoring Option *(select one)*

○ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____ .

◉ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for each policy form are indicated below.

B. Scope of Test *(select one)*

◉ 1. Test was applied to entire policy form(s).

○ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards of Certification (A checked block indicates the standard has been achieved.)

○ 1. The text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

◉ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)

◉ 3. Layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

◉ 4. The section titles are captioned in bold face or otherwise stand out significantly from the text.

◉ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

◉ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

◉ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

The undersigned officer of the insurer certifies that the forms in this filing meet the minimum reading ease score. Following are the individual Flesch Scores for each form submitted with this filing:

Form #	Words	Sentences	Syllables	Flesch Score
MHI-SG-15-OFF	35727	1498	61902	35.7
MHI-A29R-15	213	8	314	54.8
MHI-FPR-15	243	11	443	29.8
MHI-DPR-15	515	9	748	25.6
MHI-LCSWR-15	111	3	186	27.2
MHI-SNFR-15	159	6	270	36.2
MHI-SG-GSOB-15-OFF	2986	11	3296	24.9

(Insert signature, name of officer, title of officer, and name of insurer)

[redacted]

(To list more forms, complete and submit the 'Additional Sheet(s)' attached to the requirement for Readability Certification. If submitting multiple sheets complete and attach them individually.)

Reset Form

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE FILING

Company Name: **Managed Health, Inc.**
NAIC Code: [redacted]
SERFF Tracking #: [redacted]
Market Segment: **Small Groups Off Exchange**

A. Insurer Information:

Managed Health, Inc.	HMO - 44	Not-for-Profit	[redacted]
Company submitting the rate filing request	Company Type	Org. Type	Company NAIC Code

100 Church Street, 18th Floor, New York, NY 10007
Company mailing address

B. Contact Person:

[redacted]	[redacted]	[redacted]
Rate filing contact person name, title	Contact phone number	Contact Email address

C. Actuarial Contact (If different from above):

[redacted]	[redacted]	[redacted]
Actuary name, title	Actuary phone number	Actuary Email address

D. New Rate Information:

January 1, 2015 - December 31, 2015	1/1/2015	[redacted]
New rate applicability period	New rate effective date	SERFF Tracking Number

E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing): Small Group

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 (1). If yes, provide a brief description of the contract language changes included in this filing.	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? If yes, mention these filings on Exhibit 16.	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 (2).	Yes. Sent June 13, 2014.
4. Have all the required exhibits been submitted with this rate filing? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary and numerical summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of	Yes. SERFF tracking number: [redacted]

Notes:

(1) As mentioned in the checklist, this combined non-grandfathered product rate adjustment and form/rate filing can only include minor contract revisions, such as due to changes in the model language, changes to the catastrophic plan due to change in out of pocket maximum, changes to the standard plan designs. Substantial changes need to be submitted as a separate rate and form filing (e.g., a new plan design not replacing an existing plan design, contract language changes not just due to changes in the model language).

(2) §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 filing is submitted to the Department of Financial Services.

Unified Rate Review v2.0.2

Company Legal Name:	**Managed Health, Inc**	State:	**NY**
HIOS Issuer ID:	**83744**	Market:	**Small Group**
Effective Date of Rate Change(s):	**1/1/2015**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2013 to 12/31/2013

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$472,137	$398.09	100.00%
Incurred Claims in Experience Period	$431,140	363.52	91.32%
Allowed Claims:	$518,821	437.45	109.89%
Index Rate of Experience Period		$437.00	
Experience Period Member Months	1,186		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2015 to 12/31/2015 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	157.97	$17,740.36	$233.53	1.000	1.000	1.000	1.000	157.97	$17,740.36	$233.53	107.59	$16,213.00	$145.37
Outpatient Hospital	Visits	1,495.41	196.13	24.44	1.000	1.000	1.000	1.000	1,495.41	196.13	24.44	3976.58	266.09	88.18
Professional	Services	10,720.63	112.34	100.37	1.000	1.000	1.000	1.000	10,720.63	112.34	100.37	15592.20	126.67	164.59
Other Medical	Services	115.84	934.35	9.02	1.000	1.000	1.000	1.000	115.84	934.35	9.02	327.59	233.53	6.38
Capitation	Benefit Period	0.00	0.00	0.00	1.000	1.000	1.000	1.000	0.00	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Prescriptions	9,372.65	89.75	70.10	1.000	1.000	1.000	1.000	9,372.65	89.75	70.10	23162.32	62.69	121.01
Total				$437.45							$437.45			$525.52

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$525.52	$262,761
Paid to Allowed Average Factor in Projection Period			0.749	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$393.43	$196,717
Projected Risk Adjustments PMPM			-0.08	(40)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$393.51	$196,757
Projected ACA reinsurance recoveries, net of rein prem, PMPM			-3.67	(1,835)
Projected Incurred Claims			$397.18	$198,592
Administrative Expense Load	12.50%		59.68	29,842
Profit & Risk Load	3.50%		16.71	8,356
Taxes & Fees	0.81%		3.89	1,946
Single Risk Pool Gross Premium Avg. Rate, PMPM			$477.47	$238,736
Index Rate for Projection Period			$523.78	
% increase over Experience Period			19.94%	
% Increase, annualized:			9.52%	
Projected Member Months				500

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name: **Managed Health, Inc**
HIOS Issuer ID: **83744**
Effective Date of Rate Change(s): **1/1/2015**

State: **NY**
Market: **Small Group**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		HMO B Small Group								HMO B Small Group								Terminated Plans
Product ID:		83744NY001								83744NY002								83744NY999
Metal:		Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Gold	Catastrophic
AV Metal Value		0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	0.791	1.000
AV Pricing Value		0.960	0.993	0.960	0.993	0.953	0.985	0.953	0.985	0.846	0.874	0.846	0.874	0.839	0.867	0.839	0.867	1.000
Plan Type:		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Name		Dependent Age 26, Domestic Partner & Family	Dependent Age 29, Domestic Partner & Family	Dependent Age 26, No Domestic Partner & Family	Dependent Age 29, No Domestic Partner & Family	Dependent Age 26, No Domestic Partner & No	Dependent Age 29, No Domestic Partner & No	Dependent Age 26, Domestic Partner & No	Dependent Age 29, Domestic Partner & No	Gold Dependent Age 26, Domestic Partner & Family	Gold Dependent Age 29, Domestic Partner & Family	Gold Dependent Age 26, No Domestic Partner	Gold Dependent Age 29, No Domestic Partner	Gold Dependent Age 26, No Domestic Partner	Gold Dependent Age 29, No Domestic Partner	Gold Dependent Age 26, Domestic Partner & No	Gold Dependent Age 29, Domestic Partner & No	Terminated Plans
Plan ID (Standard Component ID):		83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032	83744NY0020009	83744NY0020010	83744NY0020011	83744NY0020012	83744NY0020013	83744NY0020014	83744NY0020015	83744NY0020016	83744NY9990001
Exchange Plan?		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		-100.00%								-100.00%								0.00%
Historical Rate Increase - Calendar Year - 1		-100.00%								-100.00%								0.00%
Historical Rate Increase - Calendar Year 0		-100.00%								-100.00%								0.00%
Effective Date of Proposed Rates		1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	-100.00%
Product Threshold Rate Increase %		0.00%								0.00%								0.00%

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032	83744NY0020009	83744NY0020010	83744NY0020011	83744NY0020012	83744NY0020013	83744NY0020014	83744NY0020015	83744NY0020016	83744NY9990001
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Average Current Rate PMPM	$477.48	$506.69	$523.58	$506.69	$523.58	$502.93	$519.70	$502.93	$519.70	$446.24	$461.12	$446.24	$461.12	$442.48	$457.23	$442.48	$457.23	$0.00
Projected Member Months	500	29	3	162	18	29	3	5	1	29	3	162	18	29	3	5	1	0

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032	83744NY0020009	83744NY0020010	83744NY0020011	83744NY0020012	83744NY0020013	83744NY0020014	83744NY0020015	83744NY0020016	83744NY9990001
Average Rate PMPM	$398.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$398.09
Member Months	1,186	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,186
Total Premium (TP)	$472,137	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$472,137
EHB Percent of TP, [see instructions]	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Total Allowed Claims (TAC)	$518,821	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$518,821
EHB Percent of TAC, [see instructions]	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$87,681	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$87,681
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%
Total Incurred claims, payable with issuer funds	$431,140	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$431,140
Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	$363.52	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$363.52
Allowed Claims PMPM	$437.45	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$437.45
EHB portion of Allowed Claims, PMPM	$437.45	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$437.45

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	83744NY0010025	83744NY0010026	83744NY0010027	83744NY0010028	83744NY0010029	83744NY0010030	83744NY0010031	83744NY0010032	83744NY0020009	83744NY0020010	83744NY0020011	83744NY0020012	83744NY0020013	83744NY0020014	83744NY0020015	83744NY0020016	83744NY9990001
Plan Adjusted Index Rate	$477.48	$506.69	$523.58	$506.69	$523.58	$502.93	$519.70	$502.93	$519.70	$446.24	$461.12	$446.24	$461.12	$442.48	$457.23	$442.48	$457.23	$0.00
Member Months	500	29	3	162	18	29	3	5	1	29	3	162	18	29	3	5	1	-
Total Premium (TP)	$238,741	$14,694	$1,571	$82,083	$9,424	$14,585	$1,559	$2,515	$520	$12,941	$1,383	$72,292	$8,300	$12,832	$1,372	$2,212	$457	$0
EHB Percent of TP, [see instructions]	99.67%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%
state mandated benefits portion of TP that are other than EHB	0.33%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$262,761	$15,208	$1,626	$84,952	$9,756	$15,094	$1,614	$2,602	$538	$15,208	$1,626	$84,952	$9,758	$15,078	$1,612	$2,600	$537	$0
EHB Percent of TAC, [see instructions]	99.67%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%	96.77%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.33%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%	3.23%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$64,169	$2,984	$320	$16,669	$1,919	$2,960	$317	$510	$106	$4,443	$476	$24,818	$2,856	$4,403	$472	$759	$157	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!
Total Incurred claims, payable with issuer funds	$198,592	$12,223	$1,306	$68,283	$7,838	$12,134	$1,297	$2,092	$432	$10,765	$1,150	$60,134	$6,902	$10,675	$1,141	$1,840	$380	$0
Net Amt of Rein	-$1,835	-$106	-$11	-$595	-$66	-$106	-$11	-$18	-$4	-$106	-$11	-$595	-$66	-$106	-$11	-$18	-$4	$0
Net Amt of Risk Adj	-$40	-$2	$0	-$13	-$1	-$2	$0	$0	$0	-$2	$0	-$13	-$1	-$2	$0	$0	$0	$0