

**State:** New York **Filing Company:** Capital District Physicians Health Plan Inc  
**TOI/Sub-TOI:** HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003C Large Group Only  
 - HMO  
**Product Name:** LG\_HMO\_Renewal  
**Project Name/Number:** /

### Filing at a Glance

Company: Capital District Physicians Health Plan Inc  
 Product Name: LG\_HMO\_Renewal  
 State: New York  
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)  
 Sub-TOI: HOrg02G.003C Large Group Only - HMO  
 Filing Type: Rate Adjustment pursuant to Section 4308(c)  
 Date Submitted: 07/16/2013  
 SERFF Tr Num: CAPD-129090271  
 SERFF Status: Assigned  
 State Tr Num: 2013070075  
 State Status:  
 Co Tr Num: LG\_HMO\_GRNF\_RENEWAL

Implementation 01/01/2014

Date Requested:

Author(s):

[Redacted]  
 [Redacted]  
 [Redacted]  
 [Redacted]

Reviewer(s):

[Redacted]

Disposition Date:

Disposition Status:

Implementation Date:

State Filing Description:

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### General Information

Project Name: Status of Filing in Domicile:  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: Group Market Size: Large  
 Group Market Type: Overall Rate Impact:  
 Filing Status Changed: 07/17/2013  
 State Status Changed: Deemer Date:  
 Created By: [REDACTED] Submitted By: [REDACTED]  
 Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:  
Renewal filing for HMO large group

### Company and Contact

#### Filing Contact Information

[REDACTED] [REDACTED]  
 [REDACTED] [REDACTED]  
 500 Patroon Creek Blvd [REDACTED]  
 Albany, NY 12206 [REDACTED]

#### Filing Company Information

Capital District Physicians Health Plan Inc	CoCode: 95491	State of Domicile: New York
Patroon Creek Corporate Center	Group Code: -99	Company Type:
1223 Washington Avenue	Group Name:	State ID Number:
Albany, NY 12206-1057	FEIN Number: 14-1641028	

### Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

### State Specific

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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 an out-of-state filing. Form submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): 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.): Yes, Prior Approval
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,CAPD-129107555, 2013070041

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## Supporting Document Schedules

<b>Satisfied - Item:</b>	Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)
<b>Comments:</b>	
<b>Attachment(s):</b>	Filing_Checklist-04182013.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Consumer Disclosure Form
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_3_LG_HMO_2014 _Narrative summary_ rev_final.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Final Notice of Proposed Rate Adjustment
<b>Comments:</b>	
<b>Attachment(s):</b>	Large Group 60 Day.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Initial Notice of Proposed Rate Adjustment
<b>Comments:</b>	
<b>Attachment(s):</b>	13-0812 Prior Approval Rate Letter and Narrative (7 12 13 edit).pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Redacted Documents for Web Posting
<b>Comments:</b>	
<b>Attachment(s):</b>	1 Actuarial Memorandum - LG HMO - Redacted.pdf Exhibit_1_LG_HMO_2014 Redacted.pdf Exhibit_1_LG_HMO_2014 Redacted.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

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<b>Satisfied - Item:</b>	Standard Exhibit 2 - Summary of Average Claim Trend and Administrative Expenses
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_2_LG_HMO_2014.pdf Exhibit_2_LG_HMO_2014.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 3 - Narrative Summary
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_3_LG_HMO_2014 _Narrative summary_ rev_final.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 4 - Part B - Summary of Proposed Percentage Rate Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_4B_LG_HMO_2014.pdf Exhibit_4B_LG_HMO_2014.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 4 - Part D - Summary of Proposed Percentage Rate Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_4D_LG_HMO_2014.pdf Exhibit_4D_LG_HMO_2014.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 5 - Part B - Distribution of Contracts Affected by Proposed Rate Adjustments
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_5B_LG_HMO_2014.pdf Exhibit_5B_LG_HMO_2014.xls
<b>Item Status:</b>	

**SERFF Tracking #:**

CAPD-129090271

**State Tracking #:**

2013070075

**Company Tracking #:**

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<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Standard Exhibit 6 - Summary of Policy Form and Product Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_6_LG_HMO_2014.pdf Exhibit_6_LG_HMO_2014.xls
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Standard Exhibit 7 - Historical Data
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_7_LG_HMO_2014_v2.pdf Exhibit_7_LG_HMO_2014_v2.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

## NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

As of 4/8/2013

The changes are summarized below:

1. For exhibits 4 and 5 the weighted averages should be based on annualized premiums (not by members or contracts). In Exhibit 5, the distribution of the size of rate change is still shown by members or contracts.
2. A draft copy of the Narrative and Initial Notice should be submitted to the Department for prior review using the “Prior Approval Prefiling” filing type code. Previously only the initial notice was mentioned in the material below.

This checklist applies to rate adjustment filings for GRANDFATHERED products and policyholders as that term is defined by HHS in their regulations. A different checklist and different filing type codes will be developed for future non-grandfathered rate adjustment filings.

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

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

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

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

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

If a company wishes to eliminate some of its approved benefit options included in the current rate manual, this cannot be done pursuant to a Section 3231(e)(1) or Section 4308(c) rate adjustment application. Such elimination is to be implemented by submitting a form and rate filing using the “Normal Pre-Approval” SERFF filing type

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code and the filing is to include a revised statement of variables for the benefit options that are available along with revised rate manual pages reflecting the revised benefit options.

A rate adjustment filing submitted pursuant to Section 3231(e)(1) or Section 4308(c) cannot include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing (a new form or a revision to an existing form) must be a separate filing from the rate adjustment filing. Once a new rate has been approved (for a new policy form or for a revision to an existing policy form), such new rate can be incorporated into the next Section 3231(e)(1) or Section 4308(c) rate adjustment filing.

The “Normal Pre-Approval” SERFF filing type code triggers the traditional Department review (generally by the Albany Health Bureau unit) and would be used for all form and rate filings, form only filings, experience rating formula filings, or commercial insurer rate only filings other than filings submitted pursuant to Section 3231(e)(1), or Article 43 Corporation and HMO rate only filings other than filings submitted pursuant to Section 4308(c).

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

The filing type codes “Exchange Form & Rate Filing” and “Off Exchange NG Form & Rate Filing” are to be used to submit form and rating filings for new non-grandfathered products/plan designs to be sold on the Exchange, and off the Exchange, respectively.

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

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

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

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

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2010, Microsoft Excel 2010, or Adobe Acrobat 9.

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

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

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

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

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

**NOTE:** Parts I and II of the HHS Preliminary Justification are now required for all market segments and for all section 3231(e)(1) or 4308(c) rate submissions. See the section “HHS Preliminary Justification Parts I and II” below for guidance. (This refers to the material that an insurer is required to submit to HHS for a rate adjustment filing on “grandfathered” business, or what would be submitted to HHS if the “subject to review” threshold was exceeded by this filing.)

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
<b>DEFINITIONS</b>		a. <b>Company</b> refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing. b. A company’s <b>commercial book of business</b> includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus. c. <b>Loss ratio</b> refers to incurred claims divided by earned premiums for a given period	

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		<p>of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered lives assessments, and the HCRA surcharge. Incurred claims do not include any administrative expenses, including “quality improvement expenses” or “community benefit expenses”. Earned premiums <u>do not include</u> any adjustment for assessments or taxes.</p> <p>d. <b>Market segment</b> refers to large group, small group, sole proprietor, direct pay, Healthy New York, Medicare Supplemental, etc. Small group is as defined in New York Insurance Law and Regulation.</p> <p>e. <b>Product street name</b> refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department.</p> <p>f. <b>Rate applicability period</b> refers to the length of time in which the rates in a rate table are assumed to remain in effect.</p> <p>(i) Example 1: A non-rolling rate table is developed to be effective January 1, 2012 and is expected to be revised January 1, 2013. The rate applicability period for this table is January 1, 2012 through December 31, 2012.</p> <p>(ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2012 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2012 (mid renewal date) through February 14, 2013. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2012 through January 31, 2013.</p> <p>g. <b>Standardized earned premium</b> is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). Refunds payable pursuant to Regulation 146 or pursuant to a loss ratio report have no impact on the earned premiums or standardized earned premiums shown in Exhibit 7 or in the rate development analysis.</p> <p>(i) Example: The rate filing is to implement quarterly rolling rate tables applicable to the 3<sup>rd</sup> and 4<sup>th</sup> quarters 2012 and 1<sup>st</sup> and 2<sup>nd</sup> quarters 2013. The 2<sup>nd</sup> quarter 2012 rates have already been approved. Therefore, the 2<sup>nd</sup> quarter 2012 rate tables are the current rate level. The earned premium for the period would be adjusted to reflect the premiums that would have been paid for that period if all the premiums had been paid at the 2<sup>nd</sup> quarter 2012 rate level. If the 2<sup>nd</sup> quarter 2012 rate table included a 2% increase due to the addition of a new</p>	
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**Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law**

		<p>benefit that is being added to all policyholders at renewal, the standardization for periods prior to April 1, 2012 would not reflect this 2% increase since the incurred claims for this earlier period did not reflect this additional benefit.</p> <p>(ii) Example: An insurance company uses a quarterly rolling rate structure and has been raising rates 4% each quarter as of the beginning of a new quarter. The first quarter 2011 rate for plan design A is \$100, the first quarter 2012 rate is \$116.99, and the second quarter 2012 rate is \$121.67. These increases reflect no revision to the underlying covered benefits. The second quarter 2012 rate table is the standard rate level. Contract X was paying \$100 per month for January-December 2011. At renewal January 1, 2012, the premium was scheduled to increase to \$116.99 but a change to plan design B occurred that reduced the premium by 5% to \$111.14 for January 2012 and later. The second quarter 2012 rate for plan design A is \$121.67 and the second quarter 2012 rate for plan design B is \$115.58 (<math>\\$121.67 \times 0.95</math>). The earned premium for this contract for each month from January through December 2011 is standardized to the second quarter 2012 level by adjusting by <math>121.67/100.00</math>, and the January 2012 earned premium is standardized to the second quarter 2012 level by adjusting by <math>115.58/111.14</math>.</p>	
<p><b>ROLLING RATE STRUCTURE</b></p>		<p>a. Every rate filing for a rolling rate structure must include rolling rates for at least a 6 month, and for no more than a 12 month, issue/renewal period (e.g., between 2 and 4 quarterly rolling rates, between 6 and 12 monthly rolling rates).</p> <p>b. Beginning with rate filings to be effective January 1, 2012 or later, all rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period.</p> <p>c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates, 24 monthly rolling rates).</p>	
<p><b>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</b></p>		<p>a. Beginning with rate adjustment filings that include rate tables to be effective January 1, 2012 or later, the rate adjustment filing must include all community rated policy forms within a given market segment (such as all small group products) whether or not a premium rate adjustment is requested for a particular product or rider in that market segment. All entities within the same holding company system are to submit filings for a given market segment at the same time; the filings can be submitted under different SERFF filings, but all the applicable filings must be submitted within a total of seven calendar days.</p> <p>b. A company can revise a previously approved non-rolling rate table provided that:</p> <p>(i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or</p>	

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		<p>(ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing.</p> <p>c. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii) the first two quarterly rate tables, or the first six monthly rate tables, included in the previously approved rate adjustment filing are not revised, and (iii) policyholders in the renewal cohort(s) affected by the change to the previously approved rate tables did not receive a final 60 day notice informing them of the approved rates from the previously approved rate adjustment filing. The revised rate adjustment filing must include a year’s worth of rates as discussed in the “Rolling Rate Structure” section above. (Example: A rolling rate filing was submitted and approved that included quarterly rolling rate tables for 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2012. The company can not revise the 1<sup>st</sup> and 2<sup>nd</sup> quarter 2012 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3<sup>rd</sup> and 4<sup>th</sup> quarter 2012 and 1<sup>st</sup> and 2<sup>nd</sup> quarter 2013.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened.</p>	
<p><b>STANDARD EXHIBITS 1 - 7</b></p>	<p>Introduction</p>	<p>Exhibits 1 through 7 must be submitted as part of each rate adjustment application. All exhibits, except Exhibit 3, must be submitted as a Microsoft Excel file and as an Adobe PDF file. For Exhibits 1-2 and 4-7 the supplied workbook must be used. Only use the first tab of each Excel workbook for data entry.</p>	<p>Supporting Document Tab</p>
<p><b>Exhibit 1</b></p>		<p><b>General information about the rate adjustment submission.</b></p> <p>a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit.</p> <p>b. Indicate the company type using the drop down list: Article 42 Accident and Health company (A&amp;H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&amp;C – 41), and Article 43 Non-Profit Medical and Dental Indemnity or Health and Hospital Service Corporations (Not for Profit – 43).</p> <p>c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list.</p> <p>d. Item D – the “new rate effective date” must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day final rate notice. This date would usually be the first date the proposed rates would</p>	

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		<p>affect renewing policyholders. So a 1/1/2013 effective date would imply that the first renewal cohort affected by the rate submission would be January 2013.</p> <p>e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected.</p> <p>f. This exhibit must be submitted as an Excel file and as an Adobe PDF file.</p>	
<b>Exhibit 2</b>		<p><b>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</b></p> <p>a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert more rows as needed. Only use the first tab for data entry.</p> <p>b. Use a separate row to enter information for each combination of market segment/rating pool included in this rate adjustment application. Use the drop down list to enter the market segment. Enter a description of the rating pool in the column indicated; if the rating pools vary by rating region, the rating pool identifier should include a region identifier. All market segments of Healthy New York are usually combined into one rating pool and in that case choose as market segment HNY-IND or HNY-SG based on which subpopulation has the most membership.</p> <p>c. Information is for medical base plans and all associated riders combined.</p> <p>d. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rate applicability period.</p> <p>e. The administrative expense components incorporated into the proposed rates are to be entered as a percentage of gross premium and as a per member per month amount.</p> <p>f. Enter the data for the rate period included in this rate adjustment filing. This refers to the various non-claim expense components included in the proposed rates and the average annualized claim trend assumed.</p> <p>g. Enter the data for the rate period included in the immediately prior rate adjustment filing (i.e., a section 3231(e)(1) or 4308(c) rate adjustment filing). This refers to the various non-claim expense components included in the proposed rates submitted with this prior filing and the average annualized claim trend assumed in this prior filing. If there is no immediately prior rate adjustment filing, enter the data assumed in the initial or prior form and rate filing.</p>	
<b>Exhibit 3</b>	Circular Letter No. 12 (2011)	<p><b>Narrative Summary.</b></p> <p>a. As indicated in Circular Letter No. 12 (2011), a draft of the narrative summary should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval</p>	

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		<p>Prefiling” filing type code.</p> <ul style="list-style-type: none"> <li>b. The format of the exhibit is illustrative, but must include the required material. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file. If submitted as a Word or Excel file, also submit another version in PDF format.</li> <li>c. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</li> <li>d. The narrative summary will be a public document.</li> <li>e. It is suggested that once reviewed by the Department, the company post the narrative summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for entering a user ID and password. Links should be provided on key pages of the company’s website so that the information may be easily located. Any change(s) to the narrative summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified. Narrative summaries should remain on the company’s website for at least 12 months past the proposed effective date of the rate submission.</li> <li>f. The narrative summary should include, but not be limited to, the following information:             <ul style="list-style-type: none"> <li>(i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application.</li> <li>(ii) A summary of the proposed rate adjustments.</li> <li>(iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the “street name” of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy).</li> <li>(iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples:                 <ul style="list-style-type: none"> <li>i. Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy.</li> <li>ii. A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy.</li> </ul> </li> <li>(v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission.</li> <li>(vi) An explanation, in plain language, as to why it is necessary to request such rate</li> </ul> </li> </ul>	
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		<p>change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type.</p> <p>Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	
<p><b>Exhibit 4</b></p>		<p><b>Summary of Proposed Percentage Rate Change to Existing Rate.</b></p> <p>a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing.</p> <p>(i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used.</p> <p>(ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used.</p> <p>(iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used.</p> <p>(iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used.</p> <p>b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment filing. Use the drop down list to enter the market segment.</p> <p>c. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for data entry.</p> <p>d. This exhibit is to summarize the proposed percentage rate changes. The percentage rate change is the percentage change from the rate the subscriber is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which are not being revised by the current rate application) to the proposed rate that this subscriber would be paying at the subscriber’s next rate change date according to the new rate application.</p> <p>Example 1: the rate structure is quarterly rolling rates, has a 12 month rate guarantee period, and the rate adjustment application is for second quarter 2013 issues and renewals. The rate change would be the percentage change from the second quarter 2012 rates to proposed second quarter 2013 rates.</p> <p>Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2013. The prior rate application included quarterly rolling rates for each quarter of 2012. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2012 before all the third and fourth quarter 2012 renewals have taken place. The proposed percentage change for fourth quarter 2013 would be the change from the fourth quarter 2012 rates to the proposed fourth quarter 2013 rates.</p> <p>e. If the subscriber will need to change to a different plan design at renewal (i.e., a</p>	

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		<p>required change from the current plan design whether mandated by a government entity or not, but not due to the discontinuation of the current policy form or discontinuation of a particular plan design), a supplement to Exhibit 4 is to be included. The supplemental exhibit is to indicate (i) a high level summary of the difference in covered benefits and cost sharing between the current and replacement plan, and (ii) the estimated pricing percentage change due solely to the difference in the plan designs between the replacement plan and the existing plan. This supplemental exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel file; if submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>f. The weighted averages are to be based on annualized premium as of a specific date. For simplicity, the weighted averages in Parts A and B can use the same annualized premium as used in the corresponding Exhibit 5. For Parts C and D, if drug annualized premium cannot be used, the insurer should use a reasonable alternative method to develop the weighted averages.</p> <p>g. The values entered should follow the organization of the rate manual. If the drug rate is included with the rates in the medical rate table, the combined result is entered in Part A and/or Part B. If the drug rate is a separate rate table associated with a drug rider, then the medical changes are shown in Part A and/or Part B and the drug rider changes are shown in Part C and/or Part D.</p> <p>h. Parts A and B summarize the proposed changes for the base medical rate tables and excludes the impact of all optional riders. The lowest and highest values indicate for a given market segment, region, policy form, product combination the lowest percentage change that applies to a renewing subscriber/contract holder and the highest percentage change that applies to a renewing subscriber/contract holder. This difference could be due to different percentage changes proposed by rating tier or by plan design within a particular product.          Example: The rate adjustment application is only for small group PPO and within this product there are only two product designs. The proposed rate changes for design A are: employee only = 10%, employee+child(ren) = 8%, employee+spouse = 13% and employee+family = 11%. The proposed rate change for design B are: employee only = 9%, employee+child(ren) = 7%, employee+spouse = 12% and employee+family = 10%. The lowest change proposed is 7% and the highest change proposed is 13%. The weighted average change would reflect the distribution of annualized premium by plan design and rating tier.</p> <p>i. Parts C and D summarize the proposed changes just for the traditional drug riders. <u>Exclude</u> minor drug related riders such as a rider to include oral contraceptives. All the drug riders available with a given base medical product can be aggregated into one row.          Example 1: Drug riders D1 to D99 are available with the PPO product. The</p>	
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		<p>proposed changes on the drug riders vary from 10% to 16%. There would be one row for the PPO policy form/product. The lowest change proposed is 10% and the highest change proposed is 16%. The weighted average change would reflect the distribution of annualized premiums (or other reasonable basis) by plan design and rating tier.</p> <p>Example 2: As in Example 1, but drug riders HD1-HD19 are available with the HSA high deductible PPO product. There would be another row for the high deductible PPO policy form/product indicating the lowest, highest, and weighted average changes among the HD1-HD19 drug riders.</p> <p>j. A separate row should be completed for each market segment. If the percentage rate change for sole proprietor is different from small group, then a separate market segment of sole proprietor is to be reported.</p> <p>k. Where rate changes differ by rating region within a market segment, separate rows are to be used by market segment/rating region combination.</p> <p>l. Separate information should be submitted for each rolling rate table of a rolling rate structure. For example: if a calendar quarterly rolling rate structure is used and the rate adjustment filing includes proposed rate tables for first, second, third and fourth quarters 2013, separate information should be entered in Parts B and D for the impact of the first quarter 2013 rate changes, the impact of the second quarter 2013 rate changes, the impact of the third quarter 2013 rate changes, and the impact of the fourth quarter 2013 rate changes.</p>	
<p><b>Exhibit 5</b></p>		<p><b>Distribution of Contracts Affected by the Proposed Rate Adjustments.</b></p> <p>a. There are two different versions of this exhibit as indicated below. Not all versions may be required for a given rate submission.</p> <p>(i) Part A – for use with <u>Non-Rolling</u> Rate Structures.</p> <p>(ii) Part B – for use with <u>Rolling</u> Rate Structures.</p> <p>b. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for data entry.</p> <p>c. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment submission. Use the drop down list to enter the market segment.</p> <p>d. This exhibit indicates the distribution of the proposed rate changes for each market segment, rating region and product, as well as the weighted average rate change impact for that segment/region/product combination. If the same percentage rate change applies to each rating region, then a separate break out by rating region is not necessary and the results can be shown for all rating regions combined.</p>	

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		<ul style="list-style-type: none"> <li>e. The distribution basis can be by number of contracts or by number of members – fill in the applicable column. The same basis is to be used for all products within a given rate adjustment submission. Enter the applicable counts in the appropriate column (members column or contracts column), and replace the “mm/dd/yyyy” placeholder with the applicable “as of” date for the counts entered.</li> <li>f. The Weighted Average % is to be developed based on the distribution of annualized premium as of the same “mm/dd/yy” date for that market segment/rating region/product.</li> <li>g. At the end of each market segment enter a Market Segment Total row indicating the member/contract counts in total and by rate change column, the total annualized premium, and the Weighted Average % for all rating regions/products in that market segment combined.</li> <li>h. The percentage rate change reflects the expected change in premium rate that would apply to that subscriber/contract holder on that subscriber/contract holder’s next rate change date according to the new rate application. This would reflect the percentage rate change from the rate the contract holder is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application) to the proposed rate that this contract holder would be paying at the contract holder’s next rate change date according to the new rate application The rate change reflects the impact of the base medical plans and all riders applicable to that contract.</li> <li>i. Enter in Part A the information for the various products that use a <u>non-rolling</u> rate structure.</li> <li>j. Enter in Part B the information for the various products that use a <u>rolling</u> rate structure. Separate rows are to be used for each rolling rate cohort. For example, if the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2013, then separate rows would be used to enter information for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.</li> </ul>	
<p><b>Exhibit 6</b></p>		<p><b>Summary of Policy Form and Product Changes.</b></p> <ul style="list-style-type: none"> <li>a. This exhibit summarizes all rate changes filed pursuant to sections of the New York Insurance Law other than Section 3231(e)(1) or Section 4308(c) that impact the policyholders affected by this rate adjustment filing and which affect the percentage changes shown on Exhibits 4 or 5.</li> <li>b. The format of the exhibit is fixed. Insert additional rows as needed. Only use the first tab for data entry. Use the drop down list to enter the filing status. Leave the Approval Date column blank for any filing that has not yet been approved. This</li> </ul>	

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		<p>exhibit must be submitted as an Excel file and also as an Adobe PDF file.</p> <p>c. List all rate filings that have been approved since the prior Section 3231(e)(1) or Section 4308(c) rate filing that impact the percentage rate change of the policyholders affected by this rate adjustment filing. The actuarial memorandum should include a brief description of such changes, when the changes were implemented, and the impact on the rate changes in Exhibits 4 and 5.</p> <p>d. List all rate filings currently pending with the Department that if approved would impact the percentage rate change of the policyholders affected by this rate adjustment submission. This includes any pending request to discontinue a policy form, product, or plan design option.</p>	
<p><b>Exhibit 7</b></p>		<p><b>Historical Data by Each Policy Form Included in the Rate Adjustment Filing.</b></p> <p>a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert additional rows as needed. Only use the first tab for data entry.</p> <p>b. Indicate the company name, the NAIC code number for that entity, and the SERFF filing number for the applicable rate filing in the spaces indicated.</p> <p>c. Use a separate row for each base medical policy form belonging to a rating pool (i.e., a permitted aggregation of base medical policy forms). Data is to be shown for each base medical policy form included in the rate adjustment filing even if no rate adjustment is proposed for that base medical policy form. Then add another row for the rating pool total and indicate an appropriate rating pool identifier in the first column. Skip a line and then enter similar data for the next rating pool.</p> <p>d. Indicate the form number for each base medical policy form, the product name as in the rate manual, the street product name, and the rating pool identifier (the rating pool identifier should include a region identifier if rating pools vary by region). Refer to Section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360) for the requirements to aggregate substantially similar policy forms for small group policy forms and for individual policy forms.</p> <p>e. Indicate for each base medical policy form if the policy form aggregation has changed from the previous rate filing. If yes, the actuarial memorandum must include an explanation of the change, the rationale for the change, and the percentage rate impact this change has on this policy form and on the policy forms previously aggregated with this policy form.</p> <p>f. The effective date of rate change refers to the proposed effective date of the non-rolling rate table, and/or the proposed effective date of the earliest rolling rate period of a rolling rate structure.</p> <p>g. The rate guarantee period refers to a non-rolling rate table and/or to the first rate table of a rolling rate structure. (If the rate guarantee period for the rolling rate</p>	

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		<p>structure is not the same for each rolling rate period, the actuarial memorandum must discuss this and explain why the length of the rate guarantee periods are not the same.)</p> <p>h. The weighted average rate change percentage proposed (from the rate currently charged the policyholder [or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application] to the proposed rate to be charged to that same cohort of policyholders) for the indicated base medical policy form, including all associated riders. The weighting should be consistent with how the average changes were calculated in Standard Exhibit 5 (i.e., based on members or contracts). For a rolling rate structure, enter the result for the first rate table in the rolling rate structure. (Example: a quarterly rolling rate filing was submitted that includes rolling rate tables for the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarters of 2013. Rates are for a 12 month period. Indicate the average rate change percentage from the 1<sup>st</sup> quarter of 2012 rate tables to the 1<sup>st</sup> quarter 2013 rate tables.)</p> <p>i. For the number of policyholders affected and the number of covered lives affected by this rate filing, indicate the effect of all the rate tables of a rolling rate structure included in the rate filing (but not more than 12 months of issues and renewals if more than 12 months of rolling rate tables are included in the rate filing). For group business, “policyholders” is referring to the number of groups, not the number of subscribers or contracts.</p> <p>j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the expected loss ratio incorporated into the rate tables of the first rolling rate period of the rolling rate structure.</p> <p>k. The experience entered for the three indicated experience periods is the New York statewide experience for the indicated base medical policy form plus all associated riders.</p> <p>(i) Each experience period is to be for 12 months (or shorter if a new form).</p> <p>(ii) The ending date of the recent experience period cannot be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2013. The recent experience period cannot have an ending date earlier than June 30, 2012, i.e., 12 months prior to July 1, 2013.)</p> <p>(iii) The first prior period is the immediately prior 12 month experience period (or shorter period if a new form). The second prior period is the immediately prior 12 month experience period (or shorter if a new form) prior to the first prior</p>	
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		<p>period.</p> <p>(iv) The incurred claims for each of the three experience periods must be based on at least 3 months of claims run-out beyond the end of the experience period. The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience period and how many months of claim run-out were reflected in the development of the incurred claims.</p> <p>(v) Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.</p> <p>l. Enter the average annual composite medical trend assumption used in the proposed rate development for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown, as well as any other component such as for case mix or intensity (identify and discuss and justify any such other component in the actuarial memorandum along with the utilization component and unit cost component).</p> <p>m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods.</p> <p>n. If the rating differential between the New York rating regions is being revised with this rate filing, separate rows are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined, and the rating pool identifier is to include a rating region identifier.</p>	
<b>ACTUARIAL MEMORANDUM</b>	11NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <p>a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and</p> <p>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</p>	supporting Document Tab
Justification of Rates	§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42	<p>a. Description of proposed changes in rates, including the following:</p> <p>(i) The member (or contract) weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to</p>	Actuarial Memo

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	<p>(HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p>	<p>that policy form (or currently scheduled to be charged at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application). This is to be shown for each non-rolling rate table and/or each rolling rate table included in the rate filing. (The percentage change is comparable to the percentage change developed for Standard Exhibit 5.) Include comparable information for percentage rate changes implemented during the prior 24 months.</p> <p>(ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3<sup>rd</sup> quarter 2013. The change from each of the 2<sup>nd</sup> quarter 2013 rolling rate tables to the corresponding 3<sup>rd</sup> quarter 2013 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated.</p> <p>(iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment filing, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive quarterly rate tables).</p> <p>(iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio.</p> <p>(v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate</p>	<p>Actuarial Memo</p>
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		<p>filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an exhibit showing how this variance and the percentage impact of this variance were developed.</p> <p>(viii) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition.</p> <p>b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department’s approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table.</p> <p>c. Include the following (year over year exhibit):</p> <p>(i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission.</p> <p>(ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2013 and first and second quarter 2014. Rates are for 12 month periods. Show the rates for the third quarter 2012, the proposed rates for the third quarter 2013, and the dollar and percentage change from third quarter 2012 to the proposed third quarter 2013 rates. Show a similar table for the proposed fourth quarter 2013, and first and second quarter 2014 rates as well.)</p> <p>d. Discuss the standard premium development used in Standard Exhibit 7. See</p>	
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		<p>discussion above on Standard Exhibit 7.</p> <p>e. Discuss the source data used to develop the projected incurred claims for the renewal rate applicability period.</p> <p>(i) If the source data is actual claims experience, the experience period is to be at least 12 months long, and the unpaid claim reserve is to be based on at least 3 months of claims run-out beyond the end of the experience period.</p> <p>(ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data.</p> <p>(iii) Discuss the credibility of such source data.</p> <p>(iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected incurred claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment.</p> <p>f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <p>(i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend.</p> <p>(ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components.</p> <p>(iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period.</p> <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <p>(i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for</p>	Actuarial Memo
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**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

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		<p>a rolling rate structure, how the percentage change from the existing 2<sup>nd</sup> quarter 2013 rate table to the proposed 3<sup>rd</sup> quarter 2013 rate table was developed for each rating element in the proposed rate table.) This demonstration must clearly show how the proposed rate change was developed from the projected source data, current rate level, and expected loss ratio. Provide justification for the percentage change proposed.</p> <p>(ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3<sup>rd</sup> quarter 2013 rate table to the 4<sup>th</sup> quarter 2013 rate table). Provide justification for these changes between the rolling rate tables.</p> <p>(iii) Clearly show how the proposed rate development, as applicable, reflects recoveries from the standard direct pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327), and discuss how the recovery amounts used were developed.</p> <p>(iv) Clearly show how the proposed rate development, as applicable, reflects payments to, or receipts from, the Department Regulation 146 (11 NYCRR 361) and New York Insurance Law Section 3233 marketing stabilization pool. Clearly discuss how the corporation has been complying with 11 NYCRR 361 (Regulation 146), Section 361.6(g), and include in the rate application any new plan pursuant to Section 361.6(g)(2)(i). Such discussion should include an exhibit showing how all monies received from the Regulation 146 pool from calendar years 2007 to date have been used to benefit consumers pursuant to the requirements of Section 361.6(g).</p> <p>(v) Discuss if the source data includes any very large claims on an individual, how such large claims have been handled, and any internal mechanism to pool large claims across more than the rating pool that contained the large claim. Clearly show how the rate development, if applicable, reflects this internal mechanism for pooling large claims.</p> <p>h. If the percentage rate change by benefit option differs within a particular policy form (or rider form), include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. Any assumed variation in utilization by benefit option within a particular policy form (or rider form) must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the policy form, and cannot be based on differences due to age, sex, health status or industry among the members selecting the different benefit options.</p> <p>i. If the percentage rate change by policy form differs within a permitted aggregation</p>	Actuarial Memo
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		<p>of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and cannot be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms.</p> <p>j. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions.</p> <p>k. Discuss any significant change in the non claim expense components indicated on Standard Exhibit 2 between the prior rate adjustment filing and this rate adjustment filing, including any item where the \$mpm value exceeds \$1 and where the \$mpm value changed by more than 10% between the prior filing and the current filing. Discuss the source for the non-claim expense components indicated on Standard Exhibit 2 for the current rate filing and, for the percentage of gross premium values, how the proposed rate change was reflected in the development of those percentage of gross premium factors (e.g., as premiums increase the percentage of premium should decrease for an expense that is not directly tied to premium). Discuss any revision to the expense allocation basis that has occurred since the last rate adjustment filing.</p>	Actuarial Memo
Minimum Loss Ratio Requirements	§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)	<p>a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010.</p> <p>b. The minimum loss ratio for the official Medicare Supplemental products is:</p> <p>(i) Article 43 companies: as specified in Section 4308(c)(3)(B) of the Insurance Law, as amended by Chapter 107 of the Laws of 2010; and</p> <p>(ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52).</p>	Actuarial Memo & Rate Manual

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

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

<p>Actuarial Certification</p>	<p>11NYCRR 52.40(a)(1)</p>	<ul style="list-style-type: none"> <li>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</li> <li>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.</li> <li>c. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions.</li> <li>d. The benefits are reasonable in relation to the premiums charged.</li> <li>e. The rates are not unfairly discriminatory.</li> </ul>	<p>Supporting document Tab</p>
<p><b>REVISED RATE MANUAL PAGES</b></p>	<p>11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)</p>	<p><b>Rate Manual.</b></p> <ul style="list-style-type: none"> <li>a. Table of contents.</li> <li>b. Rate pages, including a page indicating the composition of each rating region.</li> <li>c. Insurer/corporation name on each consecutively numbered rate page.</li> <li>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</li> <li>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</li> <li>f. Description of revised rating classes, factors and discounts, as applicable.</li> <li>g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design.</li> <li>h. Commission schedule(s) and fees.</li> <li>i. Underwriting guidelines and/or underwriting manual, to the extent applicable.</li> <li>j. Expected loss ratio(s).</li> </ul>	<p>Rate/Rule Tab</p>
<p><b>NOTICES TO POLICYHOLDERS Initial &amp; Final</b></p>	<p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p>	<ul style="list-style-type: none"> <li>a. As indicated in Circular Letter No. 12 (2011), a draft of the initial notice should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval Prefiling” filing type code.</li> <li>b. Include with the rate adjustment filing a sample copy of the initial written notice sent to policyholders and subscribers/contract holders of the proposed rate adjustment submitted to the Department of Financial Services. <ul style="list-style-type: none"> <li>(i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Department.</li> <li>(ii) If different notices are used for different products or different rating regions, submit a sample for each such product and/or each such rating region.</li> </ul> </li> </ul>	<p>Supporting Document Tab</p>

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

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

		<p>c. Include with the rate adjustment filing a sample copy of the final written notice to be sent to policyholders after the proposed rates are finalized.</p>	
<p><b>HHS PRELIMINARY JUSTIFICATION PARTS I AND II</b></p>	<p>PPACA §1003</p>	<p>a. This refers to the material that an insurer is required to submit to HHS for a rate adjustment filing on “grandfathered” business, or what would be submitted to HHS if the “subject to review” threshold was exceeded by this filing.</p> <p>b. For every rate submission pursuant to section 3231(e)(1) or section 4308(c) of the New York Insurance Law, the insurer is to submit Parts I and II of the U.S. Department of Health and Human Services (HHS) Preliminary Justification, whether or not such justification material is required to be submitted to HHS.</p> <p>c. This requirement applies to large group community rated products as well as to small group and individual products, and to non-grandfathered and grandfathered products, but this requirement does not apply to a product type that would never require such justification material to be submitted to HHS (for example: Medicare Supplemental products, stand-alone dental products).</p> <p>d. The justification material is to be prepared using the template and instructions provided by HHS.</p>	<p>URRT Supporting document Tab</p>
<p><b>PUBLIC DISCLOSURE OF THE RATE APPLICATION</b></p>		<p><b>Posting a Redacted Version of the Rate Adjustment Application to the Department’s Website.</b></p> <p>a. A redacted version of this rate application will be posted to the Department’s website to aid consumers’ understanding of the reason(s) for the requested rate change(s).</p> <p>b. The Department will accept redaction of only the following information in the rate application:</p> <p>(i) personally identifiable information, including names and contact information of actuaries or other individuals, including those who work for the health plan, a consulting firm, or the Department, that are contained in the application; and</p> <p>(ii) information that identifies in reasonably precise terms specific provider reimbursement rates contained in contracts between the health plan and a particular provider or formally affiliated provider group. Information that discloses trend, even specific trend, will <i>not</i> qualify for redaction. For example, if an insurer has a single pharmacy benefit manager (PBM), information about generic, brand and specialty drug costs per member will be disclosed. However, information about per unit dispensing fees paid to the PBM, or the level of rebates received, may be redacted.</p> <p>c. In order to expedite the posting of the redacted application to the Department’s website, the company is to attach within SERFF as a PDF file the redacted version of each document submitted with the application, including the completed</p>	<p>Narrative Summary Supporting document tab</p>

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

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

		<p>checklist, all of the standard exhibits, the actuarial memorandum plus any attachments or appendices, the rate manuals and year over year exhibits, as well as any other documentation submitted. A redacted attachment/file should be clearly labeled as a redacted version.</p> <p>d. The redacted version of the application that will be posted to the Department’s website will be constructed by the Department and will not be submitted to the insurer for prior review. <i>Where a document is attached to SERFF without a clearly labeled redacted version in PDF format, it will be assumed that no redactions are requested and the unredacted version of the document will be posted to the website as filed.</i></p>	
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**EXHIBIT 3  
NARRATIVE SUMMARY**

**Company Name:** Capital District Physicians' Health Plan, Inc.

**NAIC Code:** 95491

**SERFF Tracking #:** CAPD-129090271

Capital District Physicians' Health Plan, Inc. (CDPHP) offers a Health Maintenance Organization (HMO) product on a community rated basis to an employer group with 51 or more full time employees.

CDPHP has filed with the NYS Department of Financial Services a request for approval for changes to premium rates as follows:

	<b>Renewals Effective</b>			
	<b>01/01/2014 to 03/31/2014</b>	<b>04/01/2014 to 06/30/2014</b>	<b>07/01/2014 to 09/30/2014</b>	<b>10/01/2014 to 12/31/2014</b>
<b>Average Rate Adjustment *</b>	5.43%	5.37%	5.31%	5.25%
<b>Number of Policyholders Affected</b>	173	25	68	27
<b>Number of Members Affected</b>	69,009	3,256	10,177	4,029

\* Rate Adjustment will vary based on specific plan design

Large group HMO policyholders will receive the rate adjustments on the policyholder's next anniversary on or after January 1, 2014.

These increases are necessary due to changes in administrative expenses, correction for past pricing and to cover expected increases in claim costs due to the expected change in medical and pharmacy trend as discussed below.

Changes in administrative expenses will increase premiums 2.82%. This increase is due largely to fees associated with the Affordable Care Act.

Corrections for past pricing will reduce premiums -0.18%.

Due to changes in membership in the covered pool, CDPHP has adjusted underlying demographic assumptions used in the rate derivation by 1.67%.

In 2013 and 2014, CDPHP expects to see increases in utilization due to advances in medical technology, increased frequency of genetic testing, aging of the covered population, and increased use of pharmaceuticals used to manage rare and complex medical conditions. These increases will be held lower than industry trends due to CDPHP medical management programs which include care management, disease management, medical therapy management, hospital readmission avoidance, and the Enhanced Primary Care program, an innovative CDPHP program designed to improve

coordination of care and promote delivery of cost-effective services through greater use of technology and efficiency in the physician's office. Utilization of outpatient and office-based services will increase as CDPHP lowers utilization of more costly inpatient stays through case management.

The net overall utilization of medical services is expected to decrease by 0.1% for 2013 and to increase by 1.8% for 2014.

CDPHP negotiates reimbursement rates with hospitals on an annual or semi-annual basis. CDPHP's negotiated increases in rates for hospitals for inpatient and outpatient services averaged 5.3% in 2013. For 2014, CDPHP is targeting 6.4%.

CDPHP's physician fee schedule was increased by 2.75% in 2013 and is estimated to increase by 2.4% in 2014.

The expected average overall annual medical cost increase, based on the above factors, is 5.20% for 2013 and for 2014.

CDPHP contracts with CVS Caremark for pharmacy benefit management. Projected increase in pharmacy utilization is 2.5% annually. Pharmacy per script cost is projected to decrease by 2.0% in 2013 and increase by 4.1% in 2014. Pharmacy rebates are expected to remain flat from 2013 to 2014. Based on these factors, average pharmacy costs are projected to decrease by 1.6% in 2013 and increase by 8.1% in 2014.



[Date]

Group Number: «Group\_ID»

Health Benefits Administrator

«Group\_Name»

«Group\_Address»

«Group\_Address\_2»

«Group\_City», «Group\_State» «Group\_Zip»

**Re: Notice of Premium Rates for 2013**

Dear Health Benefits Administrator:

As you may know, New York State requires health plans to submit proposed premium rates to the New York State Department of Financial Services (NYSDFS) for review and approval.

This letter is to inform you that the premium rate listed below was approved by NYSDFS and will be effective as of [Date].

<b>Proposed 2013 Benefit Package</b>	
<b>Medical Plan:</b>	«Product_Type» «Rider1»
<b>Office Visit Copay:</b>	\$«OV_Copay»
<b>Specialist Visit Copay:</b>	\$«Spec_Copay»
<b>In-Network Deductible:</b>	N/A
<b>In-Network Coinsurance:</b>	N/A
<b>Rx Rider:</b>	«Description2»
<b>Other Riders:</b>	Domestic Partner-Same or Opposite Sex
	«Description3»
	«Description4»
	«Description5»
	«Description6»
<b>Proposed Monthly Premium on Your 2013 Effective Date</b>	
<b>Individual</b>	\$«rate1»
<b>Employee+1</b>	\$«rate2»
<b>Employee/Child</b>	\$«rate3»
<b>Family</b>	\$«rate4»
<b>Current Monthly Premium</b>	
<b>Individual</b>	\$«Individual_Total_Old»
<b>Employee+1</b>	\$«Employee1_Total_Old»
<b>Employee/Child</b>	\$«EmployeeChild_Total_Old»
<b>Family</b>	\$«Family_Total_Old»

The premium rates above are for your existing plan and do not reflect any changes that you, as the health benefits administrator, may be making for 2013.

If you are interested in reviewing an alternative CDPHP® plan to cost-effectively meet the needs of your employees, our staff is ready to assist you and your broker.

Enclosed is a copy of a notice that employees enrolled in your CDPHP HMO plan are required to receive. If, for any reason, you are unable or unwilling to deliver these notices to your employees, please let us know within three business days by contacting us at employerinfo@cdphp.com. We

also recommend providing additional information with the notice, such as employee contribution levels, as the notice may be confusing to employees.

If you have questions or wish to request a PDF or extra copies of the member notice, please contact us as shown below, and indicate the correct contact person, address, and quantity desired. Thank you.

CDPHP  
Att: Broker/Client Service Unit  
500 Patroon Creek Blvd.  
Albany, NY 12206

employerinfo@cdphp.com  
(518) 641-5000

Sincerely,

[Redacted Signature]

[Redacted Title]

CDPHP

cc: «Broker\_Name»

[Date]

**Re: Notice of Premium Rates for 2013**

As you may know, a new law in New York State requires health plans to submit proposed premium rates to the New York State Department of Financial Services (NYSDFS) for review and approval.

This letter is to inform you that the premium rates listed below are approved by NYSDFS and will be effective as of [Date].

<b>Proposed 2013 Benefit Package</b>	
<b>Medical Plan:</b>	«Product_Type» «Rider1»
<b>Office Visit Copay:</b>	\$«OV_Copay»
<b>Specialist Visit Copay:</b>	\$«Spec_Copay»
<b>In-Network Deductible:</b>	N/A
<b>In-Network Coinsurance:</b>	N/A
<b>Rx Rider:</b>	«Description2»
<b>Other Riders:</b>	Domestic Partner-Same or Opposite Sex
	«Description3»
	«Description4»
	«Description5»
	«Description6»
<b>Proposed Monthly Premium on Your 2013 Effective Date</b>	
<b>Individual</b>	\$«rate1»
<b>Employee+1</b>	\$«rate2»
<b>Employee/Child</b>	\$«rate3»
<b>Family</b>	\$«rate4»
<b>Current Monthly Premium</b>	
<b>Individual</b>	\$«Individual_Total_Old»
<b>Employee+1</b>	\$«Employee1_Total_Old»
<b>Employee/Child</b>	\$«EmployeeChild_Total_Old»
<b>Family</b>	\$«Family_Total_Old»

The rates shown above do not reflect any benefit changes that your employer may make for 2013. It is also important to recall that details on premium cost-sharing are between you and your employer.

If you have any questions about your benefits, please speak with your employer's health benefits administrator or call the CDPHP member services department at the number on your member ID card. Thank you for your membership in CDPHP.

CDPHP®  
500 Patroon Creek Blvd.  
Albany, NY 12206-1057



[date]

[Contact Name]  
[Group Name]  
[Address]  
[City State Zip]

Group ID#  
Plan Code:

Dear Employer Group Contact:

Capital District Physicians' Health Plan Inc. (CDPHP®) will be filing a request for approval to adjust 2014 large group community-rated premiums with the Department of Financial Services (NYSDFS). The New York Insurance Law requires that health insurers provide an initial notice to you when we submit requests for premium rate adjustment to the Superintendent of Financial Services. The requested rate adjustment for the large group HMO product that you offer your employees is \_\_%. Please note that the Superintendent of Financial Services may approve, modify, or disapprove the rate adjustment request. This letter is giving you notice that CDPHP is filing a rate adjustment request with NYSDFS.

You have 30 days from the date CDPHP submits its request to contact CDPHP or NYSDFS to request additional information about the rate change, or to submit written comments to NYSDFS. We anticipate submitting our request on July 15, 2013. You may also contact CDPHP to learn the start and end dates of the comment period. You can submit your comment to the Department online at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>, email to [PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov), or mail to NYSDFS. Any written comments you submit to NYSDFS should include CDPHP as your insurer and Large Group HMO as your policy. Comments submitted to NYSDFS will be posted on the DFS website with personally identifying information redacted. You can find contact information for CDPHP and NYSDFS's address on the reverse side of this letter.

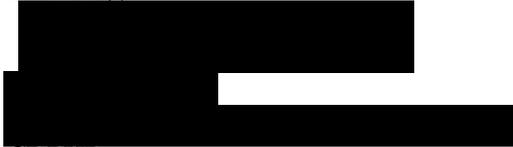
These premium rate changes are necessary due to expected increases in claim costs due to the increase in medical and pharmacy trend, correction for past pricing and a change in administrative expenses. In 2014, CDPHP expects to see increases in medical care utilization due to advances in medical technology, genetic testing, aging of the population, and improvement in the economy. These increases will be held lower than industry trends due to CDPHP medical management programs including disease management, medical therapy management, and programs targeted to improve quality of care and cost-effectiveness in the physician's office.

CDPHP has prepared a narrative summary that provides a detailed, plain English explanation of the reason or reasons for seeking an adjustment. You may view the narrative by visiting our website at [www.cdphp.com/members](http://www.cdphp.com/members) or the Department's website at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>.

You will receive details on your rates at least 60 days before your benefits renewal date. If you are interested in reviewing one of our other cost-effective plans to meet the needs of your employees, our staff is ready to assist you and your broker. After NYSDFS makes the final decision, CDPHP will send you a final notice of the approved rate adjustment for your current benefit at least 60 days before your benefit renewal date.

Enclosed is a copy of a notice that employees enrolled in your CDPHP group plan are required to receive. If you are unable or unwilling to deliver these notices to your employees, please let us know within three business days by contacting us at [employerinfo@cdphp.com](mailto:employerinfo@cdphp.com). We also recommend providing additional information with the notice, such as employee contribution levels, as the notice may be confusing to employees. If you would prefer a PDF of the document, or need additional copies, please contact us as shown on the reverse, and indicate the correct contact person, address, and quantity desired.

Sincerely,

A large black rectangular redaction box covering the signature and name of the sender.

CDPHP

CDPHP  
Att.: Membership & Billing  
500 Patroon Creek Blvd.  
Albany, NY 12206-1057

[employerinfo@cdphp.com](mailto:employerinfo@cdphp.com)

(518) 641-3900

Health Bureau—Premium Rate Adjustments  
NYS Dept. of Financial Services  
One State Street, 2<sup>nd</sup> Floor  
New York, NY 10004-1511

<https://myportal.dfs.ny.gov/web/prior-approval/welcome>

[PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov)



### **Important Information for CDPHP Members**

Capital District Physicians' Health Plan Inc. (CDPHP®) will be filing a request for approval to adjust 2014 large group community-rated premiums with the Department of Financial Services (NYSDFS). The New York Insurance Law requires that health insurers provide an initial notice to you when we submit requests for premium rate adjustment to the Superintendent of Financial Services. The requested rate adjustment for the large group HMO product that you offer your employees is \_\_%. Please note that the Superintendent of Financial Services may approve, modify, or disapprove the rate adjustment request. This letter is giving you notice that CDPHP is filing a rate adjustment request with NYSDFS.

You have 30 days from the date CDPHP submits its request to contact CDPHP or NYSDFS to request additional information about the rate change, or to submit written comments to NYSDFS. We anticipate submitting our request on July 15, 2013. You may also contact CDPHP to learn the start and end dates of the comment period. You can submit your comment to the Department online at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>, email to PremiumRateIncreases@dfs.ny.gov, or mail to NYSDFS. Any written comments you submit to NYSDFS should include CDPHP as your insurer and Large Group HMO as your policy. Comments submitted to NYSDFS will be posted on the DFS website with personally identifying information redacted. You can find contact information for CDPHP and NYSDFS's address on the reverse side of this letter.

These premium rate changes are necessary due to expected increases in claim costs due to the increase in medical and pharmacy trend, correction for past pricing and a change in administrative expenses. In 2014, CDPHP expects to see increases in medical care utilization due to advances in medical technology, genetic testing, aging of the population, and improvement in the economy. These increases will be held lower than industry trends due to CDPHP medical management programs including disease management, medical therapy management, and programs targeted to improve quality of care and cost-effectiveness in the physician's office.

CDPHP has prepared a narrative summary that provides a detailed, plain English explanation of the reason or reasons for seeking an adjustment. You may view the narrative by visiting our website at [www.cdphp.com/members](http://www.cdphp.com/members) or the Department's website at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>.

The proposed percentage above does not reflect any benefit changes that your employer may make. It is also important to note that details on premium cost-sharing are between you and your employer. Therefore, the percentage of change in your payroll deduction may differ from the percentage stated above. You will receive details on your rates at least 60 days before your benefits renewal date. After NYSDFS makes the final decision, CDPHP will send you a final notice of the approved rate adjustment for your current benefit at least 60 days before your benefit renewal date.

CDPHP  
Att.: Member Services  
500 Patroon Creek Blvd.  
Albany, NY 12206-1057

Health Bureau—Premium Rate Adjustments  
NYS Dept. of Financial Services  
One State Street, 2<sup>nd</sup> Floor  
New York, NY 10004-1511

[www.cdphp.com](http://www.cdphp.com)

<https://myportal.dfs.ny.gov/web/prior-approval/welcome>

1-800-777-2273

[PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov)

**Capital District Physicians' Health Plan  
Premium Rate Filing  
Forms #01-0001-2010, 01-0002-2010; 01-0004-2012**

**ACTUARIAL MEMORANDUM**

**Large Group HMO**

**Base Medical Plans, Medical Riders, and Pharmacy Riders**

**General Information**

**Company Legal Name:** Capital District Physicians' Health Plan

**State:** New York

**HIOS Issuer ID:** 94788

**SERFF #:** CAPD - 129090271

**Market:** Large Group

**Effective Date:** January – December 2014

**Primary Contact Name:**

**Primary Contact Telephone Number:** 518-641-

**Primary Contact Email Address:** \_\_\_\_\_

Capital District Physicians' Health Plan (CDPHP) offers a Health Maintenance Organization (HMO) and High Deductible HMO (HDHMO) product on a community rated basis to large employer groups (>50 employees). This filing explains the development of the pure renewal rates for existing benefit plans for Q1-Q4 2014.

**Overview**

This document contains the Actuarial Memorandum for Capital District Physicians' Health Plan, Inc.'s ("CDPHP") large group comprehensive medical block of business, effective January 1, 2014. These large group rates are guaranteed 12 months following the group's effective date.

The information in this actuarial memorandum has been prepared for the use of CDPHP. We understand that this actuarial memorandum will be provided to the New York State Department of Financial Services, the Center for Consumer Information and Insurance Oversight (CCIIO), and their subcontractors to assist in the review of CDPHP's rate filing process. We understand that the information provided may be considered public documents, and, as such, may be subject to disclosure to other third parties. Milliman makes no representations or warranties regarding the contents of this actuarial memorandum or rate filing to third parties. Likewise, third parties are to place no reliance upon this actuarial memorandum or rate filing prepared for CDPHP by Milliman that would create any legal duty under any theory of law by Milliman to any third party.

The analysis in this report is based on our current understanding of federal and state rules and regulations. To the extent that these rules and regulations continue to evolve, our work may be subject to change. Milliman is not a law firm. Nothing in this correspondence should be construed as legal advice. In the event a legal interpretation is required, we recommend review by your legal counsel.

**Capital District Physicians' Health Plan  
Premium Rate Filing  
Forms #01-0001-2010, 01-0002-2010; 01-0004-2012**

**Reliance**

In performing this analysis, I relied on data and other information provided by CDPHP. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

A data reliance letter is included in this rate submission.

**Identification**

I, , Principal and Consulting Actuary, am associated with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and have been retained by Capital District Physicians' Health Plan, Inc. with regard to rate setting and related items. I meet the Academy qualification standards for rendering this opinion.

**Justification of Rates**

**a. (i) Member weighted average proposed percentage change over the current rates charged**

1st Quarter 2014 over 1st Quarter 2013	Large Group
Current Year	5.43%
Prior Year 1	6.87%
Prior Year 2	1.91%
2nd Quarter 2014 over 2nd Quarter 2013	Large Group
Current Year	5.37%
Prior Year 1	6.45%
Prior Year 2	1.10%
3rd Quarter 2014 over 3rd Quarter 2013	Large Group
Current Year	5.31%
Prior Year 1	6.03%
Prior Year 2	6.06%
4th Quarter 2014 over 4th Quarter 2013	Large Group
Current Year	5.25%
Prior Year 1	5.61%
Prior Year 2	5.77%

**Capital District Physicians' Health Plan  
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**(ii) Percentage Change over prior quarter**

<b>Period</b>	<b>Large Group</b>
1st Quarter 2014 over 4th Quarter 2013	-0.65%
2nd Quarter 2014 over 1st Quarter 2014	1.38%
3rd Quarter 2014 over 2nd Quarter 2014	1.38%
4th Quarter 2014 over 3rd Quarter 2014	1.38%

**(iii) Quarterly Percentage Change over prior 24-month period**

		<b>Large Group</b>		
		Medical	Pharmacy	Total
2012	Q1	0.14%	0.14%	0.14%
	Q2	1.84%	1.84%	1.84%
	Q3	1.84%	1.84%	1.84%
	Q4	1.84%	1.84%	1.84%
2013	Q1	1.18%	1.18%	1.18%
	Q2	1.44%	1.44%	1.44%
	Q3	1.44%	1.44%	1.44%
	Q4	1.44%	1.44%	1.44%

**(iv) Percentage change due to any change in the projected loss ratio from the prior rate filing**

CDPHP revised its target loss ratio for 2014 by projecting membership, administrative expenses, broker commissions, and contribution to reserves and surplus. This provided an estimate of total revenue. The retention for CY 2014 compared to the prior filing is as follows:

	<b>Large Group</b>		
	Prior Filing 2013	This Filing 2014	Change
Administration	10.37%	9.53%	
Contribution to Reserves & Surplus	1.50%	1.50%	
Commissions	1.51%	1.58%	
Total	13.38%	12.61%	
ACA related Fees	n/a	3.15%	
<b>Expected Incurred Loss Ratio</b>	<b>86.62%</b>	<b>84.24%</b>	<b>2.82%</b>

**Capital District Physicians' Health Plan**  
**Premium Rate Filing**  
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(v) **Tier structure relationships:** No change

(vi) **Conversion factors**

The conversion factor has been updated to reflect the change in membership distribution for the Large Group HMO pool. See Exhibit VI of Rating Manual.

(vii) **Variance**

Additional run-out indicated an adjustment to the prior year pricing due to over/understatement of claims incurred than expected, detailed calculation of this adjustment can be found on Exhibit C-2

(viii) **Regional factors:**

CDPHP is aligning Large Group rating regions to match the Small Group HMO market filings. Regional factors are shown in Exhibit VII of Rating Manual.

**b. New benefit options**

Effective 1/1/2014 all plan designs with an unlimited OOP Maximum will now have a limit of \$6350 for Individual and \$12700 for Family, as required under the ACA. The language for this change has been filed as an amendment under SERFF ID: CAPD-129097858.

**c. Changes in rate tables**

The dollar change and percentage change per each rolling rate table is shown in the rate manual.

**d. Standardized Premium Development**

The standardized premium shown in Exhibit 7 was generated using a similar methodology as the previous filing. The quarterly increases used were from previously approved filings. Renewals by month indicate 2013 group renewals. See Exhibit A for the standardized premium calculation.

**e. Source Data used to develop the claims projected for the renewal rate applicability period**

(i) The data used in the development of the renewal rate period CDPHP medical expenses is based on incurred claims and membership for the 12 months ending December 31, 2012 with runout through April 30, 2013. Completion to fully incurred levels was accomplished by adding an estimate of incurred but not reported claims (IBNR).

(ii) Not applicable

(iii) The source data is considered 100% credible with 1,113,587 member months for large groups, and a full year of claims data.

**Capital District Physicians' Health Plan  
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Forms #01-0001-2010, 01-0002-2010; 01-0004-2012**

**(iv) Adjustment made to source data to develop the projected claims for the renewal rate applicability period**

Exhibits C and C-2 show the derivation of the necessary increase due to claims trend and correction of past pricing.

**f. Assumed annualized claim trend factors**

The following table provides a summary of the utilization and cost assumptions used in CDPHP's claim projections for the commercial lines of business. Composite trend factors provided in section (i) are derived based on the distribution of services within each rate pool. These factors were derived from an analysis of historical data, actual and projected contract provider reimbursement rates, and input by CDPHP's medical utilization management team. See Exhibit IV.

**(i) Composite Trend Factors**

Large Group: For the base medical benefits and for the medical riders, this data was trended to 2013 and 2014 rate effective periods using an annual trend of 5.2%. For the pharmacy riders, the data was trended to the same basis using a trend of -1.55% for 2013 and 8.10% to 2014.

**(ii) Composite Utilization and Cost Components**

	2013		2014	
Large Group	Utilization	Cost	Utilization	Cost
Medical	-0.07%	4.15%	1.75 %	4.89%
Pharmacy	2.50%	-3.28%	2.50%	4.49%

**(iii) Application of annualized trend factors**

Please refer to Exhibit C.

**g. Actuarial justification of proposed rate change.**

**(i) Combined Overall Annual Rate Changes**

	Q1 2014	Q2 2014	Q3 2014	Q4 2014
Large Group	5.43%	5.37%	5.31%	5.25%

See Exhibit C-2 for actuarial justification of the proposed rate changes by quarter.

**Capital District Physicians' Health Plan  
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Forms #01-0001-2010, 01-0002-2010; 01-0004-2012**

**(ii) Provide justification for changes between the rolling rate tables.**

See Exhibit C-2 for actuarial justification of the proposed rate changes.

**(iii) Standard Direct Pay and Healthy NY stop loss pools**

Not Applicable

**(iv) Regulation 146 and Market Stabilization pool**

Not Applicable

**(v) Large Claims**

The net reinsurance for each market segment has been included in the underlying claims data. The impact on a per member per month (PMPM) basis is \$0.73 for Large Group.

**h. Demonstration of rate change by benefit option (if variable)**

CDPHP is proposing a pricing adjustment to the benefit option relativities. This adjustment is being made to more accurately reflect claim costs by benefit option. The following data was used in the re-pricing:

- 2012 CDPHP HMO cost and utilization experience (All Regions Large Group)
- 2012 CDPHP HMO membership (All Regions Large Group)
- CDPHP allowed trend assumptions provided by CDPHP's Medical Affairs department
- Milliman's 2011 Commercial Managed Care Rating Model

Milliman's 2011 Rating Model was used to produce a starting point PMPM for each benefit option. The PMPMs were used to determine the relativity between each plan design for 2013. The 2014 PMPMs were developed by applying trend to the 2013 PMPMs and adjusting for the change in relativity. The individual rate was calculated by multiplying the PMPM by the conversion factor and dividing by the expected loss ratio. Exhibit D outlines how this calculation was performed.

**i. Demonstration of rate change by permitted aggregation of policy forms (if variable)**

Not Applicable

**j. Demonstration of rate change by rating region (if variable)**

Not applicable

**Capital District Physicians' Health Plan  
Premium Rate Filing  
Forms #01-0001-2010, 01-0002-2010; 01-0004-2012**

**k. Non-claim expense components**

	<b>Large Group</b>	
	Percentage	PMPM
Regulatory licenses and fees	0.81%	\$3.78
Admin fees for activities that improve health care quality	0.92%	\$4.29
Commissions/broker fees	1.58%	\$7.37
Premium Taxes (ACA fees)	3.15%	\$14.70
Other Admin Expenses	7.80%	\$36.40
After-tax profit/contribution to surplus	1.50%	\$7.00
State income taxes	0.00%	0.00
Federal income taxes	0.00%	0.00
Reduction for net investment income	0.00%	0.00
Total of the above	15.76%	\$73.54

Where possible, expenses are recorded directly to products. If this is not possible, expenses are allocated across companies and products. Administrative expenses are primarily incurred by Capital District Physicians' Health Plan, Inc (CDPHP) and are allocated according the following methodology:

The costs aggregated by cost center include the salary expense, fringe and other administrative costs directly incurred in that function. Rent expense is allocated to each cost center based on budgeted full-time employees (FTEs). Fringe expense is allocated to each cost center based upon payroll expense. Leasehold improvements and cubicles depreciation is allocated to cost centers based on budgeted FTEs.

Where costs aggregated by cost center are not booked directly to specific products, CDPHP allocates expenses across companies and products by applying statistical metrics by cost center. Each cost center has provided Cost Accounting a statistical metric to allocate their indirect administrative expenses to companies and products. The metrics are generally activity based for operational functions. Overhead related functions generally utilize member months.

**Minimum Loss Ratio Requirements**

The minimum loss ratio required for the Large Group community rated products in this filing is 85%. The targeted MLR in this filing is 88.67%.

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

A.	Insurer Information: <u>Captial District Physicians' Health Plan</u> Company submitting the rate adjustment request  500 Patroon Creek Boulevard, Albany NY 12206  Company mailing address	<u>HMO - 44</u> Company Type	<u>Not-for-Profit</u> Org. Type	<u>95491</u> Company NAIC Code
B.	Contact Person: _____ Rate filing contact person name, title	_____ Contact phone number	_____ Contact Email address	
C.	Actuarial Contact (If different from above): _____ Actuary name, title	_____ Actuary phone number	_____ Actuary Email address	
D.	New Rate Information (See Note #1): <u>January 1, 2014 - December 31, 2014</u> New rate applicability period	_____ New rate effective date	<u>1/1/2014</u>	<u>CAPD-129090271</u> SERFF Tracking Number
E.	Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement): <u>Large Group HMO</u>			
F.	Provide responses for the following questions: <span style="float: right;"><b>Response</b></span>			
	1. Does this filing include any revision to contract language that is not yet approved? See note (2).	No		
	2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No		
	3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Yes July 16, 2014		
	4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	Yes		
	5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	Yes, CAPD-129091129		

Notes:

- (1) It is recommended that a rate filing application subject to §3231(e)(1) or §4308(c) of the New York Insurance Law be submitted at least 150 days before the proposed effective date. It is recommended that a rate adjustment application not be submitted more than 180 days prior to the proposed effective date. It is recommended that a rate adjustment application not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing.
- (2) A rate adjustment filing submitted pursuant to §3231(e)(1) or §4308(c) of the New York Insurance Law should **not** include any revision to existing contract language or include new contract language. Any rate filing in connection with a form filing, a new form or a revision to an existing form, must be a separate filing from the rate adjustment filing.  
 Use the following SERFF filing types for rate adjustment filings:
  - \* For a rate adjustment filing pursuant to §3231(e)(1): Rate Adjustment pursuant to §3231(e)(1)
  - \* For a rate adjustment filing pursuant to §4308(c): Rate Adjustment pursuant to §4308(c)
  - \* For all other prior approval filings: Normal Pre-Approval
- (3) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Insurance Department.

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

Company Name: Capital District Physicians' Health Plan  
 NAIC Code: 95491  
 SERFF Number: CAPD-129090271

- A. Complete a separate ROW for each market segment/rating pool combination included in the current rate adjustment filing:
- Information should be for medical base plans and associated riders combined.
  - Indicate the market segment the rating pool belongs to by using the drop down list. Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-IND), Small Group Medicare Supplement (MS-SG), and Large Group Medicare Supplement (MS-LG). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group.
  - Enter a description of the rating pool within the indicated market segment. If the rating pools vary by rating region, the rating pool description should include a region identifier (eg., SG HMO Downstate, SG HMO Upstate).
  - Use a separate row for each market segment/rating pool combination included in the current rate adjustment filing.
  - Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.
- B. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
- C. Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components included in the proposed rates and the average annual claim trend assumed.
- D. Enter the corresponding information requested for the immediately prior rate adjustment filing. This refers to the various expense components included in the proposed rates submitted with the immediately prior rate adjustment filing and the average claim trend assumed. If there is no immediately prior rate adjustment filing, enter the data from the initial form and rate filing.
- E. This form must be submitted as an Excel file and as a PDF file.

Data Item for Specified Rating Pool																														
For the period included in this rate adjustment filing																														
1. Market Segment	2. Description of rating pool within the market segment	3. Period assumed - beginning date (MM/DD/Y)	4. Period assumed - ending date (MM/DD/Y)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	12.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	12.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	12.3 Commissions and broker fees - as \$mpm	12.4 Premium Taxes - as \$mpm	12.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as \$mpm	12.6 Other administrative expenses - as \$mpm	12.7 Subtotal columns 12.1 through 12.6	13. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	14. State income tax component - as \$mpm	15. Federal income tax component - as \$mpm	16. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	17. Subtotal columns 12.7 through 16
LG	HMO	XX 01/01/14	12/31/14	5.67%	0.81%	0.92%	1.58%	0.00%	3.15%	3.12%	9.58%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	11.08%	3.78	4.29	7.37	0.00	14.70	14.56	44.70	7.00	0.00	0.00	0.00	51.70
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**EXHIBIT 3  
NARRATIVE SUMMARY**

**Company Name:** Capital District Physicians' Health Plan, Inc.

**NAIC Code:** 95491

**SERFF Tracking #:** CAPD-129090271

Capital District Physicians' Health Plan, Inc. (CDPHP) offers a Health Maintenance Organization (HMO) product on a community rated basis to an employer group with 51 or more full time employees.

CDPHP has filed with the NYS Department of Financial Services a request for approval for changes to premium rates as follows:

	<b>Renewals Effective</b>			
	<b>01/01/2014 to 03/31/2014</b>	<b>04/01/2014 to 06/30/2014</b>	<b>07/01/2014 to 09/30/2014</b>	<b>10/01/2014 to 12/31/2014</b>
<b>Average Rate Adjustment *</b>	5.43%	5.37%	5.31%	5.25%
<b>Number of Policyholders Affected</b>	173	25	68	27
<b>Number of Members Affected</b>	69,009	3,256	10,177	4,029

\* Rate Adjustment will vary based on specific plan design

Large group HMO policyholders will receive the rate adjustments on the policyholder's next anniversary on or after January 1, 2014.

These increases are necessary due to changes in administrative expenses, correction for past pricing and to cover expected increases in claim costs due to the expected change in medical and pharmacy trend as discussed below.

Changes in administrative expenses will increase premiums 2.82%. This increase is due largely to fees associated with the Affordable Care Act.

Corrections for past pricing will reduce premiums -0.18%.

Due to changes in membership in the covered pool, CDPHP has adjusted underlying demographic assumptions used in the rate derivation by 1.67%.

In 2013 and 2014, CDPHP expects to see increases in utilization due to advances in medical technology, increased frequency of genetic testing, aging of the covered population, and increased use of pharmaceuticals used to manage rare and complex medical conditions. These increases will be held lower than industry trends due to CDPHP medical management programs which include care management, disease management, medical therapy management, hospital readmission avoidance, and the Enhanced Primary Care program, an innovative CDPHP program designed to improve

coordination of care and promote delivery of cost-effective services through greater use of technology and efficiency in the physician's office. Utilization of outpatient and office-based services will increase as CDPHP lowers utilization of more costly inpatient stays through case management.

The net overall utilization of medical services is expected to decrease by 0.1% for 2013 and to increase by 1.8% for 2014.

CDPHP negotiates reimbursement rates with hospitals on an annual or semi-annual basis. CDPHP's negotiated increases in rates for hospitals for inpatient and outpatient services averaged 5.3% in 2013. For 2014, CDPHP is targeting 6.4%.

CDPHP's physician fee schedule was increased by 2.75% in 2013 and is estimated to increase by 2.4% in 2014.

The expected average overall annual medical cost increase, based on the above factors, is 5.20% for 2013 and for 2014.

CDPHP contracts with CVS Caremark for pharmacy benefit management. Projected increase in pharmacy utilization is 2.5% annually. Pharmacy per script cost is projected to decrease by 2.0% in 2013 and increase by 4.1% in 2014. Pharmacy rebates are expected to remain flat from 2013 to 2014. Based on these factors, average pharmacy costs are projected to decrease by 1.6% in 2013 and increase by 8.1% in 2014.

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

### -- for Base Medical Plan with ROLLING Rate Structure

Capital District Physicians' Health P  
Company submitting the rate adjustment request

95491  
Company NAIC Code

CAPD-129090271  
SERFF tracking number

- => Use this Exhibit for the base medical plan type policy forms/products with ROLLING rate structure that are included in the rate adjustment submission.
- => This form must be submitted as an Excel file and as a PDF file.
- => The format of this exhibit is discussed below. Insert more rows as needed. Only use the first tab for data entry.
- => Market segment refers to Individual (IND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), and Group Medicare Supplement (MS-GRP). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- => The proposed percentage rate change reflects the expected change in premium rate that would apply to the contract holder on that contract holder's next rate change date for each contract holder with the indicated base medical plan.
- => The effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure.)
- => The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- => Provide a list of proposed rate changes for each base medical plan type, by product name/street name. If one policy form is used for more than one product, then a separate row should be entered for each policy form/product name/product street name combination.
- => The "proposed rate change" is just for the base medical product, excluding the impact of any riders.
  - Lowest should be the smallest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
  - Highest should be the largest percentage change that could affect any contract holder due to the proposed rate filing with that base medical product; the impact of riders is not included.
  - **The weighted average percentage should be developed based on annualized premium volume for that market segment/rating region/base medical product; the impact of riders is not included.**

#### Base Medical Plan Rolling Rate Products

SERFF#      CAPD-129090271

Policy Form #	Market Segment	Rating Region	Product Name	Product Street Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
01-0001-2010	LG	Region 1 (Albany)	HMO	HMO	01/01/2014	Q1 2014	3.86%	12.07%	6.57%
01-0001-2010	LG	Region 1 (Albany)	HMO	HMO	04/01/2014	Q2 2014	3.80%	12.01%	7.54%
01-0001-2010	LG	Region 1 (Albany)	HMO	HMO	07/01/2014	Q3 2014	3.75%	11.94%	6.99%
01-0001-2010	LG	Region 1 (Albany)	HMO	HMO	10/01/2014	Q4 2014	3.69%	11.88%	7.32%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO	HMO	01/01/2014	Q1 2014	-3.43%	6.65%	1.81%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO	HMO	04/01/2014	Q2 2014	-3.49%	6.59%	0.00%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO	HMO	07/01/2014	Q3 2014	-3.54%	6.53%	1.35%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO	HMO	10/01/2014	Q4 2014	-3.60%	6.47%	1.49%
01-0001-2010	LG	Region 6 (Syracuse)	HMO	HMO	01/01/2014	Q1 2014	0.93%	5.80%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO	HMO	04/01/2014	Q2 2014	0.87%	5.74%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO	HMO	07/01/2014	Q3 2014	0.81%	5.68%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO	HMO	10/01/2014	Q4 2014	0.76%	5.62%	0.00%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO	HMO	01/01/2014	Q1 2014	-3.07%	1.61%	-1.76%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO	HMO	04/01/2014	Q2 2014	-3.12%	1.55%	0.29%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO	HMO	07/01/2014	Q3 2014	-3.18%	1.50%	-0.88%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO	HMO	10/01/2014	Q4 2014	-3.23%	1.44%	0.00%

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

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

Capital District Physicians' Health F  
Company submitting the rate adjustment request

95491  
Company NAIC Code

CAPD-129090271  
SERFF tracking number

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

#### Drug Riders Available With Rolling Rate Base Medical Products

SERFF:

CAPD-129090271

Base Medical Policy Form #	Market Segment	Rating Region	Drug Rider	Base Medical Product Name	Effective Date of New Rate	Effective Period of New Rate	Proposed Percentage Rate Change		
							Lowest	Highest	Weighted Avg
01-0001-2010	LG	Region 1 (Albany)	HMO Rx	HMO	01/01/2014	Q1 2014	-24.48%	-0.43%	-10.03%
01-0001-2010	LG	Region 1 (Albany)	HMO Rx	HMO	04/01/2014	Q2 2014	-24.53%	-0.48%	-10.42%
01-0001-2010	LG	Region 1 (Albany)	HMO Rx	HMO	07/01/2014	Q3 2014	-24.57%	-0.54%	-9.97%
01-0001-2010	LG	Region 1 (Albany)	HMO Rx	HMO	10/01/2014	Q4 2014	-24.62%	-0.60%	-11.48%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO Rx	HMO	01/01/2014	Q1 2014	-24.48%	-0.43%	-12.02%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO Rx	HMO	04/01/2014	Q2 2014	-24.53%	-0.48%	0.00%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO Rx	HMO	07/01/2014	Q3 2014	-24.57%	-0.54%	-10.36%
01-0001-2010	LG	Region 3 (Mid-Hudson)	HMO Rx	HMO	10/01/2014	Q4 2014	-24.62%	-0.60%	-6.21%
01-0001-2010	LG	Region 6 (Syracuse)	HMO Rx	HMO	01/01/2014	Q1 2014	-24.48%	-0.43%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO Rx	HMO	04/01/2014	Q2 2014	-24.53%	-0.48%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO Rx	HMO	07/01/2014	Q3 2014	-24.57%	-0.54%	0.00%
01-0001-2010	LG	Region 6 (Syracuse)	HMO Rx	HMO	10/01/2014	Q4 2014	-24.62%	-0.60%	0.00%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO Rx	HMO	01/01/2014	Q1 2014	-24.48%	-0.43%	-9.58%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO Rx	HMO	04/01/2014	Q2 2014	-24.53%	-0.48%	-10.39%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO Rx	HMO	07/01/2014	Q3 2014	-24.57%	-0.54%	-10.71%
01-0001-2010	LG	Region 7 (UticaWatertown)	HMO Rx	HMO	10/01/2014	Q4 2014	-24.62%	-0.60%	0.00%

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

Company Name: Capital District Physicians' Health Plan, Inc  
 NAIC Code: 95491  
 SERFF Tracking #: CAPD-129090271

**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. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure)
- 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 should be developed based on the distribution of annualized premiums for that Market Segment/Rating Region/Product and for the market segment in total.
- 5) Market segment refers to Individual (IIND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY-IND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), and Group Medicare Supplement (MS-GRP). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- 6) Under each market segment, the table should provide the distribution by broad product type (e.g., HMO, POS, EPO, PPO, Indemnity, High Deductible/Consumer Driven, Medicare Supplement, etc.).
- 7) Provide distribution information for each rolling rate cohort of a rolling rate structure contract affected by this rate submission (e.g., by quarter of renewal for a quarterly rolling rate structure).
- 8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
- 9) After each effective period/market segment combination there should be a market segment total row. Enter Total in the "Product" column, the sum of the counts in the various columns, and the market segment weighted avg %.
- 10) This exhibit must be submitted as an Excel file and a PDF file.

**FOR ROLLING RATE STRUCTURE PRODUCTS - Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort**

SERFF#: CAPD-129090271

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Annualized Premiums as of 6/15/2013	Total # of Members as of 6/15/2013	Total # of Contracts as of 6/15/2013	Decrease	No Change	Number of (*) with Proposed Percentage Rate Change at Renewal								
											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
Jan 1, 2014	Q1 2014	LG	Region 1 (Albany)	HMO	5.4%	329,611,165	68,603	32,534	126	0	8,494	23,914	0	0	0	0	0	0	0
Jan 1, 2014	Q1 2014	LG	Region 3 (Mid-Hudson)	HMO	0.1%	2,436,983	402	225	152	0	73	0	0	0	0	0	0	0	0
Jan 1, 2014	Q1 2014	LG	Region 6 (Syracuse)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jan 1, 2014	Q1 2014	LG	Region 7 (Utica/Watertown)	HMO	-3.0%	36,690	4	3	3	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>	<b>Total</b>	<b>Total</b>	<b>5.4%</b>	<b>332,084,838</b>	<b>69,009</b>	<b>32,762</b>	<b>281</b>	<b>0</b>	<b>8,567</b>	<b>23,914</b>	<b>0</b>						
Apr 1, 2014	Q2 2014	LG	Region 1 (Albany)	HMO	5.3%	16,014,736	3,235	1,764	0	0	648	1,116	0	0	0	0	0	0	0
Apr 1, 2014	Q2 2014	LG	Region 3 (Mid-Hudson)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Apr 1, 2014	Q2 2014	LG	Region 6 (Syracuse)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Apr 1, 2014	Q2 2014	LG	Region 7 (Utica/Watertown)	HMO	-1.2%	139,111	21	19	19	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>	<b>Total</b>	<b>Total</b>	<b>5.2%</b>	<b>16,153,848</b>	<b>3,256</b>	<b>1,783</b>	<b>19</b>	<b>0</b>	<b>648</b>	<b>1,116</b>	<b>0</b>						
Jul 1, 2014	Q3 2014	LG	Region 1 (Albany)	HMO	4.7%	49,891,271	9,419	4,645	0	0	3,416	1,124	105	0	0	0	0	0	0
Jul 1, 2014	Q3 2014	LG	Region 3 (Mid-Hudson)	HMO	-0.5%	4,823,867	712	311	158	0	153	0	0	0	0	0	0	0	0
Jul 1, 2014	Q3 2014	LG	Region 6 (Syracuse)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jul 1, 2014	Q3 2014	LG	Region 7 (Utica/Watertown)	HMO	-2.7%	308,505	46	22	22	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>	<b>Total</b>	<b>Total</b>	<b>4.3%</b>	<b>55,023,643</b>	<b>10,177</b>	<b>4,978</b>	<b>180</b>	<b>0</b>	<b>3,569</b>	<b>1,124</b>	<b>105</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Oct 1, 2014	Q4 2014	LG	Region 1 (Albany)	HMO	4.0%	7,244,048	1,280	877	0	0	840	37	0	0	0	0	0	0	0
Oct 1, 2014	Q4 2014	LG	Region 3 (Mid-Hudson)	HMO	1.4%	14,676,994	2,749	1,327	169	0	1,015	143	0	0	0	0	0	0	0
Oct 1, 2014	Q4 2014	LG	Region 6 (Syracuse)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oct 1, 2014	Q4 2014	LG	Region 7 (Utica/Watertown)	HMO	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>	<b>Total</b>	<b>Total</b>	<b>2.4%</b>	<b>21,921,042</b>	<b>4,029</b>	<b>2,204</b>	<b>169</b>	<b>0</b>	<b>1,855</b>	<b>180</b>	<b>0</b>						

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

**Company Name:** Capital District Physicians' Health Plan, Inc

**NAIC Code:** 95491

**SERFF Number:** CAPD-129090271

**Instructions:**

- This Exhibit summarizes all benefit/rate changes filed under sections other than §3231(e)(1)/4308(c) that impact the rate tables in this filing.
- The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
- Enter filing status (approved or pending) using the drop down list. For pending files leave the approval date blank.
- Extend the worksheet to add more rows as needed. Only use the first tab for data entry.

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

Filing Status	SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
Pending	CAPD-129064030	2013060043	6/7/2013	01-0004-2012	HDHMO	Updating to comply with regulation	
Approved	CAPD-129107555	2013070041	7/8/2013	01-0001-2010 01-0003-2011	HMO	Pre-file	7/15/2013



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

C

- A. Complete a separate form for each policy form:
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment 1 Supplement (MS-1) the market segment
- D. Product type is HMO Medicare Supplement
- E. The product street
- F. Note that many cells
- G. If members, cover
- H. This form must be

		Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)																				
1a. Base medical policy form number	1b. Product Name as in Rate Manual	14.1 Beginning Date of the experience period (MM/DD/YY)	14.2 Ending Date of the experience period (MM/DD/YY)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	14.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	14.11 Earned premiums for experience period (\$mpm)	14.12 Standardized premiums for experience period (\$mpm)	14.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	14.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	14.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	14.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	14.18 Ratio: Col 14.7/ Col 14.4 (Incurred Claims / Earned Premiums)	14.19 Ratio: Col 14.7/ Col 14.5 (Standardized Claims / Earned Premiums)	14.20 Ratio: Col 14.10/ Col 14.4 (Administration Expenses / Earned Premiums)	
01-0001-2010		XX	01/01/12	12/31/12	1,113,094	460,138,466	512,571,880	396,017,960	397,812,352	0	0	51,112,312	413.39	460.49	355.78	357.39	0.00	0.00	45.92	0.865	0.776	0.111
01-0003-2011	HMO	XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX										0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000



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

C

- A. Complete a separate form for each policy form:
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment 1 Supplement (MS-1) for the market segment
- D. Product type is HMO, Medicare Supplement
- E. The product street
- F. Note that many cells are blank
- G. If members, cover
- H. This form must be

		First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																			
1a. Base medical policy form number	1b. Product Name as in Rate Manual	15.1 Beginning date of the experience period (MM/DD/YY)	15.2 Ending Date of the experience period (MM/DD/YY)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts 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 (enter receipts as a negative value and payments to the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	15.11 Earned premiums for experience period (\$mpm)	15.12 Standardized premiums for experience period (\$mpm)	15.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	15.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	15.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	15.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	15.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	15.18 Ratio: Col 15.7/ Col 15.4 (Incurred Claims / Earned Premiums)	15.19 Ratio: Col 15.7/ Col 15.5 (Incurred Claims / Standardized Earned Premiums)	15.20 Ratio: Col 15.10/ Col 15.4 (Administrative Expenses / Earned Premiums)
01-0001-2010		XX	01/01/11																		
01-0003-2011	HMO	XX		1,109,987	456,911,168	492,733,311	376,865,510	379,339,701	0	0	50,073,199	411.64	443.91	339.52	341.75	0.00	0.00	45.11	0.830	0.770	0.110
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000



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

C

- A. Complete a separate form for each policy form:
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment 1 Supplement (MS-1) for the market segment
- D. Product type is HMO, Medicare Supplement
- E. The product street name
- F. Note that many cells are blank
- G. If members, cover
- H. This form must be

		Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)																			
1a. Base medical policy form number	1b. Product Name as in Rate Manual	16.1 Beginning date of the experience period (MM/DD/YYYY)	16.2 Ending Date of the experience period (MM/DD/YYYY)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.11 Earned premiums for experience period (\$mpm)	16.12 Standardized premiums for experience period (\$mpm)	16.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	16.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$mpm)	16.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	16.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a positive value) (\$mpm)	16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	16.18 Ratio: Col 16.7/ Col 16.4 (Incurred Claims / Earned Premiums)	16.19 Ratio: Col 16.7/ Col 16.5 (Incurred Claims / Standardized Earned Premiums)	16.20 Ratio: Col 16.10/ Col 16.4 (Administration Expenses / Earned Premiums)
01-0001-2010		XX	01/01/10																		
01-0003-2011	HMO	XX	12/31/10	1,161,326.00	446,673,438	491,179,174	372,657,705	374,382,826	0	0	50,089,144	384.62	422.95	320.89	322.38	0.00	0.00	43.13	0.838	0.762	0.112
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000
		XX									0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000



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

C

- A. Complete a separate row for each of the following:
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment 1 Supplement (MS-1) the market segment
- D. Product type is HMO Medicare Supplement
- E. The product street
- F. Note that many cells
- G. If members, cover
- H. This form must be

1a. Base medical policy form number	1b. Product Name as in Rate Manual	Annualized Medical Trend Factors Assumed in Rate Development (%)					Ratios: Most Recent Experience Period to First Prior Period						Ratios: First Prior Period to Second Prior Period						Ratio: Standard Premium to Earned Premium				
		17.1 All benefits combined, composite	17.2 Due to utilization	17.3 Due to unit cost	17.4 Due to case mix/intensity/other	18.1 Member months	18.2 Earned premiums (\$mpm)	18.3 Standardized premiums (\$mpm)	18.4 Paid claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	18.5 Incurred claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	18.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	19.1 Member months	19.2 Earned premiums (\$mpm)	19.3 Standardized premiums (\$mpm)	19.4 Paid claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	19.5 Incurred claims for experience period before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	19.6 Administrative expenses (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	20.1 Most Recent Experience Period	20.2 First Prior Experience Period	20.3 Second Prior Experience Period			
01-0001-2010		XX	5.63%	2.06%	3.21%	XX	1,003	1,004	1,037	1,048	1,046	1,018	XX	0.956	1,070	1,050	1,058	1,060	1,046	XX	1,114	1,078	1,100
01-0003-2011	HMO	XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000
		XX				XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.000	0.000	0.000