

**State:** New York **Filing Company:** HealthNow New York Incorporated  
**TOI/Sub-TOI:** H15G Group Health - Hospital/Surgical/Medical Expense/H15G.003 Small Group Only  
**Product Name:** 2013 Q3/Q4 Prior Approval Application - Commercial  
**Project Name/Number:** /

1. Is a parallel product being submitted for another entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: Article 43, HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Group
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 Adjustment pursuant to Section 4308(c)
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.): Rate Adjustment pursuant to Section 4308(c)
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 - State Tracking Number: 2013010031, SERFF Tracking Number: HLTH-128843795

SERFF Tracking #:

HLTH-128847546

State Tracking #:

2013010085

Company Tracking #:

State:

New York

Filing Company:

HealthNow New York Incorporated

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## Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

%

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

## Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
HealthNow New York Incorporated	Increase	13.500%	13.500%	\$26,075,184	28,862	\$193,293,270	16.900%	-4.200%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	6,234	0	0	29,181	0	17,607	1,045	0
Policy Holders:	3,519	0	0	16,221	0	8,501	621	0

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## Rate Review Detail

### COMPANY:

**Company Name:** HealthNow New York Incorporated  
**HHS Issuer Id:** 49526  
**Product Names:** Traditional Small, Aqua, POS Lite, HDHP 7000, HDHP 8000, HMO 100 Small  
**Trend Factors:**

### FORMS:

**New Policy Forms:** BCC-15, H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993), H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993), H-1575 & BCMS-1 (Rev 1993), H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993), H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993), C33G3N0392, L33G3N0289, LS3G3N0195, LS3G3N0232, HN-HMO.2 & HN-POS.2  
**Affected Forms:**  
**Other Affected Forms:**

### REQUESTED RATE CHANGE INFORMATION:

**Change Period:** Annual  
**Member Months:** 647,575  
**Benefit Change:** Increase  
**Percent Change Requested:** Min: -4.2 Max: 16.9 Avg: 13.5

### PRIOR RATE:

**Total Earned Premium:** 193,293,270.00  
**Total Incurred Claims:** 179,191,801.00  
**Annual \$:** Min: 238.00 Max: 1,185.00 Avg: 298.00

### REQUESTED RATE:

**Projected Earned Premium:** 219,368,454.00  
**Projected Incurred Claims:** 186,839,878.00  
**Annual \$:** Min: 273.00 Max: 1,135.00 Avg: 339.00

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## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Checklist-Rate Adj Filings per 3231(e)(1) or 4308(c)		
Comments:			
Attachment(s):			
PA_Rate_Adjustment_Filing_Checklist.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Consumer Disclosure Form		
Comments:			
Attachment(s):			
WNY - AQUA-POS-HDHP Part II.pdf			
WNY - HMO 100 S Part II.pdf			
WNY - TRAD S Part II.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Initial Notice of Proposed Rate Adjustment		
Comments:			
Attachment(s):			
WNY 3Q_4Q Rate Refiling Notification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Redacted Documents for Web Posting		
Comments:			
Attachment(s):			
Actuarial Memorandum - Redacted.pdf			
Exhibit 1 - Commerical (WNY Only) - Redacted Version.pdf			

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

**SERFF Tracking #:**

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Satisfied - Item:	Standard Exhibit 2 - Summary of Average Claim Trend and Administrative Expenses		
Comments:			
Attachment(s):			
Exhibit 2 - Commerical (WNY Only).xls			
Exhibit 2 - Commerical (WNY Only).pdf			

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

Satisfied - Item:	Standard Exhibit 3 - Narrative Summary		
Comments:			
Attachment(s):			
BCBSWNY Commercial Narrative.pdf			

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

Satisfied - Item:	Standard Exhibit 4 - Part B - Summary of Proposed Percentage Rate Changes		
Comments:			
Attachment(s):			
Exhibit 4B - Commercial (WNY Only).xls			
Exhibit 4B - Commercial (WNY Only).pdf			

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

Satisfied - Item:	Standard Exhibit 4 - Part D - Summary of Proposed Percentage Rate Changes		
Comments:			
Attachment(s):			
Exhibit 4D - Commerical (WNY Only).xls			
Exhibit 4D - Commerical (WNY Only).pdf			

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Satisfied - Item:	Standard Exhibit 5 - Part B - Distribution of Contracts Affected by Proposed Rate Adjustments		
Comments:			
Attachment(s):			
Exhibit 5B - Commerical (WNY Only).xls			
Exhibit 5B - Commerical (WNY Only).pdf			

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

Satisfied - Item:	Standard Exhibit 6 - Summary of Policy Form and Product Changes		
Comments:			
Attachment(s):			
Exhibit 6 - Commerical (WNY Only).xls			
Exhibit 6 - Commerical (WNY Only).pdf			

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

Satisfied - Item:	Standard Exhibit 7 - Historical Data		
Comments:			
Attachment(s):			
Exhibit 7.xls			
Exhibit 7.pdf			

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

Satisfied - Item:	Exhibit A		
Comments:			
Attachment(s):			
Exhibit A.pdf			

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

Satisfied - Item:	Exhibit B		
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Comments:	
Attachment(s):	
Exhibit B.pdf	

Item Status:

Status Date:

Satisfied - Item:	Exhibit C		
Comments:			
Attachment(s):			
Exhibit C.pdf			

Item Status:

Status Date:

Satisfied - Item:	Exhibit D		
Comments:			
Attachment(s):			
Exhibit D.pdf			

Item Status:

Status Date:

Satisfied - Item:	Exhibit E		
Comments:			
Attachment(s):			
Exhibit E.pdf			

Item Status:

Status Date:

Satisfied - Item:	Exhibit F		
Comments:			
Attachment(s):			
Exhibit F.pdf			

Item Status:

Status Date:

Satisfied - Item:	Underwriting Guidelines		
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Comments:

Attachment(s):

BlueCross BlueShield of WNY Underwriting Guidelines.pdf

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

Satisfied - Item:

Commission Schedules

Comments:

Attachment(s):

BCBSWNY 2013 Broker Commission Schedule Final 12.18.12.pdf

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

Satisfied - Item:

Development of Standardized Premium

Comments:

Attachment(s):

Development of Standardized Premium.pdf

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

Satisfied - Item:

Rate Summary Worksheet - Excel and PDF Files

Comments:

Excel and PDF files for Rate Summary Worksheet section. They are included here because SERFF will not allow more than one Excel attachment in that section.

Attachment(s):

WNY - AQUA-POS-HDHP.xls

WNY - HMO 100 S.xls

WNY - TRAD S.xls

WNY - AQUA-POS-HDHP.pdf

WNY - HMO 100 S.pdf

WNY - TRAD S.pdf

## 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 5/18/2012

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 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

## 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**

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).

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

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

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

Each attachment to the rate adjustment application must be compatible with the following software: Microsoft Word 2003, Microsoft Excel 2003, or Adobe Acrobat 9.

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.

**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**

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 new section, Public Disclosure of the Rate Application, 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.

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
<b>DEFINITIONS</b>		<ul style="list-style-type: none"> <li>a. <b>Company</b> refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing.</li> <li>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.</li> <li>c. <b>Loss ratio</b> refers to incurred claims divided by earned premiums for a given period of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools, Regulation 146 (11 NYCRR 361), covered 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.</li> <li>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.</li> <li>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.</li> <li>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.                         <ul style="list-style-type: none"> <li>(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</li> </ul> </li> </ul>	

**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>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 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 (\$121.67 x 0.95). 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 121.67/100.00, and the</p>	
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**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 align="center">January 2012 earned premium is standardized to the second quarter 2012 level by adjusting by 115.58/111.14.</p>	
<p><b>ROLLING RATE STRUCTURE</b></p>		<ul style="list-style-type: none"> <li>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).</li> <li>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.</li> <li>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).</li> </ul>	
<p><b>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</b></p>		<ul style="list-style-type: none"> <li>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.</li> <li>b. A company can revise a previously approved non-rolling rate table provided that:             <ul style="list-style-type: none"> <li>(i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or</li> <li>(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.</li> </ul> </li> <li>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></li> </ul>	

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		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.	
<b>STANDARD EXHIBITS 1 - 7</b>	Introduction	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.	
<b>Exhibit 1</b>		<p><b>General information about the rate adjustment submission.</b></p> <ul style="list-style-type: none"> <li>a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit.</li> <li>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).</li> <li>c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list.</li> <li>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 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.</li> <li>e. Item F.1 – a rate adjustment filing that also includes rate adjustments for unapproved contract language changes will be rejected.</li> <li>f. This exhibit must be submitted as an Excel file and as an Adobe PDF file.</li> </ul>	
<b>Exhibit 2</b>		<p><b>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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</li> </ul>	

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		<p>segment HNY-IND or HNY-SG based on which subpopulation has the most membership.</p> <ul style="list-style-type: none"> <li>c. Information is for medical base plans and all associated riders combined.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>	
<p><b>Exhibit 3</b></p>		<p><b>Narrative Summary.</b></p> <ul style="list-style-type: none"> <li>a. 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>b. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</li> <li>c. The narrative summary will be a public document.</li> <li>d. 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>e. The narrative summary should include, but not be limited to, the following</li> </ul>	

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		<p>information:</p> <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>(a) Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy.</li> <li>(b) A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy.</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 plan language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type.</li> </ul> <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> <ul style="list-style-type: none"> <li>a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing.             <ul style="list-style-type: none"> <li>(i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used.</li> <li>(ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used.</li> <li>(iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used.</li> <li>(iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used.</li> </ul> </li> <li>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.</li> <li>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</li> </ul>	

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		<p>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 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 may be based on membership or contract as used in Standard Exhibit 5 instead of premium volume.</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</p>	
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		<p>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.</p> <p>Example: The rate adjustment application is only for small group PPO and within this product there are only two product designs. The proposed rate changes for design A are: employee only = 10%, employee+child(ren) = 8%, employee+spouse = 13% and employee+family = 11%. The proposed rate change for design B are: employee only = 9%, employee+child(ren) = 7%, employee+spouse = 12% and employee+family = 10%. The lowest change proposed is 7% and the highest change proposed is 13%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</p> <p>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.</p> <p>Example 1: Drug riders D1 to D99 are available with the PPO product. The proposed changes on the drug riders vary from 10% to 16%. There would be one row for the PPO policy form/product. The lowest change proposed is 10% and the highest change proposed is 16%. The weighted average change would reflect the distribution of contracts by plan design and rating tier.</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>	
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<p><b>Exhibit 5</b></p>		<p><b>Distribution of Contracts Affected by the Proposed Rate Adjustments.</b></p> <ol style="list-style-type: none"> <li>a. There are two different versions of this exhibit as indicated below. Not all versions may be required for a given rate submission.             <ol style="list-style-type: none"> <li>(i) Part A – for use with <u>Non-Rolling</u> Rate Structures.</li> <li>(ii) Part B – for use with <u>Rolling</u> Rate Structures.</li> </ol> </li> <li>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.</li> <li>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.</li> <li>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.</li> <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. The Weighted Average % should be developed based on the distribution of contracts or members for that market segment/rating region/product. 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 and the Weighted Average % for all rating regions/products in that market segment combined.</li> <li>f. 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>g. Enter in Part A the information for the various products that use a <u>non-rolling</u> rate structure.</li> <li>h. 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</li> </ol>	
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		<p>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.</p>	
<p><b>Exhibit 6</b></p>		<p><b>Summary of Policy Form and Product Changes.</b></p> <ol style="list-style-type: none"> <li>a. This exhibit summarizes all rate changes filed pursuant to sections of the New 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 exhibit must be submitted as an Excel file and also as an Adobe PDF file.</li> <li>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.</li> <li>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.</li> </ol>	
<p><b>Exhibit 7</b></p>		<p><b>Historical Data by Each Policy Form Included in the Rate Adjustment Filing.</b></p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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).</li> </ol>	

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		<p>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 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</p>	
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		<p>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 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</p>	
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		<p>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> <ul style="list-style-type: none"> <li>a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and</li> <li>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</li> </ul>	
Justification of Rates	<p>§3231(e)                  §4308(c)                  11NYCRR 52.40                  11NYCRR 52.42 (HMOs)                  11NYCRR 52.45                  11NYCRR 59.5(b)                  11NYCRR 360.11</p>	<ul style="list-style-type: none"> <li>a. Description of proposed changes in rates, including the following:                         <ul style="list-style-type: none"> <li>(i) The member (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 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.</li> <li>(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.</li> <li>(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</li> </ul> </li> </ul>	

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		<p>quarterly rate tables).</p> <ul style="list-style-type: none"> <li>(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.</li> <li>(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.</li> <li>(vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</li> <li>(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.</li> <li>(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.</li> </ul> <ul style="list-style-type: none"> <li>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.</li> <li>c. Include the following (year over year exhibit):             <ul style="list-style-type: none"> <li>(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</li> </ul> </li> </ul>	
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		<p>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 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>	
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**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**

		<ul style="list-style-type: none"> <li>(ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components.</li> <li>(iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period.</li> </ul> <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <ul style="list-style-type: none"> <li>(i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for 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.</li> <li>(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.</li> <li>(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.</li> <li>(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).</li> <li>(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</li> </ul>	
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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>for pooling large claims.</p> <ul style="list-style-type: none"><li>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.</li><li>i. If the percentage rate change by policy form differs within a permitted aggregation of policy forms, include an actuarial demonstration that the rate changes were developed assuming the same insured population selects each of the available benefit options among the aggregated policy forms, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option within 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.</li><li>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.</li><li>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</li></ul>	
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**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**

		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.	
Minimum Loss Ratio Requirements	§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)	<ul style="list-style-type: none"> <li>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.</li> <li>b. The minimum loss ratio for the official Medicare Supplemental products is: <ul style="list-style-type: none"> <li>(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</li> <li>(ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52).</li> </ul> </li> </ul>	
Actuarial Certification	11NYCRR 52.40(a)(1)	<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>	
<b>REVISED RATE MANUAL PAGES</b>	11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)	<p><b>Rate Manual.</b></p> <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>	

**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><b>NOTICES TO POLICYHOLDERS Initial &amp; Final</b></p>	<p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p>	<p>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. (It is strongly recommended that the company also include a draft of the Narrative Summary in this prefiling submission.)</p> <p>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.</p> <p>(i) Section 3231(e)(1) and Section 4308(c) of the New York Insurance Law require that the initial notice be sent on or before the date the rate application is submitted to the Department.</p> <p>(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.</p> <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. 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>b. 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>c. The justification material is to be prepared using the template and instructions provided by HHS.</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</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>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 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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## **Increase Justification Narrative for WNY AQUA/POS/HDHP**

### Scope and Range of the Rate Increase:

The proposed rate increase for this pool is 16.5%. This increase impacts approximately 14,811 individuals. The min increase is 1.4%. The max increase is 18.4%. The main reason for the rate increase is due to rising medical costs. See explanation below.

### Financial Experience of the Product:

Based on the proposed average increase above, the projected MLR for this rating pool is 84.6%. The 2011 MLR for this pool was 90.8%. The 2010 MLR for this pool was 85.0%.

The increase requested was determined as the increase needed assuming the same benefits were kept upon renewal. The impact of benefit buy-downs (ups), and increases due to federal or state mandates are not included in the calculation.

### Explanations of Rising Health Care Costs:

We change premium rates only after careful review of the current costs we are paying for our members' health care and we determine there is a pattern of rising costs. Below is a summary of the key factors in determining our premium rates, and why the rates need to change.

A. Use of services. How many medical services members use – doctor visits, prescriptions, surgeries, x-rays, lab tests, hospital stays, etc. is part of this calculation. We measure the numbers of services used per 1,000 members to calculate usage rates. But, in addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones used last year, the amount we pay rises. In many years, there is an increase both in the number of services used on average and in the intensity/cost of those services.

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services.

C. Copay/Deductible Leveraging. When the price of medical services increases, if a plan design has deductibles and copays that are fixed dollar amounts rather than a percent coinsurance, the costs to the insurer will increase at a higher rate. As an example, suppose the fee for a typical doctor's office visit is \$100 and the patient pays a \$25 copay. The cost to the insurer would then be \$75. Now suppose the next year the doctor's fees increase 5% to \$105 and the patient's copay is still \$25. This leaves \$80 for the insurer to pay, a 6.67% increase. This additional 1.67% increase above the 5% increase in fees is called leveraging.

D. Population Demographics. Different age and gender combinations tend to have different average costs to insure. At younger ages, women tend to cost more than men; at older ages, men tend to cost more than women; and older people tend to cost more than younger people. Because

community rating does not allow us to vary rates by age or gender, the costs for everyone must go up if the mix within a product, or our entire block of business, shifts toward more expensive age/gender combinations.

E. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, and detecting fraud and abuse.

## **Increase Justification Narrative for WNY HMO 100 S**

### Scope and Range of the Rate Increase:

The proposed rate increase for this pool is 19.0%. This increase impacts approximately 1,818 individuals. The min increase is -7.6%. The max increase is 21.0%. The main reason for the rate increase is due to rising medical costs. See explanation below.

### Financial Experience of the Product:

Based on the proposed average increase above, the projected MLR for this rating pool is 85.2%. The 2011 MLR for this pool was 104.3%. The 2010 MLR for this pool was 95.1%.

The increase requested was determined as the increase needed assuming the same benefits were kept upon renewal. The impact of benefit buy-downs (ups), and increases due to federal or state mandates are not included in the calculation.

### Explanations of Rising Health Care Costs:

We change premium rates only after careful review of the current costs we are paying for our members' health care and we determine there is a pattern of rising costs. Below is a summary of the key factors in determining our premium rates, and why the rates need to change.

A. Use of services. How many medical services members use – doctor visits, prescriptions, surgeries, x-rays, lab tests, hospital stays, etc. is part of this calculation. We measure the numbers of services used per 1,000 members to calculate usage rates. But, in addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones used last year, the amount we pay rises. In many years, there is an increase both in the number of services used on average and in the intensity/cost of those services.

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services.

C. Copay/Deductible Leveraging. When the price of medical services increases, if a plan design has deductibles and copays that are fixed dollar amounts rather than a percent coinsurance, the costs to the insurer will increase at a higher rate. As an example, suppose the fee for a typical doctor's office visit is \$100 and the patient pays a \$25 copay. The cost to the insurer would then be \$75. Now suppose the next year the doctor's fees increase 5% to \$105 and the patient's copay is still \$25. This leaves \$80 for the insurer to pay, a 6.67% increase. This additional 1.67% increase above the 5% increase in fees is called leveraging.

D. Population Demographics. Different age and gender combinations tend to have different average costs to insure. At younger ages, women tend to cost more than men; at older ages, men tend to cost more than women; and older people tend to cost more than younger people. Because

community rating does not allow us to vary rates by age or gender, the costs for everyone must go up if the mix within a product, or our entire block of business, shifts toward more expensive age/gender combinations.

E. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, and detecting fraud and abuse.

## **Increase Justification Narrative for WNY TRAD S**

### Scope and Range of the Rate Increase:

The proposed rate increase for this pool is -5.6%. This increase impacts approximately 217 individuals. The min increase is -16.8%. The max increase is 10.1%. The main reason for the rate increase is due to a restatement of prior period claims.

### Financial Experience of the Product:

Based on the proposed average increase above, the projected MLR for this rating pool is 91.4%. The 2011 MLR for this pool was 88.7%. The 2010 MLR for this pool was 91.5%.

The increase requested was determined as the increase needed assuming the same benefits were kept upon renewal. The impact of benefit buy-downs (ups), and increases due to federal or state mandates are not included in the calculation.

### Explanations of Rising Health Care Costs:

We change premium rates only after careful review of the current costs we are paying for our members' health care and we determine there is a pattern of rising costs. Below is a summary of the key factors in determining our premium rates, and why the rates need to change.

A. Use of services. How many medical services members use – doctor visits, prescriptions, surgeries, x-rays, lab tests, hospital stays, etc. is part of this calculation. We measure the numbers of services used per 1,000 members to calculate usage rates. But, in addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones used last year, the amount we pay rises. In many years, there is an increase both in the number of services used on average and in the intensity/cost of those services.

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services.

C. Copay/Deductible Leveraging. When the price of medical services increases, if a plan design has deductibles and copays that are fixed dollar amounts rather than a percent coinsurance, the costs to the insurer will increase at a higher rate. As an example, suppose the fee for a typical doctor's office visit is \$100 and the patient pays a \$25 copay. The cost to the insurer would then be \$75. Now suppose the next year the doctor's fees increase 5% to \$105 and the patient's copay is still \$25. This leaves \$80 for the insurer to pay, a 6.67% increase. This additional 1.67% increase above the 5% increase in fees is called leveraging.

D. Population Demographics. Different age and gender combinations tend to have different average costs to insure. At younger ages, women tend to cost more than men; at older ages, men tend to cost more than women; and older people tend to cost more than younger people. Because

community rating does not allow us to vary rates by age or gender, the costs for everyone must go up if the mix within a product, or our entire block of business, shifts toward more expensive age/gender combinations.

E. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, and detecting fraud and abuse.



BlueCross BlueShield of Western New York  
257 West Genesee Street • Buffalo, New York 14202

<Date>

<First Name> <Last Name>

<Address 1>

<Address 2>

<City>, <ST> <Zip>

**Rate Filing Notification**

Dear <First Name>,

At BlueCross BlueShield of Western New York, we want to keep you informed.

<p>Why you're receiving this letter</p>	<p>We will be filing an application to amend our previous rate increase filing with the Department of Financial Services (DFS) for the community rated policies renewing between July 1, 2013 and December 31, 2013.</p> <p>New York state law requires that health insurance carriers provide an initial notice to you when we submit requests for premium rate changes to the DFS.</p>
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<p>What you need to know</p>	<p>We periodically file requests to update our rates, which allows us to continue to meet the changing costs of care and other health-related services that we offer our members.</p> <p><b>Rate Filing Details</b> A detailed summary about our rate filing and the reasons we are seeking an adjustment are available on our website, <a href="http://bcbswny.com">bcbswny.com</a>. You may also visit the DFS website, <a href="https://myportal.dfs.ny.gov/web/prior-approval/welcome">https://myportal.dfs.ny.gov/web/prior-approval/welcome</a>.</p> <p>Please see the enclosed list for details on the anticipated rate change for the plan or plans you offer.</p> <p>The actual rate for your 2013 renewal may be different. Additional benefits, provided by the federal Women's Preventive Health mandate, will increase your rate by \$0.48 to \$1.35 (up to 0.19%) depending on coverage tier (single, employee plus spouse, family, etc.). Two state benefit mandates will also increase your rates: Autism, \$1.08 - \$3.04 (up to 0.43%); and Oral Treatments for Cancer, by \$0.41 - \$1.16 (up to 0.16%).</p> <p>Rates are also being adjusted on our prescription drug riders. If you have drug coverage with us, the premium rate change will vary based upon the drug rider you've chosen. Therefore, the overall requested rate change may be higher or lower than the change on the base medical policy.</p>
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	<p>This rate increase filing supersedes the previous rate increase filing submitted to the DFS in July 2012.</p> <p>Please note that the Superintendent may approve the proposed rate adjustment as requested, modify the proposed rate adjustment, or disapprove the proposed rate adjustment in its entirety. Therefore, the actual rate increase will not be available until approval is received. At that time, we will send you information on approved rates at least 60 days before your new rates take effect.</p> <p><b>Your rates are not changing at this time.</b></p> <p>This letter is simply to let you know that we will be filing a request for new rates for 2013 renewals with the DFS on &lt;file date&gt;. You have until &lt;comment date&gt; (30 days) to request information or comment on our proposed filing.</p>
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<p>What you need to do</p>	<ul style="list-style-type: none"> <li> <p><b>To comment on our proposed rate filing:</b></p> <p>You may comment on or ask for more information about these proposed rates by following instructions on the DFS’s website: <a href="https://myportal.dfs.ny.gov/web/prior-approval/welcome">https://myportal.dfs.ny.gov/web/prior-approval/welcome</a>. You can also contact the DFS directly by email at <a href="mailto:PremiumRateIncreases@dfs.ny.gov">PremiumRateIncreases@dfs.ny.gov</a>. You may also mail your comments to the following address:</p> <p style="padding-left: 40px;">Health Bureau - Premium Rate Adjustment New York State Department of Financial Services 25 Beaver Street New York, NY 10004</p> <p>If you submit comments to the DFS, please be sure to include our name, BlueCross BlueShield of Western New York, as well as the plan type (e.g. HMO, PPO, etc.) you are commenting on. Written comments sent to DFS will be posted on the DFS website with personal identifying information removed.</p> </li> <li> <p><b>If you have any questions:</b></p> <p>Please call your account representative at 1-888-249-2583, visit our website <a href="http://bcbswny.com">bcbswny.com</a>, or mail your questions to:</p> <p style="padding-left: 40px;">BlueCross BlueShield of Western New York PO Box 80 Buffalo, NY 14240-0080</p> </li> </ul>
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Thank you for choosing BlueCross BlueShield. We value your business and hope you enjoy your experience with us.

Sincerely,

{Commercial Group Name: <AE name>}  
 {Commercial Group Title: Account Executive}

**Proposed Rate Changes for 2013**

Commercial, Small Group:

The <PRODUCT> base medical plan is changing <NUMBER>%

The <PRODUCT> base medical plan is changing <NUMBER>%

**Comment [ECS1]:** Add logo to the page.

**HealthNow New York Incorporated**  
**3<sup>rd</sup> & 4<sup>th</sup> Quarter 2013 Community Rate Submission**  
**Actuarial Memorandum**

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**Attached Exhibits:**

- A: Summary of Rate Development
- B: Trend Development
- C: Summary of Demographic Changes
- D: Rx Claims and Premiums
- E: Calculation of Quarterly Load for the Affordable Care Act Excise Tax
- F: Calculation of Quarterly Load for the Affordable Care Act Reinsurance, CER, and Risk Adjustment Administrative Fees

## Actuarial Memorandum

### **Purpose**

The purpose of this rate filing is to develop premium rates to be offered by HealthNow New York to new and renewing groups and subscribers between July 1, 2013 and December 31, 2013 as required by New York statute and regulation for community-rated products. This filing may not be appropriate for other purposes.

With the prior approval law enacted on June 8, 2010, we are following the prior approval procedure outlined in the Department's Checklist for "Review Standards for Medical Rate Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the Insurance Law" ("Prior Approval Review Standards").

### **Summary of Rating Pools**

#### **Western New York (WNY) - Buffalo Region**

HealthNow NY conducts community rated business in WNY under both Article 43 and 44 of the NYS Public Health Law.

WNY pools product offerings together into following Rating Pools:

- AQUA-POS-HDHP
- Traditional Large
- Traditional Small
- Dental
- Vision
- HMO 100 Large
- HMO 100 Small
- HMO 200 Large
- HMO 200 Small

Due to unforeseen increases in the claim payments in the Aqua-POS-HDHP and HMO 100 Small pools and due to an increase in inpatient utilization and drug complexity (members shifting utilization from brands to generics) we are re-filing rate increases for those pools. Conversely, due to better than expected performance in the Traditional Small pool, we are re-filing rate decreases for that pool.

### **Overview of Rating Approach**

#### **Medical**

The base claim period for rate development was a 12 month span from July 2011 through June 2012. Four months of claims run-out was included in the base paid claims, and a completion factor was applied to convert the base paid claims to base incurred claims.

#### **2013 Proposed Medical Rate Increases were Determined as Follows:**

- All base medical claims and other non-system claims were grouped into the rating pools specified above.
- Large base medical claim amounts over \$100,000 were removed from each pool and pooled.

- The pooled large claim amounts were then added back in to the base medical claims.
- The base medical claims were trended from the midpoint of the experience period (January 1, 2012) to the midpoint of the projection period (January 1, 2014) using 2 years of medical pricing trend to create projected medical claims. Below summarizes the components of the 2 years of medical pricing trend.
  - 2012, 2013 & 2014 Medical Unit Cost and Utilization Trend
  - 2012, 2013 & 2014 Medical Demographic Aging Trend
  - 2012, 2013 & 2014 Fixed Cost Leveraging
- Other non-system base period claims are were also trended from the midpoint of the experience period to the midpoint of the projection period, and then added to projected medical claims to create total projected medical claims. Included in the other non-system claims are:
  - Demo pool adjustments
  - SMC payments
  - GME payments,
  - HMO Guest (away from home care) claims
  - Vendor / provider payments
  - Stop loss receivables
  - Other
- Administrative expenses are then added to total projected medical claims to create expected required premiums.
  - Administrative expenses were developed through an allocation process involving estimated time spent on various lines of business. Total budgeted expenses are split between each business line including an amount allocation to HealthNow's community rated business. Within the community rated business line, HealthNow split the administrative costs between its two regions (Buffalo and Albany) and then by HMO and Traditional products. The amounts shown in Exhibit A are the output of this process and reflect HealthNow's expected actual cost to administer these products. The administrative expenses contained in the rate filing include provisions for taxes and commissions.
- Expected required premiums serve as the basis for our proposed medical rate increases.
- The buildup of the proposed medical rate increases for each pool is shown in "Exhibit A - Summary of Medical Rate Development - Commercial Community Rated - 2013 - Buffalo".

### **Pharmacy (Rx)**

The current rates for our different Rx plans have recently become misaligned. There are a few different causes of this. First of all, in 2012, there is a high volume of brand drugs coming off patent. The effect of this is that our generic substitution rate is increasing significantly. There has also been a significant increase in the underlying ingredient cost on our brand name and non-formulary drug tiers (Tiers 2 & 3). This underlying cost has dramatically changed the true cost differential between co-pay and coinsurance plans.

The combination of these two issues makes realignment necessary at this time. Therefore, we are realigning our 2013 Rx rates in Buffalo by recalculating and implementing new relativities between the different plans.

**Rx Plan Rate Relativities were Determined as Follows:**

- Base period claims experience and two years of projected trends and rebates were input into a Milliman Pricing tool, which projected a rating period Claims PMPM.
- A flat company-wide retention PMPM was added to the Claims PMPMs to determine the Premium PMPMs. The reason for the flat company-wide retention PMPM is to prevent a loss of margin when members shift to lower premium plans.
- The relativities between the Premium PMPMs were used to realign the 2013 proposed Rx rates.
- The Claims PMPMs and Premium PMPMs can be seen on “Exhibit D - Rx Claims and Premiums”.

**2013 Proposed Rx Rate Actions were Determined as Follows:**

- Base Rx claims were trended from the midpoint of the experience period (January 1, 2012) to the midpoint of the projection period (January 1, 2014) using 2 years of Rx pricing trend to create projected Rx claims. Below summarizes the components of the 2 years of Rx pricing trend.
  - 2012, 2013 & 2014 Rx Unit Cost and Utilization Trend
  - 2012, 2013 & 2014 Rx Demographic Aging Trend
- Expected rebates were also included in the projected Rx claims.
- A loss ratio was targeted for each pool to set the Rx rate action.
- The Rx plan specific realigned rates were set so that the same premium would be collected under both pre and post realignment.
- The details of the proposed rate actions for each pool can be seen on “Exhibit A - Summary of Drug Rate Development - Commercial Community Rated - 2013 - Buffalo”.

The composite rate action (Medical + Rx) and composite loss ratio for each pool is shown in “Exhibit A - Summary of Composite Rate Development - Commercial Community Rated - 2013 - Buffalo”

**Affordable Care Act Excise Tax for 2014**

An additional load is being applied to the 2013 rates to incorporate the Excise Tax being assessed on the portion of premium from contracts that carry into 2014 in accordance with the Affordable Care Act. Exhibit E contains the details of how the load was calculated for each quarter and division. This load is in addition to the composite increase shown in Exhibit A.

**Affordable Care Act Reinsurance, CER, and Risk Adjustment Administrative Fees for 2014**

Similar to the Excise Tax load, an additional load is being applied to the 2013 rates to incorporate the Reinsurance, CER, and Risk Adjustment administrative fees in accordance with the Affordable Care Act. Exhibit F contains the details of how the load was calculated for each quarter. This load is also in addition to the composite increase shown in Exhibit A.

**Summary of Rate Actions & Projected Loss Ratios**

A summary of rate actions for each aggregation of policy forms is contained in “Exhibit A”. The details of the trend development are included in “Exhibit B”. The details of the medical and drug demographic aging trends are included in “Exhibit C”. The 2012/2011 factor was based on actual observed demographics.

The 2013/2012 and 2014/2013 factor was based on anticipated demographic changes.

### **Aggregate Group Community Rated**

This filing contains third and fourth quarter 2013 rates for BlueCross BlueShield of Western New York's Aqua/POS/HDHP, Traditional Small, and HMO 100 Small pools. The third quarter rates submitted in this rate filing have an average increase of 13.5% over rates for the same product and plan design that were effective for third quarter 2012. This average was computed based on projected 2013 enrollment in each rating block. The resulting third quarter rates are projected to produce an aggregate loss ratio of 85.2%. Rates for each subsequent quarter are calculated by rolling the previous quarter's rates at trend, which is 2.0% quarterly. Also being applied to the quarterly roll is the load for the Affordable Care Act Excise Tax and Reinsurance, CER, and Risk Adjustment administrative fees. The details of the development of the Excise Tax load are outlined in Exhibit E and the details of the development of the Reinsurance, CER, and Risk Adjustment administrative fees are outlined in Exhibit F.

### **Other Required Information**

Based on the requirements in Prior Approval Review Standards, this rate application includes:

- Applicable rate manuals
- An exhibit (part of rate manual) which shows the following: (a) current rates, (b) revised rates, (c) dollar change in rates, and (d) percentage change in rates. The proposed rate increases for each rating pool is applied to each policy form within that aggregation. The calculated rate increases may differ slightly from this due to rounding ("Exhibit A").
- Sample copy of initial and final rate change notices to be sent.
- Required Exhibits:
  - Exhibit 1: General Information About the Rate Adjustment Submission
  - Exhibit 2: Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustments Filings
  - Exhibit 3: Narrative Summary
  - Exhibit 4: Summary of Proposed Percentage Rate Change to Existing Rate
  - Exhibit 5: Distribution of Contracts Affected by Proposed Rate Adjustments
  - Exhibit 6: Summary of Policy Form and Product Changes
  - Exhibit 7: Historical Data by Each Policy Form Included in Rate Adjustment Filing

Rate Manuals:

The POS Lite, Aqua, HDHP, and Transitional Rate Manuals are filed with both BlueCross BlueShield of Western New York and BlueShield of Northeastern New York's rates. To maintain consistency of the rate manuals, rates from both divisions are included. Only rates for BlueCross BlueShield of Western New York have been updated while rates for BlueShield of Northeastern New York remain unchanged from the previous filing.

Exhibit 2:

Year end 2012 financial exhibits that are used to produce this exhibit were not created at the time of submission. Prior year end (2011) financial exhibits were thus used to produce this exhibit. If requested, we will recreate this exhibit with updated financial information when it becomes available.

Exhibit 4B:

For LG Market Segment [both Q3 and Q4], the Weighted Avg for all policy forms is listed as "N/A" because there is no membership.

For SG Market Segment, the Weighted Avg for policy forms "H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)" [Q3 and Q4], "HN-HMO.MAND-10" [Q3 and Q4], and "L33G3N0289" [Q3 only] are listed as "N/A" because there is no membership.

For Exhibit 4D:

For LG Market Segment [both Q3 and Q4], the Weighted Avg for all policy forms is listed as "N/A" because there is no membership.

For SG Market Segment, the Weighted Avg for policy forms "L33G3N0289" [Q3 Only], "BCC-15" [Q3 only], "H-1575 & BCMS-1 (Rev 1993)" [Q3 and Q4], "H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)" [Q3 and Q4], and "HN-HMO.MAND-10" [Q3 and Q4] are listed as "N/A" because there is no membership.

For Exhibit 5B:

For LG Market Segment [both Q3 and Q4], the Weighted Avg for all products is listed as "N/A" because there is no membership.

For SG Market Segment [Q3 only], the Weighted Avg for product "PPO 7000" is listed as "N/A" because there is no membership.

For Exhibit 7:

As requested, the entire Commercial Community Rated block of business for both Western New York and Northeastern New York has been represented.

**Actuarial Certification**

I, [REDACTED], am the Chief Actuary for HealthNow New York, Inc. I am a member of the American Academy of Actuaries, and meet the appropriate Qualification Standards of the Academy to render the actuarial opinion contained herein.

I certify that:

- a. The filing is in compliance with all applicable laws and regulations of the State of New York
- b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.
- c. The expected loss ratio meets the minimum requirement of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions.
- d. The benefits are reasonable in relation to the premiums charged.
- e. The rates are not unfairly discriminatory.

[REDACTED]

[REDACTED]

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

A. Insurer Information:	<b>HealthNow NY Inc.</b> <small>Company submitting the rate adjustment request</small>	<b>Not-For-Profit - 43</b> <small>Company Type</small>	<b>Not-for-Profit</b> <small>Org. Type</small>	<b>55204</b> <small>Company NAIC Code</small>
	<b>257 West Genesee St, Buffalo, NY 14202</b> <small>Company mailing address</small>			
B. Contact Person:				
	<small>Rate filing contact person name, title</small>	<small>Contact phone number</small>		<small>Contact Email address</small>
C. Actuarial Contact (If different from above):	<small>Actuary name, title</small>	<small>Actuary phone number</small>		<small>Actuary Email address</small>
D. New Rate Information (See Note #1):	<b>Commercial Q3 Renewal (WNY Only)</b>	<b>07/01/2013</b>		<b>HLTH-128847546</b>
	<small>New rate applicability period</small>	<small>New rate effective date</small>		<small>SERFF Tracking Number</small>
E. Market segments included in filing (e.g., Large Group, Small Group, Sole Proprietors, Individual, Healthy NY, Medicare Supplement):	<b>Small Group</b>			
F. Provide responses for the following questions:	<b>Response</b>			
1. Does this filing include any revision to contract language that is not yet approved? See note (2).	<b>No</b>			
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	<b>No</b>			
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).	<b>Yes - All policy holders and contract holders - 01/18/2013</b>			
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?	<b>Yes</b>			
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 prefiling.	<b>Yes - HLTH-128843795</b>			

**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

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

Company Name: HealthNow NY Inc.  
 NAIC Code: 55204  
 SERFF Number: HLTH-129847546

- 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 assessments) - 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
SG	Buffalo Trad	XX 07/01/13	06/30/14	3.00%	1.15%	0.71%	2.27%	0.00%	0.00%	7.85%	11.98%	-2.42%	0.00%	0.00%	0.16%	20.00%	0.00%	9.72%	3.37	2.07	6.63	0.00	0.00	22.91	34.98	(7.06)	0.00	0.47	0.00	28.38
SG	Buffalo MC	XX 07/01/13	06/30/14	3.00%	0.78%	0.45%	0.88%	0.00%	0.00%	6.87%	8.99%	-11.08%	0.00%	0.00%	0.10%	20.00%	0.00%	-1.99%	3.52	2.04	3.93	0.00	0.00	30.88	40.38	(49.77)	0.00	0.47	0.00	(8.92)

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

EXHIBIT 2: SUMMARY C

Company Name  
NAIC Code  
SERFF Number

- A. Complete a separate filing for each rating pool within the market segment.
- Information should be provided for each rating pool within the market segment.
- Indicate the market segment (e.g., Small Group, Individual, etc.)
- Enter a descriptive title for the rating pool.
- Use a separate rate filing for each rating pool.
- Append additional information to the rate filing.
- B. The average claim filing to project the rate.
- C. Enter the required information included in the filing.
- D. Enter the corresponding information included in the filing immediately prior to the current filing.
- E. This form must be filed with the rate filing.

Data Item for Specified Rating Pool																																
For the rate period included in the immediately prior rate adjustment filing (or initial form & rate filing)																																
1. Market Segment	2. Description of rating pool within the market segment	3. NAIC Code	4. SERFF Number	5. Period assumed - beginning date (MM/DD/YYYY)	6. Period assumed - ending date (MM/DD/YYYY)	7. Average annual claim trend assumed	8. 21.1 Regulatory authority licenses and fees, including New York State 332 assessment	9. 21.2 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	10. 21.3 Commissions and broker fees - as a % of gross premium	11. 21.4 Premium Taxes - as a % of gross premium	12. 21.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	13. 21.6 Other administrative expenses as a % of gross premium	14. 21.7 Subtotal columns 21.1 through 21.6	15. 22. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	16. 23. State income tax component - as a % of gross premium	17. 23.1 State income tax rate assumed (eg 3%)	18. 24. Federal income tax component - as a % of gross premium	19. 24.1 Federal income tax rate assumed (eg 30%)	20. 25. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	21. 26. Subtotal lines 21.7 + 22 + 23 + 24 + 25	22. 27.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as \$mpm	23. 27.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as \$mpm	24. 27.3 Commissions and broker fees - as \$mpm	25. 27.4 Premium Taxes - as \$mpm	26. 27.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as \$mpm	27. 27.6 Other administrative expenses - as \$mpm	28. 27.7 Subtotal lines 27.1 through 27.6	29. 28. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	30. 29. State income tax component - as \$mpm	31. 30. Federal income tax component - as \$mpm	32. 31. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	33. 32. Subtotal columns 27.7 through 31
SG	Buffalo Trad	XX		07/01/12	06/30/13	3.00%	1.15%	0.71%	2.27%	0.00%	0.00%	7.85%	11.98%	-2.42%	0.00%	0.00%	0.16%	20.00%	0.00%	9.72%	3.27	2.01	6.44	0.00	0.00	22.24	33.96	(6.86)	0.00	0.46	0.00	27.56
SG	Buffalo MC	XX		07/01/12	06/30/13	3.00%	0.78%	0.45%	0.88%	0.00%	0.00%	6.87%	8.99%	-11.08%	0.00%	0.00%	0.10%	20.00%	0.00%	-1.99%	3.42	1.98	3.82	0.00	0.00	29.98	39.20	(48.32)	0.00	0.45	0.00	(8.66)



BlueCross BlueShield of Western New York  
257 West Genesee Street • Buffalo, New York 14202

APPLICATION BY BLUECROSS BLUESHIELD OF WESTERN NEW YORK  
TO THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES  
FOR A PREMIUM ADJUSTMENT

NAIC #: 55204  
SERFF Tracking #: HLTH-128847546

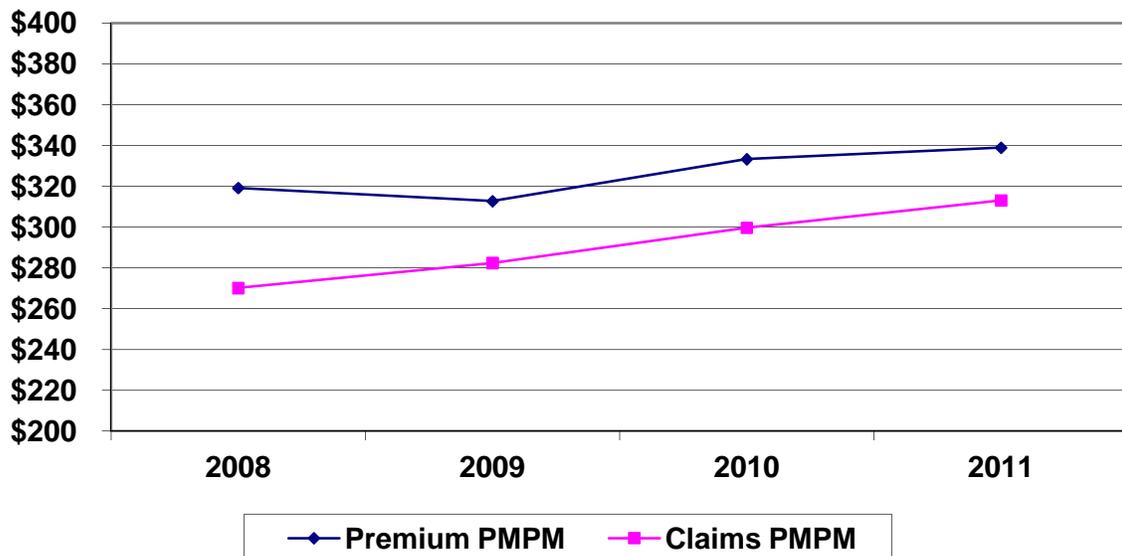
TO BE EFFECTIVE UPON 2013 RENEWAL DATE

THIS APPLICATION IS FOR OUR COMMUNITY RATED PRODUCTS

**1. Introduction.** BlueCross BlueShield of Western New York has submitted this application to modify premium rates. We are well aware of the difficulty that all businesses and individuals have in paying premiums. The trend of constantly rising health care costs has been going on for some time and, as a company that listens carefully to our customers, we are well aware of the financial problems and difficult choices that rising premiums cause in our customer's budgets. We did not submit this application lightly; we did so only after serious consideration of the impact of the increases, and only after implementing measures to reduce costs as much as possible.

Consistent with experience around the country, the annual rise in premium rates closely tracks the underlying annual rise in health care costs. The amounts that hospitals, doctors and others charge for their services rises each year, as does the number and intensity of services that are used by the people we insure. It logically follows that premiums will therefore rise as well. For example, the chart below demonstrates that premiums rise to follow the increasing per person costs of health care incurred by our community rated members. More information about those rising healthcare costs is listed below. We hope that review of the materials below will at least explain why the premium increases are occurring.

**History of Increases**



We have done our best to limit those underlying annual increases in health care costs. We have in place a number of programs designed to reduce medical waste and to help our members to better manage their health to avoid costly medical conditions (See section 7 below for more detail on these programs.). We have also negotiated vigorously with doctors, hospitals and other providers of care to limit their annual fee increases. However, we need to be cautious during those negotiations because it is important that those providers receive sufficient payments from us to assure they are ready, willing and able to provide the high quality care members expect when they seek care. We have also created alternative products which provide valuable coverage but at a lower price, such as our high deductible health plans.

## 2. Who is affected and when.

This rate change application affects only the customers enrolled in small group, sole proprietor, or direct pay products (as well as a few large group customers). All the customers and products subject to this application are community rated. This means that all members holding the same coverage have the same premium; the premiums do not vary by age, sex, medical conditions or usage of health care services.<sup>1</sup> Most large groups and government programs are subject to different premium setting rules and a different approval process than applies to this application.

For the small group, large group, and sole proprietor community rated groups, the rate change will be effective upon renewal date in the 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2013. The rates vary by the 2013 calendar year quarter in which the group renews and are guaranteed for the 12 month period starting on the renewal date. Commercial community rated includes all HMO (100 series and 200 series), POS Lite (aka 250D), EPO (Sky), PPO 800 series, High Deductible (8000 series (aka Healthy Balance), 7000 series (POS 7000 is also called Slate) and POS / PPO Denim), Indemnity 900 series products, and Dental.

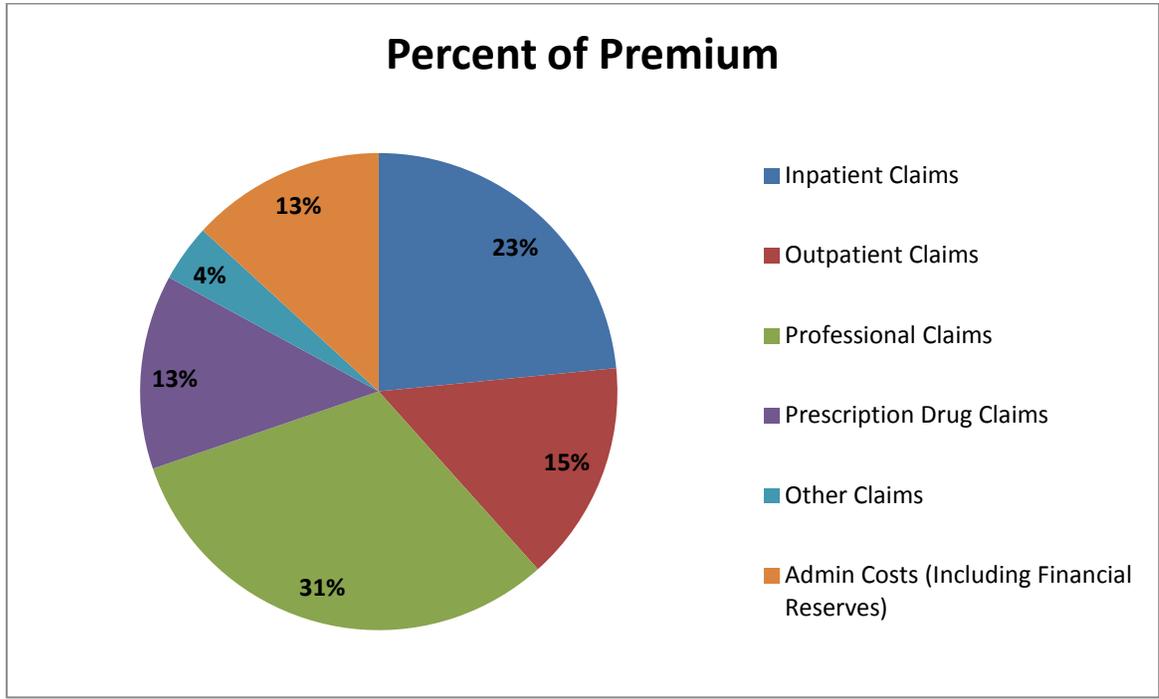
The estimated total number of members affected by the rate change based on current membership is 16,846.

## 3. Where premium dollars go.

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<sup>1</sup> Community rating is mandated by New York law for all insurers and HMOs for all direct payment customers and all small groups (including associations containing small groups).

The chart below shows the percent of premium represented by various cost categories in a typical year.



**4. Rising Health Care Costs.** We change premium rates only after careful review of the current costs we are paying for our members' health care and we determine there is a pattern of rising costs. Below is a summary of the key factors in determining our premium rates, and why the rates need to change.

**A. Use of services.** How many medical services members use – doctor visits, prescriptions, surgeries, x-rays, lab tests, hospital stays, etc. is part of this calculation. We measure the numbers of services used per 1,000 members to calculate usage rates. But, in addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones used last year, the amount we pay rises. In many years, there is an increase both in the number of services used on average and in the intensity/cost of those services. In general, we expect that utilization will increase in our region as follows:

Utilization Changes	2012 (Proj) <sup>2</sup>	2013
Inpatient Hospital utilization	3.6%	0.7%
Outpatient Hospital utilization	5.2%	2.9%
Professional utilization	4.0%	3.8%
Prescription Drug utilization	-1.4%	-2.6%

<sup>2</sup> The current year is not yet concluded so our data at the time of this application is a projection.

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services. Despite our best efforts to negotiate to keep rates lower, we expect the following fee increases:

<u>Price Changes</u>	2012 (Proj)	2013
Inpatient Hospital prices	7.9%	6.5%
Outpatient Hospital prices	6.4%	6.0%
Professional prices	2.6%	1.8%
Prescription Drug prices	0.8%	1.9%

C. Copay/Deductible Leveraging. When the price of medical services increases, if a plan design has deductibles and copays that are fixed dollar amounts rather than a percent coinsurance, the costs to the insurer will increase at a higher rate. As an example, suppose the fee for a typical doctor’s office visit is \$100 and the patient pays a \$25 copay. The cost to the insurer would then be \$75. Now suppose the next year the doctor’s fees increase 5% to \$105 and the patient’s copay is still \$25. This leaves \$80 for the insurer to pay, a 6.67% increase. This additional 1.67% increase above the 5% increase in fees is called leveraging. We expect this to impact the community rated products as follows:

<u>Leveraging</u>	2012 (Proj)	2013
Small/Large Group	1.2%	1.2%
Direct Pay	0.1%	0.1%
Healthy New York	1.1%	1.1%

D. Population Demographics. Different age and gender combinations tend to have different average costs to insure. At younger ages, women tend to cost more than men; at older ages, men tend to cost more than women; and older people tend to cost more than younger people. Because community rating does not allow us to vary rates by age or gender, the costs for everyone must go up if the mix within a product, or our entire block of business, shifts toward more expensive age/gender combinations. We expect this to impact the community rated products as follows:

<u>Medical Demographic Shift</u>	2012 (Proj)	2013
Small/Large Group	2.1%	2.1%
Direct Pay	0.5%	0.0%
Healthy New York	4.0%	1.0%

<u>Prescription Drug Demographic Shift</u>	2012 (Proj)	2013
Small/Large Group	1.5%	1.5%
Direct Pay	-4.4%	0.0%
Healthy New York	7.0%	1.0%

E. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, detecting fraud and abuse, and maintaining our financial reserves so that we have sufficient funds to pay members’ claims if

there is an unexpected rise in claims payments. The anticipated change in our per member per month administrative costs and financial reserves (as reflected in our premium rates) is as follows:

Market	2012 (Proj)	2013
Small/Large Group	\$41.55	\$42.79
Direct Pay	\$43.51	\$39.65
Healthy New York	\$40.25	\$27.40
Medicare Supplement	\$44.04	\$55.31

**5. State Healthcare Taxes & Assessments.** New York State law requires that we pay several state taxes or assessments:

A. A “surcharge” of 9.63% on each claim payment we make for hospital inpatient care or hospital outpatient care. This is similar to a sales tax. We paid approximately \$13.9 million<sup>3</sup> on our community rated business during 2011.

B. An “assessment” on each person (life) we cover for persons residing in N.Y.S. The assessment is larger for family coverage than for single persons. The assessment varies by geographic region of N.Y.S. We paid approximately \$3.5 million<sup>3</sup> on our community rated business during 2011.

The surcharges and assessments are mandated by New York’s Health Care Reform Act (HCRA). The State uses the monies for a variety of purposes, such as funding the State Medicaid program, funding hospitals for providing care to patients without any health insurance, and a variety of other State health care grants and insurance subsidy programs.

C. All insurers pay a fee to fund the operations of the New York Department of Financial Services (formerly the Insurance Department). Thus the State Department of Financial Services is funded by insurers rather than by state income or typical state taxes. We paid approximately \$4.6 million<sup>3</sup> on our community rated business during 2011.

The combination of all our payments of the State health care taxes above constitutes approximately 4% of our community rated premiums.

**6. Our Financial Information.**

We maintain financial reserves for the protection of our customers. These are monies we have in the bank or other accounts so that funds are available when there is a surge in claims or for any other reason that we need to reach into our bank accounts in order to pay claims for our members in the event current premiums are not sufficient to pay current claims and expenses. Reserves are measured as a percentage of our annual premiums. We are a not-for-profit insurer, so none of the funds in our reserves are used to pay stockholders or dividends to investors. These reserves are funded by gains from our product portfolio and income from

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<sup>3</sup> This amount represents the entire Community Rated Commercial business of HealthNow New York Inc.

investment of these reserves in fixed income and other securities. As of December 31, 2011, our corporate reserves were 22.1% of annual premium. This was a \$39 million decline from December 31, 2010, when they were 23.7%.

There are a few financial measures that directly impact pricing.

A. Medical Loss Ratio. One method to evaluate the value members receive from their health plan is to determine what portion of all premiums paid are used to pay for medical services members use, as opposed to the expenses of the insurer. This is called the “medical loss ratio” (MLR).

Loss Ratios	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Small/Large Group	92%	91%	96%	87%
Direct Pay	105%	102%	110%	94%
Healthy New York	88%	96%	107%	90%
Med. Supp.	87%	85%	89%	82%

B. Gains/Losses. In order to produce funds to add to our financial reserves our revenues must exceed our expenses. Our gain/loss on community rated business is as follows:

Gain/Loss	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Small/Large Group	-4.6%	-1.4%	-6.8%	3.0%
Direct Pay	-21.7%	-13.0%	-23.6%	-6.1%
Healthy New York	-1.7%	-8.2%	-18.8%	0.3%
Med. Supp.	-19.7%	-10.0%	-13.1%	-4.4%

7. Our Cost Control and Quality Improvement Efforts. We have implemented several initiatives that are important to improving the health care of our members and assuring they receive the high quality medical care they deserve. These important initiatives include:

A. Disease Management. We have programs that work with members with certain chronic conditions to help them learn to keep their conditions under control. The major conditions that these programs focus on are:

- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Asthma
- Diabetes
- Back Pain

B. Coordination of Care. Comprehensive care management programs are designed to improve the health outcomes and satisfaction of our members through collaborative relationships with the members and our providers. We achieve our goals by enabling our members to make informed health care decisions and assisting them to navigate through the health care continuum. This assures appropriate quality care in a cost effective manner.

C. Hospital Readmission Reduction. Prior authorization processes ensure that the member having the right procedure performed by the right professional in the right place at the right time.

We do extensive medical review on claims to make sure the procedure would be medically necessary.

D. Improving Patient Safety and Reducing Medical Errors. Our Medical Economics staff provides analytics and information that allow us to contact members in order to manage their quality of care, ensure they do not get re-admitted into the hospital, or coordinate a plan of care with the member's physician.

E. The focus of the Quality Improvement Program is to continuously assess and improve the care delivered by our participating practitioners/providers.

F. Wellness and Health Promotion Activities. A number of wellness initiatives support engagement of healthy activities for individuals.

G. Fraud detection. It is an unfortunate reality that some customers, and some providers of health care, submit claims for services that were not in fact delivered, or which were billed at amounts higher than they should be. Our dedicated fraud detection staff conducts audits of claims payments, and works with the State Department of Financial Services (formerly the Insurance Department) and local prosecutors.

8. Unusual Increases or Decreases. Many people ask why premium rates are rising faster than the inflation rate of the general economy, especially when they themselves do not frequently use medical services. The shifting population within each of our products is an important factor in premium increases (called adverse selection). Just like fire insurance, the premium for health insurance consists of costs for many people who use little or no health care services in a particular year, which is balanced against the costs of a few people who have extensive health care costs. The balance of those two categories is a key factor in determining premiums.

For example, assume the product pool consists of 98 members with low health costs (\$5 each) and two persons with high costs (\$55 each), and thus total claims expenses of \$600.<sup>4</sup> That produces an average cost of \$6 per member. If 8 of the low cost members depart to buy other coverage or drop their insurance, there are now 90 members with low costs and two persons with high costs. The average cost rises to \$6.90 per member<sup>5</sup>. That is a 15% increase in premium due solely to the changed composition of our insurance pool. Then 10% or so is added to account for the rising price of prescriptions, hospitals etc., (see section 4 above) and thus the premium increase becomes 25%. The impact of this constant factor in premium setting is made much worse when rising health care costs, and a sluggish economy, cause more people than usual to drop their coverage, or seek other, lower cost products.

For more specific information about any increase of 10% or more, visit <http://companyprofiles.healthcare.gov> .

9. Conclusion. For all these reasons, BlueCross BlueShield must respectfully request a rate adjustment. Although we understand our customers' reluctance to have premiums increase, it is an unfortunate reality of the business world that our revenues must rise to meet our rising expenses, and we must maintain funds in our reserve account to protect our customers.

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<sup>4</sup>  $(98 * 5 = 490) + (2 * 55 = 110) = \$600$  total. Divided by 100 members = \$6 per member.

<sup>5</sup>  $(90 * 5 = 450) + (2 * 55 = 110) = \$560$  total. Divided by 92 members = \$6.90 per member. \$6.90 is 15% more than \$6.00.

The remaining page(s) show the rate changes requested by region, product, and group size in the rate filing. For Community Rated groups, the rate change is dependent upon anniversary date which is identified at the top of each page.

# Proposed Rate Adjustments

## Buffalo – Small Group

- The Aqua base medical plan has a proposed rate change of 17.0%
- The HMO 100 base medical plan has a proposed rate change of 18.0%
- The POS 7000-series base medical plan has a proposed rate change of 17.0%
- The PPO 7000-series base medical plan has a proposed rate change of 17.0%
- The POS 8000-series base medical plan has a proposed rate change of 17.0%
- The PPO 8000-series base medical plan has a proposed rate change of 17.0%
- The POS 250D Select base medical plan has a proposed rate change of 17.0%
- The Traditional Indemnity base medical plan has a proposed rate change of -5.0%

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

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

**HealthNow NY Inc**  
Company submitting the rate adjustment request

**55204**  
Company NAIC Code

**HLTH-128847546**  
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), 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. 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 should reflect the average using the distribution of contracts within each base medical product; the impact of riders is not included.

**Base Medical Plan Rolling Rate Products**

SERFF# HLTH-128847546

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
LS3G3N0232	LG	Buffalo	Aqua	Aqua	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
L33G3N0289	LG	Buffalo	POS 7000	Slate	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
C33G3N0392	LG	Buffalo	POS 8000	Healthy Balance	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
LS3G3N0195	LG	Buffalo	POS Lite	POS Lite	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
L33G3N0289	LG	Buffalo	PPO 7000	PPO 7000	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
C33G3N0392	LG	Buffalo	PPO 8000	Healthy Balance	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
LS3G3N0232	LG	Buffalo	Aqua	Aqua	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A
L33G3N0289	LG	Buffalo	POS 7000	Slate	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A
C33G3N0392	LG	Buffalo	POS 8000	Healthy Balance	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A
LS3G3N0195	LG	Buffalo	POS Lite	POS Lite	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A
L33G3N0289	LG	Buffalo	PPO 7000	PPO 7000	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A
C33G3N0392	LG	Buffalo	PPO 8000	Healthy Balance	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	N/A

Base Medical Plan Rolling Rate Products

SERFF# HLTH-128847546

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
LS3G3N0232	SG	Buffalo	Aqua	Aqua	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	17.4%
L33G3N0289	SG	Buffalo	POS 7000	Slate	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	17.4%
C33G3N0392	SG	Buffalo	POS 8000	Healthy Balance	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	17.4%
LS3G3N0195	SG	Buffalo	POS Lite	POS Lite	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	17.4%
L33G3N0289	SG	Buffalo	PPO 7000	PPO 7000	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	N/A
C33G3N0392	SG	Buffalo	PPO 8000	Healthy Balance	7/1/2013	7/1/2013-6/30/2014	17.4%	17.4%	17.4%
BCC-15	SG	Buffalo	Traditional	Traditional	7/1/2013	7/1/2013-6/30/2014	-1.6%	-1.6%	-1.6%
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	SG	Buffalo	Traditional	Traditional	7/1/2013	7/1/2013-6/30/2014	-1.6%	-1.6%	-1.6%
H-1575 & BCMS-1 (Rev 1993)	SG	Buffalo	Traditional	Traditional	7/1/2013	7/1/2013-6/30/2014	-1.6%	-1.6%	-1.6%
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	SG	Buffalo	Traditional	Traditional	7/1/2013	7/1/2013-6/30/2014	-1.6%	-1.6%	-1.6%
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	SG	Buffalo	Traditional	Traditional	7/1/2013	7/1/2013-6/30/2014	-1.6%	-1.6%	N/A
HN-HMO.2 & HN-POS.2	SG	Buffalo	HMO 100	HMO 100	7/1/2013	7/1/2013-6/30/2014	18.0%	18.0%	18.0%
HN-HMO.MAND-10	SG	Buffalo	HMO 100	HMO 100	7/1/2013	7/1/2013-6/30/2014	18.0%	18.0%	N/A
LS3G3N0232	SG	Buffalo	Aqua	Aqua	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
L33G3N0289	SG	Buffalo	POS 7000	Slate	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
C33G3N0392	SG	Buffalo	POS 8000	Healthy Balance	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
LS3G3N0195	SG	Buffalo	POS Lite	POS Lite	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
L33G3N0289	SG	Buffalo	PPO 7000	PPO 7000	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
C33G3N0392	SG	Buffalo	PPO 8000	Healthy Balance	10/1/2013	10/1/2013-9/30/2014	17.0%	17.0%	17.0%
BCC-15	SG	Buffalo	Traditional	Traditional	10/1/2013	10/1/2013-9/30/2014	-5.0%	-5.0%	-5.0%
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	SG	Buffalo	Traditional	Traditional	10/1/2013	10/1/2013-9/30/2014	-5.0%	-5.0%	-5.0%
H-1575 & BCMS-1 (Rev 1993)	SG	Buffalo	Traditional	Traditional	10/1/2013	10/1/2013-9/30/2014	-5.0%	-5.0%	-5.0%
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	SG	Buffalo	Traditional	Traditional	10/1/2013	10/1/2013-9/30/2014	-5.0%	-5.0%	-5.0%
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	SG	Buffalo	Traditional	Traditional	10/1/2013	10/1/2013-9/30/2014	-5.0%	-5.0%	N/A
HN-HMO.2 & HN-POS.2	SG	Buffalo	HMO 100	HMO 100	10/1/2013	10/1/2013-9/30/2014	18.0%	18.0%	18.0%
HN-HMO.MAND-10	SG	Buffalo	HMO 100	HMO 100	10/1/2013	10/1/2013-9/30/2014	18.0%	18.0%	N/A

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

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

HealthNow NY Inc  
Company submitting the rate adjustment request

55204  
Company NAIC Code

HLTH-128847546  
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), 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. 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: HLTH-128847546						Proposed Percentage Rate Change		
	Base Medical Policy Form #	Market Segment	Rating Region	Drug Rider	Base Medical Product Name	Effective Date of New Rate	Effective Period of New Rate	Lowest	Highest
LS3G3N0232	LG	Buffalo	LS3G3N0195; HNDRUG (0602)	Aqua	07/01/2013	07/01/2013-06/30/2014	-37.6%	40.0%	N/A
L33G3N0289	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	POS 7000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	N/A
C33G3N0392	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	POS 8000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	N/A
LS3G3N0195	LG	Buffalo	HNDRUG (0602); LS3G3N0195	POS Lite	07/01/2013	07/01/2013-06/30/2014	-53.8%	40.0%	N/A
L33G3N0289	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	PPO 7000	07/01/2013	07/01/2013-06/30/2014	-37.6%	40.0%	N/A
C33G3N0392	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	PPO 8000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	N/A
LS3G3N0232	LG	Buffalo	LS3G3N0195; HNDRUG (0602)	Aqua	10/01/2013	10/01/2013-09/30/2014	-37.6%	40.0%	N/A
L33G3N0289	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	POS 7000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	N/A
C33G3N0392	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	POS 8000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	N/A
LS3G3N0195	LG	Buffalo	HNDRUG (0602); LS3G3N0195	POS Lite	10/01/2013	10/01/2013-09/30/2014	-53.8%	40.0%	N/A
L33G3N0289	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	PPO 7000	10/01/2013	10/01/2013-09/30/2014	-37.6%	40.0%	N/A
C33G3N0392	LG	Buffalo	HNDRUG (0602); LS3G3N0195; LS3G3N0289	PPO 8000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	N/A

Drug Riders Available With Rolling Rate Base Medical Products

SERFF: HLTH-128847546

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
LS3G3N0232	SG	Buffalo	LS3G3N0195; HNRUG (0602);	Aqua	07/01/2013	07/01/2013-06/30/2014	-37.6%	40.0%	14.0%
L33G3N0289	SG	Buffalo	LS3G3N0195; LS3G3N0289	POS 7000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	-2.9%
C33G3N0392	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	POS 8000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	6.1%
LS3G3N0195	SG	Buffalo	HNRUG (0602); LS3G3N0195	POS Lite	07/01/2013	07/01/2013-06/30/2014	-53.8%	40.0%	4.5%
L33G3N0289	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	PPO 7000	07/01/2013	07/01/2013-06/30/2014	-37.6%	40.0%	N/A
C33G3N0392	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	PPO 8000	07/01/2013	07/01/2013-06/30/2014	-27.6%	40.0%	1.4%
BCC-15	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	07/01/2013	07/01/2013-06/30/2014	-10.6%	63.2%	N/A
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	07/01/2013	07/01/2013-06/30/2014	-30.7%	63.2%	31.9%
H-1575 & BCMS-1 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	07/01/2013	07/01/2013-06/30/2014	-30.7%	16.2%	N/A
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	07/01/2013	07/01/2013-06/30/2014	-9.6%	63.2%	19.8%
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	07/01/2013	07/01/2013-06/30/2014	-9.6%	63.2%	N/A
HN-HMO.2 & HN-POS.2	SG	Buffalo	CB147REV; CB-249; CB-250; HNRUG-HMO.1; CR1A4N0096	HMO 100	07/01/2013	07/01/2013-06/30/2014	-19.2%	81.0%	31.2%
HN-HMO.MAND-10	SG	Buffalo	CB147REV; CB-249; CB-250; HNRUG-HMO.1; CR1A4N0096	HMO 100	07/01/2013	07/01/2013-06/30/2014	-19.2%	81.0%	N/A

Drug Riders Available With Rolling Rate Base Medical Products

SERFF: HLTH-128847546

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
LS3G3N0232	SG	Buffalo	LS3G3N0195; HNRUG (0602);	Aqua	10/01/2013	10/01/2013-09/30/2014	-37.6%	40.0%	11.7%
L33G3N0289	SG	Buffalo	LS3G3N0195; LS3G3N0289	POS 7000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	4.5%
C33G3N0392	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	POS 8000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	11.7%
LS3G3N0195	SG	Buffalo	HNRUG (0602); LS3G3N0195	POS Lite	10/01/2013	10/01/2013-09/30/2014	-53.8%	40.0%	3.8%
L33G3N0289	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	PPO 7000	10/01/2013	10/01/2013-09/30/2014	-37.6%	40.0%	-3.2%
C33G3N0392	SG	Buffalo	HNRUG (0602); LS3G3N0195; LS3G3N0289	PPO 8000	10/01/2013	10/01/2013-09/30/2014	-27.6%	40.0%	9.7%
BCC-15	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	10/01/2013	10/01/2013-09/30/2014	-10.6%	63.2%	28.4%
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	10/01/2013	10/01/2013-09/30/2014	-30.7%	63.2%	14.5%
H-1575 & BCMS-1 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	10/01/2013	10/01/2013-09/30/2014	-30.7%	16.2%	N/A
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	10/01/2013	10/01/2013-09/30/2014	-9.6%	63.2%	24.1%
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	SG	Buffalo	PD1(S/L); PD2(S/L); PD3(S/L); PD10; PD11; PD12; GPD2; GPD3; HNRUG; CR1A3N0097	Traditional	10/01/2013	10/01/2013-09/30/2014	-9.6%	63.2%	N/A
HN-HMO.2 & HN-POS.2	SG	Buffalo	CB147REV; CB-249; CB-250; HNRUG-HMO.1; CR1A4N0096	HMO 100	10/01/2013	10/01/2013-09/30/2014	-19.2%	81.0%	24.8%
HN-HMO.MAND-10	SG	Buffalo	CB147REV; CB-249; CB-250; HNRUG-HMO.1; CR1A4N0096	HMO 100	10/01/2013	10/01/2013-09/30/2014	-19.2%	81.0%	N/A

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

Company Name: HealthNow NY Inc.  
 NAIC Code: 55204  
 SERFF Tracking #: HLTH-128847546

**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 contracts or members for that market segment/product and for the market segment in total.
- 5) 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), 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. 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#: HLTH-128847546

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Total # of Members as of	Total # of Contracts as of	Number of (*) with Proposed Percentage Rate Change at Renewal													
								10/15/2012	Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher		
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	Aqua	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	POS 7000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	POS 8000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	POS Lite	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	PPO 7000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	LG	Buffalo	PPO 8000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>			<b>N/A</b>	<b>0</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	Aqua	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	POS 7000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	POS 8000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	POS Lite	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	PPO 7000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	LG	Buffalo	PPO 8000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>			<b>N/A</b>	<b>0</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	Aqua	16.0%	2,599		0	0	0	218	0	2,381	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	POS 7000	11.9%	952		0	0	355	0	0	597	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	POS 8000	14.6%	970		0	0	132	0	0	838	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	POS Lite	14.2%	2,307		0	0	11	515	0	1,781	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	PPO 7000	N/A	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	PPO 8000	13.3%	569		0	0	137	0	0	432	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	Traditional	-1.1%	92		85	0	5	1	1	0	0	0	0	0	0	0	0	0
7/1/2013	7/1/2013-6/30/2014	SG	Buffalo	HMO 100	18.5%	722		0	0	0	0	231	1	490	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>			<b>14.7%</b>	<b>8,211</b>		<b>85</b>	<b>0</b>	<b>640</b>	<b>734</b>	<b>232</b>	<b>6,030</b>	<b>490</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	Aqua	15.7%	3,747		0	0	44	294	0	3,409	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	POS 7000	14.0%	1,787		0	0	333	0	0	1,454	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	POS 8000	16.0%	885		0	0	26	0	0	859	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	POS Lite	14.3%	1,595		0	0	5	313	0	1,277	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	PPO 7000	11.7%	584		68	0	115	0	0	401	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	PPO 8000	14.6%	121		0	0	21	0	0	100	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	Traditional	-0.3%	99		85	0	3	11	0	0	0	0	0	0	0	0	0	0
10/1/2013	10/1/2013-9/30/2014	SG	Buffalo	HMO 100	17.9%	979		0	0	0	52	336	6	585	0	0	0	0	0	0	0
		<b>Market Segment Total:</b>			<b>15.0%</b>	<b>9,797</b>		<b>153</b>	<b>0</b>	<b>547</b>	<b>670</b>	<b>336</b>	<b>7,506</b>	<b>585</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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

**Company Name:** HealthNow NY Inc

**NAIC Code:** 55204

**SERFF Number:** HLTH-128847546

**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
Approved	HLTH-128566238	2012070197	07/20/2012	CN3RAS0418	All Products	NYS Autism Mandate
Approved	HLTH-128585061	2012070222	07/25/2012	L33G3N0289	POS / PPO 7000	Several benefit and copay changes
Approved	HLTH-128586866	2012070241	07/26/2012	C33G3N0428	POS 250 Blended	New POS Product with Deductible and Copay/Coinsurance
Approved	HLTH-128568601	2012070240	07/26/2012	CR1RAN0421	All Products	Drug Rate Realignment
Approved	HLTH-128595819	2012080006	07/31/2012	LS3G3N0232	Aqua	Lifestyle Benefit Change
Approved	HLTH-128566119	2012070131	07/13/2012	CN3RAS0411	All Products	Oral Chemo NYS Mandate
Approved	HLTH-128566158	2012070142	07/13/2012	CH1R4N0241	HMO 100	WNY Inpatient Copay Change
Approved	HLTH-128566006	2012070150	07/14/2012	CS1R4N0122	HMO 100	WNY Out-of-Network
Pending	HLTH-128818352	2012120090	12/18/2012	CS1R4N0122	POS 250 Blended	Convert from a new policy form to a rider

partment).

his filing.

Approval Date
09/20/2012
08/07/2012
11/21/2012
08/27/2012
08/03/2012
08/21/2012
08/27/2012
10/11/2012
N/A

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

Company Name: HealthNow NY Inc  
 NAIC Code: 55204  
 SERFF Number: HLTH-128847546

- A. Complete a separate ROW 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.
  - Information requested applies to New York State business only.
  - Include riders that may be available with that policy form in each policy form response.
  - Insert additional rows as needed to include all base medical policy forms included in a particular rating pool.
  - Add a row with the aggregate values for that entire rating pool and enter an appropriate identifier in column 1a. Skip a row between the different rating pools.
- B. In Column 2 enter a Rating Pool Identifier for the rating pool the policy form belongs to, such as SG HMO, or SG HMO Upstate if rating pools vary by rating region.
- C. 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. Use the drop down list to enter the market segment.
- D. Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, Consumer Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit, Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for policy form), etc.
- E. 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). Include a region identifier in this column if needed.
- F. Note that many cells include a drop down list. Use the drop down list for entries.
- G. If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- H. This form must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form															
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identifier	3. Effective date of rate change (MM/DD/YY)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]	8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	9. Rate guarantee period incorporated into rate tables (months) (e.g., 12, for a 12 month rate guarantee period; or 0, if no rate guarantee period.)	10. Weighted average rate change % proposed across base medical policy form from current rate charged policyholder (including all associated riders)	11. Number of policyholders affected by rate change. (For group business this is number of groups.)	12. Number of covered lives affected by rate change	13. Expected NY statewide loss ratio for base medical policy form including associated riders	
BCC-15	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	8	19	91.4%	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	175	201	91.4%	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	0	0	91.4%	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	5	5	91.4%	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	433	820	91.4%	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	-4.21%	0	0	91.4%	XX
Total Traditional Small - Buffalo	Traditional	Traditional	Traditional	07/01/13		Comprehensive Major Medical	Yes	No	Open	12	-4.21%	621	1,045	91.4%	XX
BCC-15	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	1	1	87.4%	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	188	258	87.4%	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	0	0	87.4%	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	2	2	87.4%	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	93	155	87.4%	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	Traditional	Traditional	07/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	9.44%	0	0	87.4%	XX
Total Traditional Large - Buffalo	Traditional	Traditional	Traditional	07/01/13		Comprehensive Major Medical	Yes	No	Open	12	9.44%	284	416	87.4%	XX
C33G3N0392	HDHP 8000	Healthy Balance	Aqua/POS/HDHP	07/01/13	SG	Non-HMO based POS	Yes	No	Open	12	14.44%	5,482	11,197	84.6%	XX
C33G3N0392	HDHP 8000	Healthy Balance	Aqua/POS/HDHP	07/01/13	LG	Non-HMO based POS	Yes	No	Open	12	14.44%	0	0	84.6%	XX
L33G3N0289	HDHP 7000	Slate	Aqua/POS/HDHP	07/01/13	SG	Non-HMO based POS	Yes	No	Open	12	14.44%	3,019	6,410	84.6%	XX
L33G3N0289	HDHP 7000	Slate	Aqua/POS/HDHP	07/01/13	LG	Non-HMO based POS	Yes	No	Open	12	14.44%	0	0	84.6%	XX
LS3G3N0195	POS Lite	POS Lite	Aqua/POS/HDHP	07/01/13	SG	Non-HMO based POS	Yes	No	Open	12	14.44%	7,732	14,203	84.6%	XX
LS3G3N0195	POS Lite	POS Lite	Aqua/POS/HDHP	07/01/13	LG	Non-HMO based POS	Yes	No	Open	12	14.44%	0	0	84.6%	XX
LS3G3N0232	Aqua	Aqua	Aqua/POS/HDHP	07/01/13	SG	Non-HMO based POS	Yes	No	Open	12	14.44%	8,489	14,978	84.6%	XX
LS3G3N0232	Aqua	Aqua	Aqua/POS/HDHP	07/01/13	LG	Non-HMO based POS	Yes	No	Open	12	14.44%	0	0	84.6%	XX
Total Aqua/POS/HDHP - Buffalo			Aqua/POS/HDHP	07/01/13		Non-HMO based POS	Yes	No	Open	12	14.44%	24,722	46,788	84.6%	XX

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

CB-229	HMO 200	HMO 200	HMO 200	07/01/13	SG	HMO	Yes	No	Open	12	6.74%	0	0	82.8%	XX
CB-251	HMO 200	HMO 200	HMO 200	07/01/13	SG	HMO	Yes	No	Open	12	6.74%	0	0	82.8%	XX
CB-251 & POS-12	HMO 200	HMO 200	HMO 200	07/01/13	SG	HMO	Yes	No	Open	12	6.74%	0	0	82.8%	XX
CB-283	HMO 200	HMO 200	HMO 200	07/01/13	SG	HMO	Yes	No	Open	12	6.74%	5	8	82.8%	XX
LS1G4N0004	HMO 200	HMO 200	HMO 200	07/01/13	SG	HMO based POS	Yes	No	Open	12	6.74%	875	1,598	82.8%	XX
Total HMO 200 Small - Buffalo	HMO 200	HMO 200	HMO 200	07/01/13			Yes	No	Open	12	6.74%	880	1,606	82.8%	XX
CB-229	HMO 200	HMO 200	HMO 200	07/01/13	LG	HMO	Yes	No	Open	12	0.99%	3,133	5,744	96.2%	XX
CB-251	HMO 200	HMO 200	HMO 200	07/01/13	LG	HMO	Yes	No	Open	12	0.99%	0	0	96.2%	XX
CB-251 & POS-12	HMO 200	HMO 200	HMO 200	07/01/13	LG	HMO	Yes	No	Open	12	0.99%	0	0	96.2%	XX
CB-283	HMO 200	HMO 200	HMO 200	07/01/13	LG	HMO	Yes	No	Open	12	0.99%	0	0	96.2%	XX
LS1G4N0004	HMO 200	HMO 200	HMO 200	07/01/13	LG	HMO based POS	Yes	No	Open	12	0.99%	2,029	3,761	96.2%	XX
Total HMO 200 Large - Buffalo	HMO 200	HMO 200	HMO 200	07/01/13			Yes	No	Open	12	0.99%	5,162	9,505	96.2%	XX
HN-HMO.2	HMO 100	HMO 100	HMO 100	07/01/13	SG	HMO	Yes	No	Open	12	16.87%	0	0	85.2%	XX
HN-HMO.2 & HN-POS.2	HMO 100	HMO 100	HMO 100	07/01/13	SG	HMO based POS	Yes	No	Open	12	16.87%	3,519	6,234	85.2%	XX
Total HMO 100 Small - Buffalo	HMO 100	HMO 100	HMO 100	07/01/13			Yes	No	Open	12	16.87%	3,519	6,234	85.2%	XX
HN-HMO.2	HMO 100	HMO 100	HMO 100	07/01/13	LG	HMO	Yes	No	Open	12	11.91%	0	0	84.9%	XX
HN-HMO.2 & HN-POS.2	HMO 100	HMO 100	HMO 100	07/01/13	LG	HMO based POS	Yes	No	Open	12	11.91%	2,188	3,675	84.9%	XX
Total HMO 100 Large - Buffalo	HMO 100	HMO 100	HMO 100	07/01/13			Yes	No	Open	12	11.91%	2,188	3,675	84.9%	XX
BS-CC-1AB (6/90)	Traditional	Traditional	Traditional	01/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	20	38	85.3%	XX
BS-CCM-1(Rev) (7/94)	Traditional	Traditional	Traditional	01/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	65	100	85.3%	XX
BSNNY-1 (12/83)	Traditional	Traditional	Traditional	01/01/13	SG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	10	17	85.3%	XX
Total Traditional Small - Albany	Traditional	Traditional	Traditional	01/01/13			Yes	No	Open	12	6.00%	95	155	85.3%	XX
BS-CC-1AB (6/90)	Traditional	Traditional	Traditional	01/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	5	6	212.1%	XX
BS-CCM-1(Rev) (7/94)	Traditional	Traditional	Traditional	01/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	0	0	212.1%	XX
BSNNY-1 (12/83)	Traditional	Traditional	Traditional	01/01/13	LG	Comprehensive Major Medical	Yes	No	Open	12	6.00%	0	0	212.1%	XX
Total Traditional Large - Albany	Traditional	Traditional	Traditional	01/01/13			Yes	No	Open	12	6.00%	5	6	212.1%	XX
C3G3N0392	HDHP 8000	Healthy Balance	Aqua/POS/HDHP	01/01/13	SG	Non-HMO based POS	Yes	No	Open	12	9.90%	111	179	83.5%	XX
C3G3N0392	HDHP 8000	Healthy Balance	Aqua/POS/HDHP	01/01/13	LG	Non-HMO based POS	Yes	No	Open	12	9.90%	0	0	83.5%	XX
L3G3N0289	HDHP 7000	HDHP 7000	Aqua/POS/HDHP	01/01/13	SG	Non-HMO based POS	Yes	No	Open	12	9.90%	1,405	2,753	83.5%	XX
L3G3N0289	HDHP 7000	HDHP 7000	Aqua/POS/HDHP	01/01/13	LG	Non-HMO based POS	Yes	No	Open	12	9.90%	0	0	83.5%	XX
LS3G3N0195	POS Lite	POS Lite	Aqua/POS/HDHP	01/01/13	SG	Non-HMO based POS	Yes	No	Open	12	9.90%	1,795	3,100	83.5%	XX
LS3G3N0195	POS Lite	POS Lite	Aqua/POS/HDHP	01/01/13	LG	Non-HMO based POS	Yes	No	Open	12	9.90%	0	0	83.5%	XX
LS3G3N0232	Aqua	Aqua	Aqua/POS/HDHP	01/01/13	SG	Non-HMO based POS	Yes	No	Open	12	9.90%	1,278	1,852	83.5%	XX
LS3G3N0232	Aqua	Aqua	Aqua/POS/HDHP	01/01/13	LG	Non-HMO based POS	Yes	No	Open	12	9.90%	12	30	83.5%	XX
Total Aqua/POS/HDHP - Albany			Aqua/POS/HDHP	01/01/13		Non-HMO based POS	Yes	No	Open	12	9.90%	4,601	7,914	83.5%	XX
HN-EPO.COM	EPO	Sky	EPO	01/01/13	SG	EPO	Yes	No	Open	12	19.50%	6,160	11,286	91.8%	XX
HN-EPO.COM	EPO	Sky	EPO	01/01/13	LG	EPO	Yes	No	Open	12	19.50%	19	34	91.8%	XX
LS3G3N0195	EPO	Sky	EPO	01/01/13	SG	EPO	Yes	No	Open	12	19.50%	1,795	3,100	91.8%	XX
Total EPO - Albany	EPO	Sky	EPO	01/01/13		EPO	Yes	No	Open	12	19.50%	7,974	14,420	91.8%	XX
HN-HMO.1	HMO 200	HMO 200	HMO 200	01/01/13	SG	HMO	Yes	No	Open	12	19.50%	0	0	92.8%	XX
LS1G4N0004	HMO 200	HMO 200	HMO 200	01/01/13	SG	HMO based POS	Yes	No	Open	12	19.50%	192	323	92.8%	XX
Total HMO 200 Small - Albany	HMO 200	HMO 200	HMO 200	01/01/13			Yes	No	Open	12	19.50%	192	323	92.8%	XX
HN-HMO.1	HMO 200	HMO 200	HMO 200	01/01/13	LG	HMO	Yes	No	Open	12	7.00%	0	0	85.0%	XX
LS1G4N0004	HMO 200	HMO 200	HMO 200	01/01/13	LG	HMO based POS	Yes	No	Open	12	7.00%	617	1,151	85.0%	XX
Total HMO 200 Large - Albany	HMO 200	HMO 200	HMO 200	01/01/13			Yes	No	Open	12	7.00%	617	1,151	85.0%	XX
HN-HMO.2 & HN-POS.2	HMO 100	HMO 100	HMO 100	01/01/13	SG	HMO based POS	Yes	No	Open	12	19.50%	929	1,772	88.3%	XX
Total HMO 100 Small - Albany	HMO 100	HMO 100	HMO 100	01/01/13		HMO based POS	Yes	No	Open	12	19.50%	929	1,772	88.3%	XX
HN-PPO.COM	PPO	PPO 800	PPO	01/01/13	SG	PPO	Yes	No	Open	12	3.00%	106	230	85.3%	XX
HN-PPO.COM	PPO	PPO 800	PPO	01/01/13	LG	PPO	Yes	No	Open	12	3.00%	0	0	85.3%	XX
HN-PPO.COM-2	PPO	PPO 800	PPO	01/01/13	SG	PPO	Yes	No	Open	12	3.00%	117	251	85.3%	XX
HN-PPO.COM-2	PPO	PPO 800	PPO	01/01/13	LG	PPO	Yes	No	Open	12	3.00%	0	0	85.3%	XX
Total PPO - Albany	PPO	PPO 800	PPO	01/01/13		PPO	Yes	No	Open	12	3.00%	223	481	85.3%	XX

EXHIBIT 7: H

- A. Complete a separate
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment r  
Group Medicare E  
segment.
- D. Product type is HI  
(A, B, C, D, E, F E)
- E. The product stree
- F. Note that many ce
- 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 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 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 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 Standardi- zed 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 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 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 Administrativ e 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 / Standardiz ed Earned Premiums)	14.19 Ratio: Col 14.7/ Col 14.5 (Incurred Claims / Standardiz ed Earned Premiums)	14.20 Ratio: Col 14.10/ Col 14.4 (Administ ration Expenses / Earned Premiums)	14.21 Ratio: (Col 14.8 + Col 14.9 + Col 14.10) / Col 14.4	
BCC-15	Traditional	07/01/11	06/30/12	230	290,846	339,351	37,722	37,924	0	(118)	7,394	1,264.55	1,475.44	164.01	164.89	0.00	(0.51)	32.15	0.130	0.112	0.025	0.155	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/11	06/30/12	2,981	3,496,589	4,096,777	1,732,646	1,741,152	0	(1,531)	95,833	1,172.96	1,374.30	581.23	584.08	0.00	(0.51)	32.15	0.498	0.425	0.027	0.525	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/11	06/30/12	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/11	06/30/12	147	137,561	164,528	11,440	11,939	0	(76)	4,726	935.79	1,119.24	77.82	81.21	0.00	(0.51)	32.15	0.087	0.073	0.034	0.121	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/11	06/30/12	12,753	11,214,580	13,169,881	9,419,031	9,527,182	0	(6,552)	409,983	879.37	1,032.69	738.57	747.05	0.00	(0.51)	32.15	0.850	0.723	0.037	0.886	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/11	06/30/12	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Traditional Small - Buffalo	Traditional	07/01/11	06/30/12	16,111	15,139,577	17,770,537	11,200,839	11,318,196	0	(8,277)	517,936	939.70	1,103.01	695.23	702.51	0.00	(0.51)	32.15	0.748	0.637	0.034	0.781	XX
BCC-15	Traditional	07/01/11	06/30/12	15	15,762	16,332	33,676	33,796	0	(0)	482	1,050.77	1,088.79	2,245.06	2,253.07	0.00	(0.00)	32.15	2.144	2.069	0.031	2.175	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/11	06/30/12	3,373	3,792,553	3,946,298	2,698,807	2,704,103	0	(12)	108,435	1,124.39	1,169.97	800.12	801.69	0.00	(0.00)	32.15	0.713	0.685	0.029	0.742	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/11	06/30/12	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/11	06/30/12	24	13,523	14,768	7,834	7,834	0	(0)	772	563.47	615.34	326.40	326.40	0.00	(0.00)	32.15	0.579	0.530	0.057	0.636	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/11	06/30/12	2,445	1,906,520	1,991,218	2,484,695	2,497,691	0	(9)	78,602	779.76	814.40	1,016.24	1,021.55	0.00	(0.00)	32.15	1.310	1.254	0.041	1.351	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/11	06/30/12	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Traditional Large - Buffalo	Traditional	07/01/11	06/30/12	5,857	5,728,357	5,968,615	5,225,012	5,243,423	0	(21)	188,291	978.04	1,019.06	892.10	895.24	0.00	(0.00)	32.15	0.915	0.878	0.033	0.948	XX
C33G3N0392	HDHP 8000	07/01/11	06/30/12	44,863	9,289,171	9,847,367	7,491,130	7,729,345	0	(21,530)	1,442,254	207.06	219.50	166.98	172.29	0.00	(0.48)	32.15	0.832	0.785	0.155	0.985	XX
C33G3N0392	HDHP 8000	07/01/11	06/30/12	0	0	0	1,490	1,569	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
L33G3N0289	HDHP 7000	07/01/11	06/30/12	141,155	34,875,897	41,030,900	34,177,948	34,897,868	0	(67,740)	4,537,845	247.08	290.68	242.13	247.23	0.00	(0.48)	32.15	1.001	0.851	0.130	1.129	XX
L33G3N0289	HDHP 7000	07/01/11	06/30/12	5	1,286	1,598	269,990	271,677	0	(2)	161	257.22	319.59	53,998.05	54,335.38	0.00	(0.48)	32.15	211.241	170.013	0.125	211.364	XX
LS3G3N0195	POS Lite	07/01/11	06/30/12	165,751	46,185,984	52,443,524	45,030,025	45,552,516	0	(79,544)	5,328,557	278.65	316.40	271.67	274.82	0.00	(0.48)	32.15	0.986	0.869	0.115	1.100	XX
LS3G3N0195	POS Lite	07/01/11	06/30/12	5	1,406	1,719	8,252	8,258	0	(2)	161	281.11	343.80	1,650.31	1,651.55	0.00	(0.48)	32.15	5.875	4.804	0.114	5.988	XX
LS3G3N0232	Aqua	07/01/11	06/30/12	181,800	47,391,530	56,525,055	38,704,723	39,185,031	0	(87,246)	5,844,499	260.68	310.92	212.90	215.54	0.00	(0.48)	32.15	0.827	0.693	0.123	0.948	XX
LS3G3N0232	Aqua	07/01/11	06/30/12	0	0	0	14,142	14,226	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Aqua/POS/HDHP - Buffalo		07/01/11	06/30/12	533,579	137,745,275	159,850,162	125,697,700	127,660,491	0	(256,065)	17,153,477	258.15	299.58	235.57	239.25	0.00	(0.48)	32.15	0.927	0.799	0.125	1.049	XX



EXHIBIT 7: H

- 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 r
- Group Medicare E
- segment.
- D. Product type is HI
- (A, B, C, D, E, F E
- E. The product stree
- F. Note that many ce
- 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 or payments to 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 15.5/ Col 15.4 (Incurred Claims / Standardized Premiums)	15.20 Ratio: Col 15.10/ Col 15.4 (Administrative Expenses / Earned Premiums)	15.21 Ratio: (Col 15.7 + Col 15.8 + Col 15.9) / Col 15.4	
BCC-15	Traditional	07/01/10	06/30/11	354	378,603	516,144	209,347	209,439	0	(352)	13,524	1,069.50	1,458.03	591.38	591.64	0.00	(1.00)	38.20	0.553	0.406	0.036	0.588	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/10	06/30/11	4,266	4,276,758	5,789,426	2,568,344	2,569,386	0	(4,247)	162,971	1,002.52	1,357.11	602.05	602.29	0.00	(1.00)	38.20	0.601	0.444	0.038	0.638	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/10	06/30/11	36	30,574	43,404	1,135	1,135	0	(36)	1,375	849.28	1,205.68	31.52	31.53	0.00	(1.00)	38.20	0.037	0.026	0.045	0.081	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/10	06/30/11	168	141,580	184,792	17,370	17,376	0	(167)	6,418	842.74	1,099.95	103.39	103.43	0.00	(1.00)	38.20	0.123	0.094	0.045	0.167	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/10	06/30/11	18,594	14,329,991	19,411,538	16,296,021	16,316,849	0	(18,511)	710,335	770.68	1,043.97	876.41	877.53	0.00	(1.00)	38.20	1.139	0.841	0.050	1.187	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/10	06/30/11	53	56,144	79,461	654	654	0	(53)	2,025	1,059.33	1,499.26	12.34	12.34	0.00	(1.00)	38.20	0.012	0.008	0.036	0.047	XX
Total Traditional Small - Buffalo	Traditional	07/01/10	06/30/11	23,471	19,213,651	26,024,766	19,092,870	19,114,839	0	(23,367)	896,648	818.61	1,108.81	813.47	814.40	0.00	(1.00)	38.20	0.995	0.734	0.047	1.040	XX
BCC-15	Traditional	07/01/10	06/30/11	31	32,640	34,517	25,120	25,122	0	0	1,184	1,052.91	1,113.44	810.34	810.40	0.00	0.00	38.20	0.770	0.728	0.036	0.806	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/10	06/30/11	4,221	4,524,778	4,768,400	2,610,224	2,610,874	0	0	161,252	1,071.97	1,129.68	618.39	618.54	0.00	0.00	38.20	0.577	0.548	0.036	0.613	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/10	06/30/11	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/10	06/30/11	120	67,768	73,485	22,053	22,063	0	0	4,584	564.74	612.37	183.78	183.86	0.00	0.00	38.20	0.326	0.300	0.068	0.393	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/10	06/30/11	4,241	3,163,677	3,365,771	3,836,505	3,840,422	0	0	162,016	745.97	793.63	904.62	905.55	0.00	0.00	38.20	1.214	1.141	0.051	1.265	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/10	06/30/11	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Traditional Large - Buffalo	Traditional	07/01/10	06/30/11	8,613	7,788,864	8,242,172	6,493,903	6,498,480	0	0	329,037	904.31	956.95	753.97	754.50	0.00	0.00	38.20	0.834	0.788	0.042	0.877	XX
C33G3N0392	HDHP 8000	07/01/10	06/30/11	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
C33G3N0392	HDHP 8000	07/01/10	06/30/11	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
L33G3N0289	HDHP 7000	07/01/10	06/30/11	171,979	38,616,038	50,176,714	38,403,762	38,471,593	0	(140,625)	6,570,010	224.54	291.76	223.30	223.70	0.00	(0.82)	38.20	0.996	0.767	0.170	1.163	XX
L33G3N0289	HDHP 7000	07/01/10	06/30/11	33	7,185	9,459	12,168	12,169	0	0	1,261	217.73	286.64	368.73	368.76	0.00	0.00	38.20	1.694	1.286	0.175	1.869	XX
LS3G3N0195	POS Lite	07/01/10	06/30/11	170,319	43,758,115	55,886,567	40,410,125	40,458,046	0	(139,268)	6,506,594	256.92	328.13	237.26	237.54	0.00	(0.82)	38.20	0.925	0.724	0.149	1.070	XX
LS3G3N0195	POS Lite	07/01/10	06/30/11	158	40,159	47,874	23,915	23,920	0	0	6,036	254.17	303.00	151.36	151.39	0.00	0.00	38.20	0.596	0.500	0.150	0.746	XX
LS3G3N0232	Aqua	07/01/10	06/30/11	142,664	33,884,885	44,732,042	27,461,779	27,497,052	0	(116,655)	5,450,107	237.52	313.55	192.49	192.74	0.00	(0.82)	38.20	0.811	0.615	0.161	0.969	XX
LS3G3N0232	Aqua	07/01/10	06/30/11	0	0	0	3,408	3,412	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Aqua/POS/HDHP - Buffalo		07/01/10	06/30/11	485,153	116,306,382	150,852,656	106,315,157	106,466,193	0	(396,548)	18,534,007	239.73	310.94	219.14	219.45	0.00	(0.82)	38.20	0.915	0.706	0.159	1.071	XX



EXHIBIT 7: H

- A. Complete a separate
  - Information re
  - Include riders
  - Insert addition
  - Add a row with
- B. In Column 2 enter
- C. Market segment r  
Group Medicare E  
segment.
- D. Product type is HI  
(A, B, C, D, E, F E)
- E. The product stree
- F. Note that many ce
- 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/Y Y)	16.2 Ending Date of the experience period (MM/DD/Y Y)	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 (\$pmpm)	16.12 Standardized premiums for experience period (\$pmpm)	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 (\$pmpm)	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 (\$pmpm)	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) (\$pmpm)	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 negative value and payments to the pool as a positive value) (\$pmpm)	16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$pmpm)	16.18 Ratio: Col 16.7/ Col 16.4 (Incurred Claims / Earned Premiums )	16.19 Ratio: Col 16.7/ Col16.5 (Incurred Claims / Standardi zed Earned Premiums )	16.20 Ratio: Col 16.10/ Col16.4 (Administr ation Expenses / Earned Premiums )	16.21 Ratio: (Col 16.7 + Col 16.8 + Col 16.10) /Col 16.4	
BCC-15	Traditional	07/01/09	06/30/10	665	577,155	883,286	291,687	291,704	0	(395)	27,668	867.90	1,328.25	438.63	438.65	0.00	(0.59)	41.61	0.505	0.330	0.048	0.553	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/09	06/30/10	7,125	6,239,007	9,700,707	4,683,194	4,683,526	0	(4,233)	296,443	875.65	1,361.50	657.29	657.34	0.00	(0.59)	41.61	0.751	0.483	0.048	0.798	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/09	06/30/10	78	62,037	95,554	8,626	8,629	0	(46)	3,245	795.35	1,225.06	110.59	110.62	0.00	(0.59)	41.61	0.139	0.090	0.052	0.191	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/09	06/30/10	144	111,095	168,570	17,729	17,731	0	(86)	5,991	771.49	1,170.63	123.12	123.13	0.00	(0.59)	41.61	0.160	0.105	0.054	0.213	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/09	06/30/10	25,600	17,341,684	27,059,299	18,068,370	18,071,630	0	(15,211)	1,065,115	677.41	1,057.00	705.80	705.92	0.00	(0.59)	41.61	1.042	0.668	0.061	1.103	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/09	06/30/10	102	101,469	153,822	21,385	21,385	0	(61)	4,244	994.80	1,508.06	209.66	209.66	0.00	(0.59)	41.61	0.211	0.139	0.042	0.252	XX
Total Traditional Small - Buffalo	Traditional	07/01/09	06/30/10	33,714	24,432,447	38,061,239	23,090,991	23,094,606	0	(20,032)	1,402,707	724.70	1,128.94	684.91	685.02	0.00	(0.59)	41.61	0.945	0.607	0.057	1.002	XX
BCC-15	Traditional	07/01/09	06/30/10	46	48,654	54,245	42,076	42,078	0	0	1,914	1,057.70	1,179.24	914.69	914.74	0.00	0.00	41.61	0.865	0.776	0.039	0.904	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	07/01/09	06/30/10	5,676	5,618,043	6,258,948	2,781,945	2,782,083	0	0	236,156	989.79	1,102.70	490.12	490.15	0.00	0.00	41.61	0.495	0.444	0.042	0.537	XX
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	07/01/09	06/30/10	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
H-1575 & BCMS-1 (Rev 1993)	Traditional	07/01/09	06/30/10	234	124,612	145,943	13,836	13,839	0	0	9,736	532.53	623.69	59.13	59.14	0.00	0.00	41.61	0.111	0.095	0.078	0.189	XX
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	07/01/09	06/30/10	5,741	4,014,545	4,553,273	4,074,716	4,075,170	0	0	238,860	699.28	793.12	709.76	709.84	0.00	0.00	41.61	1.015	0.895	0.059	1.075	XX
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	07/01/09	06/30/10	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
Total Traditional Large - Buffalo	Traditional	07/01/09	06/30/10	11,697	9,805,855	11,012,410	6,912,573	6,913,170	0	0	486,666	838.32	941.47	590.97	591.02	0.00	0.00	41.61	0.705	0.628	0.050	0.755	XX
C33G3N0392	HDHP 8000	07/01/09	06/30/10	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
C33G3N0392	HDHP 8000	07/01/09	06/30/10	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX
L33G3N0289	HDHP 7000	07/01/09	06/30/10	160,079	31,952,029	48,771,541	31,293,785	31,302,375	0	(95,114)	6,660,258	199.60	304.67	195.49	195.54	0.00	(0.59)	41.61	0.980	0.642	0.208	1.185	XX
L33G3N0289	HDHP 7000	07/01/09	06/30/10	50	9,950	13,099	15,716	15,725	0	0	2,080	199.00	261.99	314.32	314.50	0.00	0.00	41.61	1.580	1.200	0.209	1.789	XX
LS3G3N0195	POS Lite	07/01/09	06/30/10	128,956	29,899,316	43,121,324	25,353,442	25,358,767	0	(76,621)	5,365,352	231.86	334.99	196.61	196.65	0.00	(0.59)	41.61	0.848	0.588	0.179	1.025	XX
LS3G3N0195	POS Lite	07/01/09	06/30/10	782	146,552	208,114	103,518	103,521	0	0	32,536	187.41	266.13	132.38	132.38	0.00	0.00	41.61	0.706	0.497	0.222	0.928	XX
LS3G3N0232	Aqua	07/01/09	06/30/10	115,041	24,877,845	36,504,631	18,489,094	18,492,628	0	(68,353)	4,786,404	216.25	317.32	160.72	160.75	0.00	(0.59)	41.61	0.743	0.507	0.192	0.933	XX
LS3G3N0232	Aqua	07/01/09	06/30/10	124	26,858	41,169	12,494	12,494	0	0	5,159	216.59	332.01	100.75	100.76	0.00	0.00	41.61	0.465	0.303	0.192	0.657	XX
Total Aqua/POS/HDHP - Buffalo		07/01/09	06/30/10	405,032	86,912,549	128,659,879	75,268,048	75,285,509	0	(240,088)	16,851,789	214.58	317.65	185.83	185.88	0.00	(0.59)	41.61	0.866	0.585	0.194	1.057	XX



EXHIBIT 7: H

- 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 r
- Group Medicare E
- segment.
- D. Product type is HI
- (A, B, C, D, E, F E
- E. The product stree
- F. Note that many ce
- 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	17.5	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)	18.7	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)	19.7	20.1 Most Recent Experience Period	20.2 First Prior Experience Period	20.3 Second Prior Experience Period
BCC-15	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.650	1.182	1.012	0.277	0.279	0.842	XX	0.532	1.232	1.098	0.277	1.348	0.918	XX	1.167	1.363	1.530
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.699	1.170	1.013	0.965	0.970	0.842	XX	0.599	1.145	0.997	0.916	0.916	0.918	XX	1.172	1.354	1.555
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.462	1.068	0.984	0.285	0.285	0.918	XX	0.000	1.420	1.540
H-1575 & BCMS-1 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.875	1.110	1.018	0.753	0.785	0.842	XX	1.167	1.092	0.940	0.840	0.840	0.918	XX	1.196	1.305	1.517
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.686	1.141	0.989	0.843	0.851	0.842	XX	0.726	1.138	0.988	1.242	1.243	0.918	XX	1.174	1.355	1.560
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.520	1.065	0.994	0.059	0.059	0.918	XX	0.000	1.415	1.516
Total Traditional Small - Buffalo	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.686	1.148	0.995	0.855	0.863	0.842	XX	0.696	1.130	0.982	1.188	1.189	0.918	XX	1.174	1.354	1.558
BCC-15	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.484	0.998	0.978	2.771	2.780	0.842	XX	0.674	0.995	0.944	0.886	0.886	0.918	XX	1.036	1.057	1.115
H-1321 (S/L) w/H-1533, BCMS-4, BCBSMM-7 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.799	1.049	1.036	1.294	1.296	0.842	XX	0.744	1.083	1.024	1.262	1.262	0.918	XX	1.041	1.054	1.114
H-1321 (S/L) w/H-1533, BCMS-4, BCMM-4 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	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
H-1575 & BCMS-1 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.200	0.998	1.005	1.776	1.775	0.842	XX	0.513	1.060	0.982	3.108	3.109	0.918	XX	1.092	1.084	1.171
H-1575 & BCMS-1 (Rev 1993) w/BCBSMM-7 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.577	1.045	1.026	1.123	1.128	0.842	XX	0.739	1.067	1.001	1.275	1.276	0.918	XX	1.044	1.064	1.134
H-1575 & BCMS-1 (Rev 1993) w/BCMM-4 (Rev 1993)	Traditional	7.7%	3.0%	4.6%	0.00%	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
Total Traditional Large - Buffalo	Traditional	7.7%	3.0%	4.6%	0.00%	XX	0.680	1.082	1.065	1.183	1.187	0.842	XX	0.736	1.079	1.016	1.276	1.277	0.918	XX	1.042	1.058	1.123
C33G3N0392	HDHP 8000	7.7%	3.0%	4.6%	0.00%	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	1.060	0.000	0.000
C33G3N0392	HDHP 8000	7.7%	3.0%	4.6%	0.00%	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
L33G3N0289	HDHP 7000	7.7%	3.0%	4.6%	0.00%	XX	0.821	1.100	0.996	1.084	1.105	0.842	XX	1.074	1.125	0.958	1.142	1.144	0.918	XX	1.176	1.299	1.526
L33G3N0289	HDHP 7000	7.7%	3.0%	4.6%	0.00%	XX	0.152	1.181	1.115	146.442	147.347	0.842	XX	0.660	1.094	1.094	1.173	1.173	0.918	XX	1.242	1.317	1.317
LS3G3N0195	POS Lite	7.7%	3.0%	4.6%	0.00%	XX	0.973	1.085	0.964	1.145	1.157	0.842	XX	1.321	1.108	0.981	1.207	1.208	0.918	XX	1.135	1.277	1.442
LS3G3N0195	POS Lite	7.7%	3.0%	4.6%	0.00%	XX	0.032	1.106	1.135	10.903	10.909	0.842	XX	0.202	1.356	1.139	1.143	1.144	0.918	XX	1.223	1.192	1.420
LS3G3N0232	Aqua	7.7%	3.0%	4.6%	0.00%	XX	1.274	1.098	0.992	1.106	1.118	0.842	XX	1.240	1.098	0.988	1.198	1.199	0.918	XX	1.193	1.320	1.467
LS3G3N0232	Aqua	7.7%	3.0%	4.6%	0.00%	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	1.533
Total Aqua/POS/HDHP - Buffalo		7.7%	3.0%	4.6%	0.00%	XX	1.100	1.077	0.963	1.075	1.090	0.842	XX	1.198	1.117	0.979	1.179	1.181	0.918	XX	1.160	1.297	1.480

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

CB-229	HMO 200	7.7%	3.0%	4.6%	0.00%	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
CB-251	HMO 200	7.7%	3.0%	4.6%	0.00%	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
CB-251 & POS-12	HMO 200	7.7%	3.0%	4.6%	0.00%	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
CB-283	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	1.083	1.163	1.014	2.963	3.006	0.895	XX	1.050	1.141	0.996	1.225	1.227	0.957	XX	1.122	1.286	1.474
LS1G4N0004	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.520	1.158	1.001	1.045	1.055	0.895	XX	0.582	1.143	1.006	1.076	1.077	0.957	XX	1.134	1.311	1.490
Total HMO 200 Small - Buffalo	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.521	1.160	1.003	1.053	1.063	0.895	XX	0.582	1.143	1.006	1.077	1.078	0.957	XX	1.134	1.311	1.490
CB-229	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	1.116	1.033	0.940	0.945	0.955	0.895	XX	0.941	1.018	0.948	1.100	1.101	0.957	XX	1.082	1.189	1.277
CB-251	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.048	1.115	1.065	1.482	1.483	0.957	XX	0.000	1.203	1.260
CB-251 & POS-12	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.791	0.931	0.909	0.962	0.963	0.957	XX	0.000	1.187	1.216
CB-283	HMO 200	7.7%	3.0%	4.6%	0.00%	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
LS1G4N0004	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.711	1.061	0.987	1.077	1.086	0.895	XX	0.794	1.049	0.983	0.998	0.999	0.957	XX	1.063	1.144	1.221
Total HMO 200 Large - Buffalo	HMO 200	7.7%	3.0%	4.6%	0.00%	XX	0.860	1.049	0.968	1.015	1.024	0.895	XX	0.838	1.037	0.971	1.038	1.039	0.957	XX	1.073	1.162	1.241
HN-HMO.2	HMO 100	7.7%	3.0%	4.6%	0.00%	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	1.718
HN-HMO.2 & HN-POS.2	HMO 100	7.7%	3.0%	4.6%	0.00%	XX	0.685	1.145	0.987	1.239	1.251	0.895	XX	0.684	1.120	0.991	1.018	1.019	0.957	XX	1.177	1.365	1.543
Total HMO 100 Small - Buffalo	HMO 100	7.7%	3.0%	4.6%	0.00%	XX	0.685	1.145	0.987	1.239	1.251	0.895	XX	0.684	1.120	0.991	1.018	1.019	0.957	XX	1.177	1.365	1.543
HN-HMO.2	HMO 100	7.7%	3.0%	4.6%	0.00%	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	1.393
HN-HMO.2 & HN-POS.2	HMO 100	7.7%	3.0%	4.6%	0.00%	XX	0.766	1.054	0.959	0.962	0.972	0.895	XX	0.735	1.108	0.984	1.223	1.224	0.957	XX	1.048	1.152	1.297
Total HMO 100 Large - Buffalo	HMO 100	7.7%	3.0%	4.6%	0.00%	XX	0.766	1.054	0.959	0.962	0.972	0.895	XX	0.678	1.114	0.984	1.226	1.227	0.957	XX	1.048	1.152	1.304
BS-CC-1AB (6/90)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.802	1.031	1.016	0.621	0.627	0.965	XX	0.821	1.106	0.980	1.032	1.032	1.003	XX	0.943	0.956	1.080
BS-CCM-1(Rev) (7/94)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.808	1.003	0.986	1.253	1.269	0.965	XX	0.710	1.129	1.003	0.965	0.965	1.003	XX	0.945	0.961	1.082
BSNNY-1 (12/83)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.972	1.016	1.028	1.635	1.638	0.965	XX	0.745	1.155	1.026	1.087	1.088	1.003	XX	0.972	0.962	1.082
Total Traditional Small - Albany	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.821	1.013	1.000	1.076	1.087	0.965	XX	0.744	1.130	1.003	1.004	1.005	1.003	XX	0.947	0.959	1.081
BS-CC-1AB (6/90)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.385	0.883	1.006	2.680	2.681	0.965	XX	1.085	1.053	0.993	1.271	1.271	1.003	XX	0.695	0.610	0.647
BS-CCM-1(Rev) (7/94)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.181	1.115	1.122	2.652	2.651	0.965	XX	1.090	1.078	1.013	1.466	1.467	1.003	XX	0.612	0.608	0.647
BSNNY-1 (12/83)	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.083	0.993	1.000	0.854	0.853	0.965	XX	0.768	0.979	1.005	5.328	5.341	1.003	XX	0.576	0.572	0.557
Total Traditional Large - Albany	Traditional	7.6%	3.3%	4.2%	0.00%	XX	0.265	0.985	1.070	2.042	2.041	0.965	XX	1.071	1.064	1.006	1.720	1.722	1.003	XX	0.661	0.608	0.643
C33G3N0392	HDHP 8000	7.6%	3.3%	4.2%	0.00%	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	1.061	0.000	0.000
C33G3N0392	HDHP 8000	7.6%	3.3%	4.2%	0.00%	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
C33G3N0289	HDHP 7000	7.6%	3.3%	4.2%	0.00%	XX	1.174	1.085	0.993	1.008	1.024	0.965	XX	1.858	1.079	0.969	1.269	1.270	1.003	XX	1.155	1.262	1.405
LS3G3N0289	HDHP 7000	7.6%	3.3%	4.2%	0.00%	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	1.630
LS3G3N0195	POS Lite	7.6%	3.3%	4.2%	0.00%	XX	0.940	1.063	0.973	1.154	1.167	0.965	XX	3.060	1.032	0.978	0.990	0.990	1.003	XX	1.131	1.235	1.303
LS3G3N0195	POS Lite	7.6%	3.3%	4.2%	0.00%	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	1.360
LS3G3N0232	Aqua	7.6%	3.3%	4.2%	0.00%	XX	0.911	1.111	1.002	1.111	1.123	0.965	XX	1.163	1.096	0.996	0.888	0.888	1.003	XX	1.135	1.258	1.385
LS3G3N0232	Aqua	7.6%	3.3%	4.2%	0.00%	XX	0.903	1.126	1.021	1.585	1.674	0.965	XX	0.898	1.121	0.999	1.500	1.499	1.003	XX	1.126	1.242	1.394
Total Aqua/POS/HDHP - Albany		7.6%	3.3%	4.2%	0.00%	XX	1.015	1.076	0.982	1.090	1.104	0.965	XX	1.848	1.076	0.982	1.083	1.084	1.003	XX	1.140	1.249	1.369
HN-EPO.COM	EPO	7.6%	3.3%	4.2%	0.00%	XX	0.852	1.099	0.985	1.101	1.114	0.965	XX	0.947	1.187	1.003	1.198	1.200	1.003	XX	1.118	1.248	1.478
HN-EPO.COM	EPO	7.6%	3.3%	4.2%	0.00%	XX	1.069	1.152	1.034	0.641	0.644	0.965	XX	0.291	1.763	1.503	3.894	3.901	1.003	XX	1.108	1.235	1.449
LS3G3N0195	EPO	7.6%	3.3%	4.2%	0.00%	XX	2.384	1.060	0.978	1.118	1.132	0.965	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.114	1.207	0.000
Total EPO - Albany	EPO	7.6%	3.3%	4.2%	0.00%	XX	0.872	1.095	0.982	1.092	1.104	0.965	XX	0.954	1.188	1.003	1.200	1.202	1.003	XX	1.118	1.247	1.478
HN-HMO.1	HMO 200	7.6%	3.3%	4.2%	0.00%	XX	0.889	1.141	1.007	0.685	0.686	0.830	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.114	1.262	0.000
LS1G4N0004	HMO 200	7.6%	3.3%	4.2%	0.00%	XX	0.318	1.149	0.980	1.314	1.328	0.830	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.161	1.361	0.000
Total HMO 200 Small - Albany	HMO 200	7.6%	3.3%	4.2%	0.00%	XX	0.320	1.154	0.984	1.311	1.324	0.830	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.160	1.361	0.000
HN-HMO.1	HMO 200	7.6%	3.3%	4.2%	0.00%	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
LS1G4N0004	HMO 200	7.6%	3.3%	4.2%	0.00%	XX	0.726	1.037	0.974	1.100	1.117	0.830	XX	0.676	1.129	1.003	1.103	1.105	0.867	XX	1.048	1.116	1.256
Total HMO 200 Large - Albany	HMO 200	7.6%	3.3%	4.2%	0.00%	XX	0.726	1.037	0.974	1.100	1.117	0.830	XX	0.676	1.129	1.003	1.103	1.105	0.867	XX	1.048	1.116	1.256
HN-HMO.2 & HN-POS.2	HMO 100	7.6%	3.3%	4.2%	0.00%	XX	0.649	0.983	0.858	1.039	1.045	0.830	XX	0.741	1.065	0.930	1.155	1.157	0.867	XX	1.129	1.293	1.480
Total HMO 100 Small - Albany	HMO 100	7.6%	3.3%	4.2%	0.00%	XX	0.649	0.983	0.858	1.039	1.045	0.830	XX	0.741	1.065	0.930	1.155	1.157	0.867	XX	1.129	1.293	1.480
HN-PPO.COM	PPO	7.6%	3.3%	4.2%	0.00%	XX	1.123	1.115	1.023	1.121	1.149	0.965	XX	3.159	1.125	1.051	1.146	1.148	1.003	XX	1.213	1.323	1.415
HN-PPO.COM	PPO	7.6%	3.3%	4.2%	0.00%	XX	0.000	0.000	0.000														

**Exhibit A - Summary of Medical Rate Development - Commercial Community Rated - 2013 - Buffalo**

Region	Buffalo	Buffalo	Buffalo	
Product	Aqua/POS/HDHP	Traditional	HMO 100	
Segment	All	S	S	
Base Period Member Months	533579	16111	97885	
(A) Unadjusted Base Period Medical Claims PMPM	\$189.23	\$753.82	\$298.87	
(B) Pool Specific Large Claims PMPM	\$5.92	\$2.66	\$12.89	
(C)=(A)-(B) Adjusted Base Period Medical Claims PMPM	\$183.30	\$751.16	\$285.98	
(D) Pooled Large Claims PMPM	\$6.15	\$6.15	\$6.15	
(E) Base Period Other Claims PMPM	\$15.48	\$13.75	\$39.17	
(F) 2012 Medical	9.6%	9.6%	9.6%	
(G) 2013 Medical	7.0%	7.0%	7.0%	
(H) 2014 Medical	7.0%	7.0%	7.0%	
(I) Other (2 Years)	-0.7%	-2.3%	-1.7%	
(J) Medical Cost Sharing Leveraging (2 Years)	2.3%	1.3%	2.9%	
(K) 2012/2011 Med Demo	1.6%	0.6%	1.7%	
(L) 2013/2012 Med Demo	1.5%	0.0%	1.5%	
(M) 2014/2013 Med Demo	1.5%	0.0%	1.5%	
(N)=(C)*(1+(F))^0.5*(1+(G))*(1+(H))^0.5*(1+(J))*(1+(K))^0.5*(1+(L))*(1+(L))^0.5+(D)*(1+(F))^0.5*(1+(G))*(1+(H))^0.5	Rate Period Medical Claims PMPM	\$231.20	\$891.75	\$358.84
(O)=(E)*(1+(I))	Rate Period Other Claims PMPM	\$15.37	\$13.43	\$38.49
(P) Medical Premium 7/1/2012 Level	\$249.56	\$1,021.60	\$405.59	
(Q) Target Medical Loss Ratio	84.4%	93.3%	83.0%	
(R)=((N)+(O))/(Q)	7/1/2013 Medical Premium at Target MLR	\$291.98	\$970.52	\$478.60
(S)=(R)/(P)	Suggested Annual Medical Rate Action	17.0%	-5.0%	18.0%

Suggested Rate Actions apply to Q3 and Q4 renewals  
Tier and Step Up Factors are unchanged

**Exhibit A - Summary of Drug Rate Development - Commercial Community Rated - 2013 - Buffalo**

Region	Buffalo	Buffalo	Buffalo
Product	Aqua/POS/HDHP	Traditional	HMO
Segment	All	S	S
Base Period Member Months	519779	2609	119835
(A) Base Period Drug Claims PMPM	\$41.12	\$287.71	\$90.59
(B) 2012 Rx	-0.6%	-0.6%	-0.6%
(C) 2013 Rx	-0.8%	-0.8%	-0.8%
(D) 2014 Rx	-0.8%	-0.8%	-0.8%
(E) 2012/2011 Rx Demo	3.0%	0.0%	-3.7%
(F) 2013/2012 Rx Demo	1.5%	0.0%	1.5%
(G) 2014/2013 Rx Demo	1.5%	0.0%	1.5%
(H) Cost Sharing Leveraging (2 Years)	2.3%	1.3%	2.7%
(I) Rebate %	-9.9%	-9.9%	-9.9%
(J)=(A)*(1+(B))^0.5*(1+(C))*(1+(D))^0.5*(1+(E))^0.5*(1+(F))*(1+(G))^0.5*(1+(H))*(1+(I))			
Rate Period Drug Claims PMPM	\$38.75	\$258.74	\$82.87
(I) Drug Premium 7/1/2012 Level	\$45.32	\$369.13	\$76.86
(J) Target Drug Loss Ratio	85.5%	64.1%	97.6%
(K)=(H)/(J) 7/1/2013 Drug Premium at Target MLR	\$45.32	\$403.46	\$84.93
(L)=(K)/(I) Suggested Annual Rx Rate Action	0.0%	9.3%	10.5%

Suggested Rate Actions apply to Q3 and Q4 renewals

Tier and Step Up Factors are unchanged

Members actual rate increases will vary from the suggested annual rx rate action due to drug rate realignment

**Exhibit A - Summary of Composite Rate Development  
Commercial Community Rated - 2013 - Buffalo**

Region Product Segment	Buffalo Aqua/POS/HDHP All	Buffalo Traditional S	Buffalo HMO 100 S
Rate Period Medical + Other Claims PMPM	\$246.57	\$905.17	\$397.33
Rate Period Drug Claims PMPM	\$38.75	\$258.74	\$76.31
Rate Period Composite Claims PMPM	\$284.32	\$257.23	\$475.72
Rate Period Admin PMPM	\$43.22	\$43.22	\$40.39
Break Even Premium PMPM	\$327.55	\$300.45	\$516.10
Break Even Loss Ratio	86.8%	85.6%	92.2%
Medical Premium 7/1/2012 Level	\$249.56	\$1,021.60	\$405.59
Drug Premium 7/1/2012 Level	\$45.32	\$369.13	\$72.85
Composite Premium 7/1/2012 Level	\$293.71	\$293.71	\$477.75
7/1/2013 Medical Premium at Target MLR	\$291.98	\$970.52	\$478.60
7/1/2013 Drug Premium at Target MLR	\$45.32	\$403.46	\$80.50
7/1/2013 Composite Premium at Target MLR	\$336.13	\$281.34	\$558.34
Target Medical Loss Ratio	84.4%	93.3%	83.0%
Target Drug Loss Ratio	85.5%	64.1%	97.6%
Resulting Composite Loss Ratio	84.6%	91.4%	85.2%
Suggested Annual Medical Rate Action	17.0%	-5.0%	18.0%
Suggested Annual Rx Rate Action	0.0%	9.3%	10.5%
Suggested Annual Composite Rate Action	14.4%	-4.2%	16.9%

Suggested Rate Actions apply to Q3 and Q4 renewals

Tier and Step Up Factors are unchanged

Members actual rate increases will vary from the suggested annual composite rate action due to drug rate realignment

## Exhibit B - Trend Development

Buffalo 2012			
	Utilization	Unit Cost	Total
Inpatient	3.6%	7.9%	11.7%
Outpatient	5.2%	6.4%	11.9%
Medical	4.0%	2.6%	6.7%
<b>Med Total</b>	4.2%	5.2%	<b>9.6%</b>
Pharmacy			<b>-0.6%</b>

Buffalo 2013			
	Utilization	Unit Cost	Total
Inpatient	0.7%	6.5%	7.2%
Outpatient	2.9%	6.0%	9.1%
Medical	3.8%	1.8%	5.7%
<b>Med Total</b>	2.6%	4.3%	<b>7.0%</b>
Pharmacy			<b>-0.8%</b>

Buffalo 2014			
	Utilization	Unit Cost	Total
Inpatient	0.7%	6.5%	7.2%
Outpatient	2.9%	6.0%	9.1%
Medical	3.8%	1.8%	5.7%
<b>Med Total</b>	2.6%	4.3%	<b>7.0%</b>
Pharmacy			<b>-0.8%</b>

**Exhibit C - Summary of Demographic Changes  
Commercial Community Rated - 2013 - Buffalo**

Region Product Segment	Buffalo Aqua/POS/HDHP All	Buffalo Traditional All	Buffalo HMO 100 S
Base Period Medical Demographic	1.014	1.273	1.133
Current Medical Demographic	1.031	1.281	1.152
2012/2011 Medical Demographic Deterioration	1.6%	0.6%	1.7%
2013/2012 Medical Demographic Deterioration	1.5%	0.0%	1.5%
2014/2013 Medical Demographic Deterioration	1.5%	0.0%	1.5%
Base Period Drug Demographic	1.003	1.350	1.203
Current Drug Demographic	1.033	1.350	1.158
2012/2011 Drug Demographic Deterioration	3.0%	0.0%	-3.7%
2013/2012 Drug Demographic Deterioration	1.5%	0.0%	1.5%
2014/2013 Drug Demographic Deterioration	1.5%	0.0%	1.5%

**Exhibit D - Rx Claims and Premiums**

**Actuarial Justification:**

Milliman Pricing model was used to determine the expected Claim Rate shown below  
 2011 experience and projected 2012 & 2013 trends were utilized in the Milliman Pricing model  
 A flat retention rate was then added to the Claim Rate to get an expected Premium Rate  
 The relationships between the Premium Rates were used to set the rates for 2013

Retention	Claim Rate	Premium Rate
	\$8.43	
RX Copay		
\$0	\$80.88	\$89.31
\$10/\$20/\$40	\$58.73	\$67.16
\$10/\$30/\$50	\$55.88	\$64.32
\$10/\$30/50%	\$51.99	\$60.43
\$10/\$50/\$75	\$50.29	\$58.73
\$15/\$50/\$75	\$46.44	\$54.87
\$15/\$50/50%	\$44.12	\$52.56
\$5/\$20/50%	\$59.04	\$67.47
\$5/\$30/\$40	\$61.59	\$70.02
\$5/\$50/\$75	\$54.98	\$63.42
\$7	\$67.86	\$76.29
\$7 Generic Only	\$12.74	\$21.17
\$7/\$15/\$35	\$63.12	\$71.56
\$7/\$30/50%	\$54.74	\$63.17
\$10/\$20	\$60.11	\$68.55
\$5/\$10	\$69.32	\$77.75
\$5/\$20	\$65.51	\$73.95
\$1/\$5	\$77.21	\$85.65
\$10	\$63.15	\$71.58
\$15	\$57.36	\$65.79
\$5	\$71.27	\$79.70
\$5/\$15/\$35	\$65.59	\$74.03
\$5/\$30/\$50	\$60.81	\$69.24
\$7/\$25/\$40	\$60.43	\$68.86
20%	\$53.56	\$61.99
50%	\$26.65	\$35.09
\$10/\$50/\$100	\$49.19	\$57.62
\$5/\$10/\$25	\$67.83	\$76.27
\$5/\$20/\$40	\$63.77	\$72.20
\$7/\$30/\$50	\$58.72	\$67.15
\$1	\$78.86	\$87.29
\$3	\$74.95	\$83.38
\$2	\$76.88	\$85.31
\$3/\$7	\$73.34	\$81.78
\$9	\$64.67	\$73.10
50%/50%/100%	\$22.39	\$30.82
\$10 Generic Only	\$10.44	\$18.87
\$15 Generic Only	\$7.57	\$16.01
\$10/30%/50%	\$39.42	\$47.85
\$15/30%/50%	\$36.60	\$45.04
\$10/50%/50%	\$29.56	\$38.00
\$15/50%/50%	\$27.02	\$35.46
\$10/\$50/\$100	\$49.19	\$57.62
\$10/\$50/\$80/\$1000 Max- 50% on all tiers after Max.	\$25.99	\$34.42
\$10/\$50/\$80/\$2000 Max- 50% on all tiers after Max.	\$34.00	\$42.44
\$10/\$50/\$80/\$3000 Max- 50% on all tiers after Max.	\$38.24	\$46.67
\$10/\$50/\$80/\$4000 Max- 50% on all tiers after Max.	\$40.77	\$49.20
\$10/\$50/\$80/\$1000 Max- 50% on all tiers after Max. Generic carve out of max	\$32.28	\$40.72
\$10/\$50/\$80/\$2000 Max- 50% on all tiers after Max. Generic carve out of max	\$38.09	\$46.52
\$10/\$50/\$80/\$3000 Max- 50% on all tiers after Max. Generic carve out of max	\$41.02	\$49.45
\$10/\$50/\$80/\$4000 Max- 50% on all tiers after Max. Generic carve out of max	\$42.75	\$51.19
\$4/50%/50%	\$33.64	\$42.07
\$4/35%/50%	\$41.20	\$49.63
\$4/30%/50%	\$44.09	\$52.52

**Exhibit E - Calculation of Q3 and Q4 Load for the Affordable Care Act Excise Tax**

Q3 and Q4 Membership Information from October 2012 (Most Recent) Projected Excise Tax **2.00%**

Buffalo Region	Members	Renewal %	Months Active in 2014	Average 2014 Months by Quarter	Additional Increase Due to Excise Tax	Quarterly Load for 2014 Excise Tax
January	28,839	40.2%	0			
February	5,088	7.1%	1	0.5031	0.08%	0.08%
March	8,003	11.2%	2			
April	2,395	3.3%	3			
May	2,752	3.8%	4	4.2572	0.70%	0.62%
June	5,006	7.0%	5			
July	2,123	3.0%	6			
August	2,187	3.1%	7	7.2165	1.20%	0.49%
September	3,901	5.4%	8			
October	1,606	2.2%	9			
November	2,251	3.1%	10	10.5190	1.75%	0.55%
December	7,500	10.5%	11			
<b>Total</b>	<b>71,651</b>	<b>100.0%</b>				

Q3 and Q4 membership represents Buffalo Aqua/POS/HDHP, Traditional, and HMO 100 small group products  
 MediGap plans are excluded since this product is not subject to the Excise Tax  
 Healthy New York and Direct Pay plans are excluded since these products receive an annual increase on January 1st so the Excise Tax will take effect on 1/1/2014 for these products  
 Q1 and Q2 load calculations were approved in our previous prior approval application and will remain unchanged  
 Q3 and Q4 loads for pools not being refilled are sufficient and will remain unchanged from the previous application  
 December members includes the assumption that 10% of January groups will move their renewal date back to December

**Exhibit F - Calculation of Q3 and Q4 Load for the Affordable Care Act Reinsurance, Comparative Effective Research (CER), and Risk Adjustment Administrative Fees**

Q3 and Q4 Membership Information from October 2012 (Most Recent) Projected PMPM **\$5.41**

Buffalo Region	Members	Renewal %	Months Active in 2014	Average 2014 Months by Quarter	Additional PMPM Due to Reinsurance/CER/Risk	Average Premium PMPM	Additional Increase to Medical Premium	Quarterly Increase to Medical Premium
January	28,839	40.2%	0					
February	5,088	7.1%	1					
March	8,003	11.2%	2					
April	2,395	3.3%	3					
May	2,752	3.8%	4					
June	5,006	7.0%	5					
July	2,123	3.0%	6					
August	2,187	3.1%	7	7.2165	\$3.25	\$315.99	1.03%	1.03%
September	3,901	5.4%	8					
October	1,606	2.2%	9					
November	2,251	3.1%	10	10.5190	\$4.74	\$327.38	1.45%	0.41%
December	7,500	10.5%	11					
<b>Total</b>	<b>71,651</b>	<b>100.0%</b>						

\$5.41 PMPM = \$5.25 Reinsurance Contribution + \$0.08 CER Fee + \$0.08 Risk Adjustment Admin Fee

Q3 and Q4 membership represents Buffalo Aqua/POS/HDHP, Traditional, and HMO 100 small group products

MediGap plans are excluded since this product is not subject to these fees

Healthy New York and Direct Pay plans are excluded since these products receive an annual increase on January 1st so these fees will take effect on 1/1/2014 for these products

Q1 and Q2 rates were filed without this load due to inconsistent projections of the PMPMs at the time of our previous prior approval application

Q3 and Q4 rates for Buffalo Aqua/POS/HDHP, Traditional, and HMO 100 small group will reflect these loads

Q3 and Q4 rates for pools not being refilled will remain unchanged since these pools are performing well and can absorb this load without causing premium to become insufficient

December members includes the assumption that 10% of January groups will move their renewal date back to December

**BLUECROSS BLUESHIELD OF WESTERN NEW YORK**  
**GROUP UNDERWRITING GUIDELINES**

**Effective January 1, 2013**



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## Terms and Abbreviations

Article 43 – Trad, PPO, EPO, POS

Article 44 – HMO<sup>a</sup>

BCBSWNY – BlueCross Blue Shield of WNY

EPO – Exclusive Provider Organization

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

MC – Managed Care

POS – Point of Service

PPO – Preferred Provider Organization

Trad – Traditional Indemnity Product

a – Also includes HMO-based products with out of network benefits

## 1.0 Group Documentation

**NOTE: All documentation must be received and verified before any coverage is issued**

1.1 The group must produce documentation at time of enrollment that proves existence and active involvement in doing business. Groups must have a physical location in our service area. We require a physical address (not a P.O. Box) for a group address.

**Table 1: Forms of Documentation**

Required Documentation <sup>a</sup>	Alternate Forms of Documentation <sup>b</sup>
<b>NYS-45</b>	<ul style="list-style-type: none"> <li>• Schedule C</li> <li>• Schedule E</li> <li>• Schedule F</li> <li>• Schedule K-1</li> <li>• Schedule 1065</li> <li>• Schedule 1120 C</li> <li>• Schedule 1120 E</li> <li>• Schedule 1120 S</li> <li>• Form IT-204</li> </ul>
Documentation for new businesses may include a copy of a business bank statement, a cancelled business check, assignment of an EIN number, or other appropriate tax documents that demonstrate eligibility. <sup>c</sup>	

<sup>a</sup> Additional documentation may be required to prove eligibility of new subscribers. People not listed on the most recent ATT-45 form will not be accepted for coverage from BCBSWNY unless alternate documentation is submitted. For new employees, alternate documentation may include the last 2 weeks of pay stubs or a copy of the group's payroll including payroll for those new employees. For COBRA and retirees, the last applicable NYS-45, payroll, or pension records will be accepted to establish eligibility.

<sup>b</sup> If a NYS-45 is not available, these alternate forms or any combination thereof may be accepted in lieu of the required documentation. In such instances, a NYS-45 will be required within 90 days.

<sup>c</sup> Two months of premium must be submitted on a company check with the enrollment paperwork and subscriber applications to Underwriting for approval prior to enrollment.

1.2 All new groups may be subject to an on-site inspection by a BCBSWNY Representative prior to the initial enrollment in order to qualify the group's financial stability and ability to meet BCBSWNY Group Eligibility Requirements. Financial review of small groups will be limited to any termination of coverage in prior twelve months for failure to pay premiums.

1.3 In order to confirm eligibility, prospective groups must provide evidence of current coverage, if applicable, to be eligible for enrollment into a BCBSWNY program. The most recent copy of the prior carrier bill will be the standard documentation.

1.4 The employees of a multiple location group within the BCBSWNY service area will be combined to determine the size of the group. Employees in locations outside of the BCBSWNY service area will be counted in determining group size if they are eligible for BCBSWNY coverage. If requested, a multiple location group can enroll only the employees who reside within the BCBSWNY service area and only in products that adhere to the guidelines set forth in Table 2. These groups must have a facility or office in the service area. The facility or office will be classified as a separate and distinct entity.

1.5 Certain definable segments in a group may be considered for enrollment as a group when all other Employer-Employee Eligibility requirements are met and the request is from the group. A segment of a group is defined as a classification of employees from a group who are clearly distinguished from all other employees for reasons other than obtaining BCBSWNY health insurance coverage. For example: all salaried employees, all hourly employees, all employees in a specific location, employees of distinct entities acquired by merger or any combination of these segments.

## 2.0 Individual Market

2.1 The individual market consists of persons who are not enrolled through groups. The same mandated open enrollment that applies to small groups also applies to the individual market. BCBSWNY does not have to issue an individual policy if the applicant is eligible for a comparable group policy through an employer.

### **3.0 Sole Proprietors**

3.1 Sole proprietors seeking a group rate must belong to a Chamber/Association. The applicant must provide documentation that they are in business and that the business is active and exists for reasons other than as a device to seek insurance coverage.

To be eligible for enrollment as a sole proprietor, the following requirements must be met. The applicant must:

- be a member of a Chamber/Association that meets BCBSWNY eligibility criteria and the requirements of the Insurance Law
- have been a member of the Chamber/Association for a period of sixty days prior to the effective date of the insurance policy
- fulfill the documentation requirements set forth in Table 1
- work at least twenty hours per week
- not be employed by another business that has additional employees or be enrolled in any type of health care coverage under another employer group

### **4.0 Chambers of Commerce/Association Groups (Small Group Only)**

4.1 BCBSWNY will not accept any new Chambers or Associations, but those Chambers or Associations that BCBSWNY currently insures may continue. For those Chambers and Associations that continue, groups may be added or terminated within the Chamber or Association, and subscribers within those constituent groups may be added or terminated as well – subject to the rules below.

4.2 BCBSWNY must verify that each of the groups joining the Chamber or Association are actively engaged in their business. The same documentation needed for a group enrolling directly with us will be required for groups joining a Chamber or Association. All underwriting rules will be applied at the individual group level; that is, for a Chamber, each group joining through the Chamber is subject to the same underwriting criteria as if the group had purchased directly from BCBSWNY.

### **5.0 Member Documentation**

**NOTE: Member documentation may be requested at any time and is subject to verification**

5.1 Upon request, the group will be required to provide verification that all persons electing group coverage are actually employed by the group.

5.2 Full-time employees or part-time employees working a minimum of 20 hours per week or more for six or more months per year are eligible for coverage. Groups may choose to impose a higher requirement for hours for part-time employees.

5.3 Partners, shareholders, officers, owners, directors, and proprietors will be eligible only when devoting their services on a full-time basis to the business by working a minimum of 20 hours per week. These individuals must supply evidence that they work 20 hours per week, such as pay stubs, draws on a company account in lieu of payroll, and/or personal income tax records.

#### 5.4 Retiree coverage:

- Retirees are persons previously employed by the group immediately prior to the time they cease to be an active employee.
- If a group desires to offer coverage to its retirees as well as the currently active employees, we will insure the retirees as well as the active employees.
- In situations where dual carriers exist, both are required by law to offer plans to retirees in accordance with the requirements set forth in Table 2.
- The employer must make some contribution to the cost of retiree coverage except if the employer makes no contribution to the cost of active employee coverage.
- Groups may be required, upon request, to provide proof that the retirees were in fact previously active employees of the group immediately before retirement.

### **6.0 Group Participation, Location, and Contribution Requirements**

**NOTE: All groups are subject to review at any time by BCBSWNY to ensure that they meet group eligibility requirements**

6.1 The group requirements contained in this section establish the basic criteria used by BCBSWNY to determine which groups will be accepted for enrollment and which groups will be allowed to continue subsequent to initial enrollment.

6.2 BCBSWNY reserves the right to deny initial or continued enrollment to a group which does not meet the group eligibility requirements. BCBSWNY also reserves the right to terminate a group, upon appropriate notice as specified by the insurance contract, if group eligibility requirements are not met and maintained.

6.3 Groups must meet participation thresholds set forth in Table 2. Participation requirements are applied at two different levels and are determined by counting active employees and retirees on a combined basis as if they were all one group or category.

The first level is to determine participation in BCBSWNY products. To calculate, BCBSWNY divides the number of employees seeking commercial health insurance through BCBSWNY by the total number of eligible employees excluding those who have coverage through a spouse. For Community Rated only, employees enrolling in another carrier's plan are also excluded from the number of total eligible employees.

The second level is to determine overall participation. To calculate, BCBSWNY divides the number of employees seeking commercial health insurance through BCBSWNY by the total number of eligible employees. The total number of eligible employees in this calculation includes employees who have coverage through a spouse. For Community Rated only, employees enrolling in another carrier's plan are also included in the total number of eligible employees.

#### Group Participation Example

(A)	Total Employees	100
(B)	Eligible Employees	86
(C)	Spousal Waivers	7
(D)	Employees Enrolling with BCBSWNY	65
(E)	Employees Enrolling with another carrier	10
(F)	Employees Declining Coverage	4

$$(F) = (B) - (C) - (D) - (E)$$

Line (E) applicable to Community Rated slice offerings ONLY

Test 1: Participation in BCBSWNY Products	
Participation % =	$\frac{(D)}{[(B) - (C) - (E)]} \geq 50\% (CR), 75\% (ER)$
Participation % =	$\frac{65}{[86 - 7 - 10]} = 94.2\%$ ✓

Test 2: Overall Participation	
Participation % =	$\frac{(D)}{(B)} \geq 75\% (CR), 50\% (ER)$
Participation % =	$\frac{65}{86} = 75.6\%$ ✓

6.4 All eligible employees must reside in our service area to be able to offer an Article 44 product. For Article 43 Community Rated products, 75% of eligible employees must reside in our service area.

6.5 Groups must be located within BCBSWNY’s service area to be eligible for coverage. For groups with multiple locations, the group’s headquarters must reside in BCBSWNY’s service area to be eligible for coverage.

**Table 2: Group Participation, Location, and Contribution Requirements**

	<b>Small Group Community Rated</b> 50 or Fewer Eligible Employees	<b>Large Group Community Rated</b> 51+ Eligible Employees	<b>Large Group Experience Rated<sup>c</sup></b> 51+ Eligible Employees
<b>Participation Requirements:</b>			
<b>Minimum Overall Participation</b> (with BCBSWNY, another carrier, or through spouse) <sup>a b</sup> :	75%	75%	50%
<b>Minimum Participation in BCBSWNY Products</b> (excluding spousal waivers):			
<i>HMO</i>	No Minimum	No Minimum	Not Available
<i>POS</i>	50%	Higher of 50% or 10 subscribers	75%
<i>PPO, EPO, Trad</i>	Higher of 50% or 5 subscribers	Higher of 50% or 10 subscribers	75%
<b>Subscribers must be actively at work (employee absent or on leave is not eligible until returns to normal duties of employment for a specified period of time):</b>			
Article 44	No	Yes	Not Available
Article 43	No	Yes	Yes
<b>Maximum Percentage of Group Classified as Retirees</b>			
Article 44	No Maximum	50%	Not Available
Article 43	No Maximum	50%	50%
<b>Minimum Retiree Participation</b>			
Article 44	No Minimum	50%	Not Available
Article 43	No Minimum	50%	50%
<b>Minimum dollar contribution by employer: (as percent of total premium)</b>			
Article 44	0%	50%	Not Applicable
Article 43	0%	50%	50%
<b>Dental:</b>			
Minimum Participation	50%	50%	50%

<sup>a</sup> If employer contribution is 100%, employee participation must be 100%

Article 43 – Trad, PPO, EPO, POS

<sup>b</sup> For groups purchasing HMO product only, there is no minimum overall participation requirement

Article 44 – HMO (includes products with out of network benefits)

<sup>c</sup> Experience Rated does not exist with another carrier

## 7.0 Open Enrollment Policies

7.1 The employer must not inhibit free movement of eligible employees at either the initial enrollment period or at any subsequent open enrollment period. The employer must not take any action which could be interpreted as encouraging adverse selection against BCBSWNY.

7.2 At time of the initial enrollment, if there is a current carrier and a dependent or subscriber is confined to a hospital, the prior carrier shall pay the claims associated with the hospital confinement as required by applicable benefits-after-termination laws.

7.3 Groups are required to have one specified annual open enrollment period. The open enrollment will apply to all BCBSWNY products. A second open enrollment period (special open enrollment) may be permitted with the prior approval of BCBSWNY.

7.4 If a special open enrollment is offered for any carrier because of a change in rates, benefits, and/or delivery system, then BCBSWNY must also be offered the opportunity to make similar changes in benefits, rates, and/or delivery system, and to participate in the open enrollment.

7.5 Enrollment of a group is contingent upon receiving complete, appropriate paperwork (including a signed group agreement) a minimum of 15 business days (for Community Rated) or 30 business days (for Experience Rated) prior to the effective date of the group. Failure to provide this advance notice may result in the movement of the group’s effective date to the first of the following month.

7.6 Any change in the BCBSWNY benefit package inclusive of all products, including but not limited to rating tier structure, which is not coincident with the group's anniversary date must have the prior approval of BCBSWNY.

7.7 Benefit enhancements are not permitted off of a group's anniversary date except due to matching circumstances. However, dental coverage may be added at any time to any group. The group's anniversary date for medical coverage will then be the anniversary date for all of the group's coverage. If a group adds a new segment (class: an additional set of distinct employees) off anniversary, the rates and effective date will not change for the existing segment(s). The new segment(s) will receive the rates applicable on their enrollment date.

7.8 Eligible employees/retirees may only enter the plan during the open enrollment period of each year or within 30 days of first becoming eligible. Entry will not be permitted at any other time during the year except in accordance with 11 NYCRR Section 360.3 (a)(9)(i-iii) or Section 4305(K)(5)(B)(ii).

## **8.0 Product Offerings**

In order to prevent adverse selection when there are two or more carriers, the following rules apply:

8.1 When a product has multiple rating tiers, the tiers must be lined up within BCBSWNY offerings and with the dominant competitor to prevent adverse selection.

8.2 Each plan design of a high/low dual or triple offering must have the same Mental Health, Substance Abuse, and Dependent riders.

8.3 (Community Rated only) If more than one benefit is offered, the offerings must match our competitors' on co-payments, deductibles, maximums, out-of-network benefits, dependent/student coverage, prescription drug benefits, and riders. BCBSWNY may adjust its product offerings if a group significantly changes their product offerings with another carrier. Our Traditional and PPO/EPO products will not coexist with the Traditional or PPO/EPO programs of other carriers.

8.4 (Community Rated only) BCBSWNY insists that our products are offered to all the same employees as the other health plans' products. The group must also offer the same contribution (percentage or dollar amount) to BCBSWNY products as they do to products of other carriers. Exceptions may be made if BCBSWNY is the sole provider.

8.5 (Community Rated only) For a slice offering (i.e. when two or more carriers are offered) where the competitor is offering a high/low option, we will offer a high/low offering that matches or is lower in benefit than the high/low competitor offering (matching high to high and low to low).

8.6 (Community Rated only) Prescription Drug coverage is only offered in conjunction with BCBSWNY medical coverage.

8.7 (Small Group only) An Article 43 POS plan may only co-exist with an Article 43 POS plan of another carrier if the other carrier does not offer HMO coverage or if BCBSWNY is offering matching or lower HMO/POS dual offering benefits than the HMO/POS dual offering of another carrier.

8.8 (Experience Rated only) BCBSWNY will not offer healthcare coverage on an Experience-Rated basis alongside a competitor in the same coverage area. Only one rating type will be allowed – Community-Rated products will not be offered alongside Experience-Rated products.

**Table 3: Product Offerings**

	Group Size (Eligible Employees)	
	Small Group (2 - 50)	Large Group (51+)
<b>Products Available</b> <i>(Some product types not available in all markets)</i>	HMO POS EPO PPO Traditional Comprehensive	HMO <sup>a</sup> POS EPO PPO Traditional Comprehensive
<b>Number of Products Allowed</b>	Two (Three if PPO or Trad offered in Closed Class)	Two (Three if total replacement)
<b>Is Co-existence with Other Carriers Allowed?</b>		
HMO	Yes	Yes
POS	Yes	No
EPO	No	No
PPO	No	No
Traditional	No	No
Comprehensive	No	No
Dental	No	No
<b>Rating Type</b>	Community Rated	Community <sup>b</sup> or Experience Rated

<sup>a</sup> - HMO products are not available Experience Rated

<sup>b</sup> - BCBSWNY will not sell Community Rated products to new large groups

**9.0 Transition from Community Rating to Experience Rating (Large Group Only)**

9.1 Requests by current Community Rated customers to see the claims experience of their own members will be refused.

**10.0 Transition from Experience Rating to Community Rating (Large Group Only)**

10.1 If a group has Experience-Rated insurance coverage and the group's experience is worse than the claims experience in the Community-Rated insurance product that the employer now desires, the employer is not permitted to purchase or offer any Community-Rated insurance product. This is required by the DFS (formerly known as the Insurance Department) regulations.

**11.0 General Group Renewal**

**NOTE: All groups are subject to review at any time by BCBSWNY to ensure that they meet group eligibility requirements**

11.1 Refusal to renew is permitted in the following circumstances:

- Group no longer exists as a business
- Group in an Association or Chamber no longer belongs to an Association or Chamber
- Group has perpetuated fraud
- Group has failed to pay premiums
- Group falls below minimum participation requirements of Section 6.3

11.2 At the time of renewal, if the product match rules of Section 8.2 are no longer met, the group will be allowed to renew in its existing products (if still available). Note that outright termination is not permitted in this case. However, BCBSWNY will protect itself in this case by freezing current enrollment in current products and not permitting new enrollment. Failure to meet out of area requirements is treated in the same fashion as failure to meet product match requirements.



## Exhibit 4.1

# 2013 Broker Commission Schedule and Persistency Bonus Program



**At BlueCross BlueShield of Western New York, it is our mission  
in life to enhance the lives of our members.**

We are excited to present to you our **Broker Commission Schedule and Persistency Bonus Program for 2013**. We look forward to continued success and value our partnerships with our brokers. We are committed to providing excellence to you and your clients.

If you have any questions regarding BlueCross BlueShield's Broker Commission Schedule and Persistency Bonus Program, please contact our Broker Program Department.

We'd like to take this opportunity to thank you for your dedicated partnership.

Kindest Regards,

A handwritten signature in blue ink, appearing to read "Michael G. Conroy".

Michael G. Conroy  
Vice President,  
WNY Commercial Group Accounts  
BlueCross BlueShield of Western New York

Catherine Campbell  
Senior Vice President,  
Individual Market

## Qualifications



**BlueCross BlueShield**  
of Western New York

- ▶ For brokers to be considered for compensation on new business they must have been actively involved in the sales process **prior** to a written agreement by the group to offer a BlueCross BlueShield of Western New York (BCBS) product.
- ▶ To continue receiving commissions beyond the first year, and for all subsequent years, the broker must complete the renewal process on behalf of BlueCross BlueShield of Western New York.
- ▶ The commission schedule utilized for each group is based on the geographic location of the group's headquarters.
- ▶ Upon receipt of a Broker of Record letter, there will be a 5 day grace period before the BOR will be honored, to provide for comprehensive review and approval. For payment purposes, the broker will become effective on the first day of the month following receipt of notification. The broker will remain in force for a minimum of 30 days.
- ▶ Brokers will receive commissions on groups in which the broker enacted the initial sale of the group to BlueCross BlueShield, for a period of time not to exceed twelve months, commencing with the group's effective date.
- ▶ Upon broker notification of non-payment of commissions, BCBS will only pay commissions retroactively for community rated business up to a maximum of 90 days. For all other funding arrangements, including but not limited to Experience Rated business, BlueCross BlueShield will only pay commissions related to the current and prior plan years.
- ▶ Broker commissions will only be paid upon BlueCross BlueShield's receipt of payment of premiums or administrative fees from the group. Broker commissions will cease upon termination of the group with BCBS.

### **Please Note:**

DBC groups, chamber groups, associations and societies are not eligible to receive commissions.

# Commission Schedule

## Commercial Plans

### New Medical Business



#### COMMUNITY RATED

Product	Commission
Traditional Comprehensive EPO PPO POS	▶ 3.5% of monthly paid premium for full replacement.

#### Important Notes:

New Community rated groups with dual offering of competitor's program are not eligible for commissions.

Groups and brokers will be required to attest whether or not BCBS is the sole carrier.

Commission payments for HMO products cannot exceed a total of 4% of the collected premium for each individual group.

#### EXPERIENCE RATED

Products	Commission
All products for each separate account	<ul style="list-style-type: none"><li>▶ 4% on first \$250,000 annualized premium.</li><li>▶ 3.5% on next \$500,000 annualized premium.</li><li>▶ 2% on next \$250,000 annualized premium.</li><li>▶ 1% on next \$1.5 million annualized premium.</li><li>▶ 0.5% on balance.</li></ul> <p>Any deviation from the standard scale must be acknowledged on the group's rate sheet and signed by an officer of the group prior to the group's implementation.</p>

# Commission Schedule

## Commercial Plans

### New Medical Business



#### ALTERNATE FUNDED

<p>All products</p>	<p><b>Minimum Premium</b></p> <p>Commissions on Minimum Premium Funding Arrangements will be calculated based on the standard scale for Experience Rated business (see page 4). Any deviation from the standard scale must be acknowledged on the final, executed rate sheet for the group.</p> <p>The commission percentage will be applied to a fully insured premium equivalent (prospective rate), at the time of inception or renewal, to establish a projected commission amount. The amount will then be converted to a per contract per month amount to be paid monthly. Timing of payment will coincide with receipt of payment of the monthly administrative fee.</p> <p><b>Administrative Services Contract (ASC)</b></p> <p>Will be paid on a per contract per month basis with BCBS approval.</p>
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#### ADMINISTRATIVE SERVICES ONLY

<p>All products</p>	<p>Will be paid on a per contract per month basis with BCBS approval.</p>
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# Commission Schedule Broker-of-Record (BOR) Appointment Commercial Plans Existing Medical Business



## COMMUNITY RATED

Group Status	Commission								
<i>With</i> previous paid broker	Commission is effective on the first of month following BOR appointment; pay at previous broker commission level.								
<i>Without</i> previous paid broker	<p>Commissions will be paid according to the following schedule if new small group contract requirements are met:</p> <table border="1"> <thead> <tr> <th>Cumulative New Contracts</th> <th>PEPM* Rate on All Direct Business</th> </tr> </thead> <tbody> <tr> <td>0 – 24</td> <td>\$0</td> </tr> <tr> <td>25 – 149</td> <td>\$3.75</td> </tr> <tr> <td>150+</td> <td>\$7.50</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>▶ A new small group is defined as a group consisting of 2-50 eligibles with a community rated product. The new group must not have been insured by BCBS in the previous 12 months.</li> <li>▶ BOR transfers are not eligible to receive commissions on direct business until the new contract requirement, noted above, has been met.</li> <li>▶ Groups that were previously with a chamber cannot qualify for this program.</li> <li>▶ New contracts in 2011 &amp; 2012 will carry forward to 2013.</li> <li>▶ Payment will occur on a quarterly basis.</li> </ul>	Cumulative New Contracts	PEPM* Rate on All Direct Business	0 – 24	\$0	25 – 149	\$3.75	150+	\$7.50
Cumulative New Contracts	PEPM* Rate on All Direct Business								
0 – 24	\$0								
25 – 149	\$3.75								
150+	\$7.50								

\* Per Employee Per Month

### Important Note:

Existing community rated groups with dual offering of a competitor's program, currently receiving commissions will be ineligible for further commissions upon renewal unless all competitor offerings are eliminated and BCBS is the sole carrier.

If upon renewal BCBS is the sole-carrier, existing commission percentage will remain in effect.

## EXPERIENCE RATED

Group Status	Commission
<i>With</i> previous paid broker	Commission is effective first of month following BOR appointment; pay at previous broker commission level.
<i>Without</i> previous paid broker	Commission is effective at group's renewal, if BOR is received at least 90 days prior to renewal.



# Commission Schedule

## Commercial Plans

### **Important Information Regarding Experience Rated Commissions**

*Calculation:* The first month's bill will be annualized to determine annual premium. This will be applied to the aforementioned scale to calculate the annualized commission. The annualized commission is divided by the annualized premium to determine an average commission percent. The average commission percent is applied to the monthly paid premium.

*Medical:* For groups with 250+ enrolled contracts, the broker has the option to request an adjustment to the BCBS standard commission schedule. Request must be submitted in writing at time of new business and/or renewal quote, and will be honored at BCBS discretion.

# 2013 New Business Bonus Program

## Commercial Plans



### New Bonus Program for Brokers with < \$100 Million in Annual Premium

Total Number of New Contracts	Annual Payout
200-249	\$2,500
250-499	\$25,000
500-749	\$50,000
750-999	\$75,000
1000-2499	\$100,000
2500-4999	\$150,000
5000+	\$250,000

### New Bonus Program for Brokers with > \$100 Million in Annual Premium

Total Number of New Contracts	Annual Payout
200-249	\$2,500
250-499	\$25,000
500-749	\$50,000
750-999	\$75,000
1000-2499	\$100,000
2500-4999	\$250,000
5000+	\$350,000

### Qualifications

- ▶ Annual Premium will be calculated based on paid premium during the prior 12 month calendar year.
- ▶ Bonus program only applies to new business effective between January 1, 2013 and December 31, 2013.
- ▶ A change in BOR will not be counted toward the bonus program. Groups transitioned from existing business will not be counted toward the bonus program.
- ▶ If a broker loses the BOR on a group within the first twelve months of the initial sale of the group, the broker will not be penalized for the loss of the BOR as it relates to the New Business Bonus Program. The group will count towards the total number of new contracts for that broker.
- ▶ Payment will be made on a quarterly basis based upon the contract threshold level achieved year-to-date. Brokers will be subject to repayment of bonus to BCBS if contract counts fall below a threshold achieved in prior quarters. The bonus program only applies to eligible groups insured or administered by BlueCross BlueShield of Western New York.

# 2013 New Business Bonus Program

## Commercial Plans



### Qualifications (continued)

- ▶ Any existing group previously under a Chamber, Association or Society that is insured through BlueCross BlueShield will not be considered new business under any circumstance.
- ▶ The bonus program does not include business insured or administered by BlueCross BlueShield of Western New York's affiliates or by HealthNow New York, even if it is insured or administered by BlueCross BlueShield of Western New York.

# 2013 Persistency Bonus Program

In 2013, BlueCross BlueShield is offering a persistency bonus program to brokers who successfully help us retain and grow our valued membership.

<b>Retention Rate for Less than \$100 Million in Premium</b>	<b>PEPM* Payout</b>	<b>Retention Rate for Greater than \$100 Million in Premium</b>	<b>PEPM* Payout</b>
Less than 94.99%	\$0	Less than 94.99%	\$0
95.00% - 96.99%	\$1.75	95.00% - 95.50%	\$1.04
97.00% - 98.49%	\$2.50	95.51% - 96.75%	\$1.70
98.50% - 100.49%	\$4.25	96.76% - 98.25%	\$3.12
100.50% - 102.49%	\$5.25	98.26% - 99.00%	\$4.16
102.50% +	\$6.25	99.01% - 100.49%	\$5.00
		100.50% - 101.49%	\$6.00
		101.50% +	\$7.00

\* Per Employee Per Month

### Requirements for less than \$100 million in premium

- ▶ Minimum Book of Business of \$7.5 million of **Insured** annual collected premium from 1/1/13 to 12/31/13. For purposes of meeting this requirement, premiums will include the existing book of business premium, new group premium and premium for new broker of record appointments.
- ▶ Minimum of 25 in-force **Insured** groups.
- ▶ Write 5 new, insured groups with a total of 100 contracts. New business requirement will be waived if a total of 250 new contracts are sold.
- ▶ Bonus payments are reduced by 50% if new business requirements are not met.



## Requirements for greater than \$100 million in premium

- ▶ Minimum Book of Business of \$100 million of **Insured** Annual Collected Premium from 1/1/13 to 12/31/13. For purposes of meeting this requirement, premiums will include the existing book of business premium, new group premium and premium for new broker of record appointments.
- ▶ Minimum of 100 in-force **Insured** groups.
- ▶ Must bring in 350 new contracts not currently insured by BCBS.
- ▶ Bonus payments are reduced by 50% if new business requirements are not met.

## Retention Calculation

- ▶ The retention rate will be calculated based on the beginning membership as of 12/31/12 compared to ending membership on 12/31/13.
- ▶ BCBS will include 100% of total new contracts for the year in calculating the retention rate.
- ▶ If a broker loses a group due to a BOR transfer, the group will be removed from both beginning and ending membership.
- ▶ A broker will not be penalized upon the transfer of members from a Commercially Insured product to a BlueCross BlueShield Federal group product. The membership will be removed from both the beginning and ending membership.
- ▶ If a broker takes over a new BOR on an existing BCBS group and moves the business to a competitor, the membership will be added to the beginning membership of 12/31/12.

## Payments

- ▶ Payments will be limited to a maximum of \$100,000 per group.
- ▶ The combination of commission and persistency bonus payments cannot exceed a total of 5% of the collected premium for each individual group. Commission and bonus payment for HMO products cannot exceed 4% of collected premium for each individual group.
- ▶ Bonuses will be paid in March of the following year and are subject to regulatory approval.

**Please Note:** Any membership in a Chamber group, Association or Society, as well as ASO and Medicare groups, will be excluded from the persistency bonus program.

# Commission Schedule

## Medicare Advantage Plans



The schedule below applies to all Senior Blue HMO and Forever Blue Medicare PPO Group Plans:

1st Year	\$10.00 per contract per month
2nd Year	\$12.00 per contract per month
3rd Year and thereafter	\$15.00 per contract per month

### Commission Guidelines

- ▶ Members must be enrolled in the Medicare Advantage plan *through an employer group*.
- ▶ This schedule of commission is not applicable to direct pay Medicare Advantage members.
- ▶ An employer group must consist of a minimum of two applications.
- ▶ Enrollees must remain in a Senior Blue HMO or Forever Blue Medicare PPO plan for a minimum of three months.
- ▶ Brokers are not eligible for payment on the same member who cancels coverage and re-enrolls in the plan within a three-year period. For example, if a member enrolls, cancels coverage in the second year, and then re-enrolls in the third year, the broker will only be paid for the first year of membership.
- ▶ Payments will be made for active contracts, on a quarterly basis, beginning with the quarter after the effective date of the application.

### Please Note:

Government-commissioned plans are not included in the Persistency Bonus Program.

**Important Note:** *Payment of commissions shall be exclusively governed by the terms of the applicable contract between BlueCross BlueShield of Western New York and the Independent Broker. This schedule is subject to regulatory approval. BlueCross BlueShield of Western New York reserves the right to amend or clarify this schedule at any time.*

BlueCross BlueShield of Western New York is a division of HealthNow New York Inc., an independent licensee of the BlueCross BlueShield Association.

# Commission Schedule

## Medicare Plans



The following commission schedule applies to Direct Pay Products:

Year 1	\$300 per direct pay new (initial) medical application
Year 2-6	\$150 per renewal

A one-time \$75 referral fee is available to brokers appointed with BCBS that result in a new direct pay member. *(Signature form and workflow will be distributed separately.)*

Override \$75 per contract (new and renewal for special broker agreement).

### Commission Guidelines

Brokers are not eligible for payment for members who cancel coverage and re-enter the plan over a three-year period. For example, if a member enrolls, cancels coverage in the second year and then re-enrolls in the third year, the broker will only be paid only for the first year of membership.

Payments will be made quarterly after the effective date of the application so long as the member is enrolled in one of our Medicare Plans.

Referral fees will be paid quarterly for leads that result in a CMS confirmed enrollment. The member must be enrolled for a minimum of three consecutive months in order for the broker to earn the referral fee.

### Please Note:

Three month consecutive enrollment does not apply to Medigap.

**Important Note:** *Payment of commissions shall be exclusively governed by the terms of the applicable contract between BlueCross BlueShield of Western New York and the Independent Broker. This schedule is subject to regulatory approval. BlueCross BlueShield of Western New York reserves the right to amend or clarify this schedule at any time.*

**HealthNow, Inc.**  
**Development of Standardized Premiums**

Within each combination of Region, Product and Segment, Earned Premiums were split out by the year and quarter of renewal. An adjustment factor, representing the overall premium rate increase applicable to that particular region/product/segment combination between the time of renewal and Q4 2012, was then applied to develop the standardized Q4 2012 premium.

Table A below shows a grid of premium adjustment factors that would be used to adjust 2011 earned premiums to Q4 2012 standardized premiums, based on the assumed quarterly premium increases shown in Table B.

For example, to convert the Jan-11 earned premium for a February renewal group, the factor is 1.169, which is the product of all the quarterly increases in Table B. In January 2011, a February renewal group would still be paying its Q1 2010 premium rate; thus the need to step up its premium rate through all the applicable quarterly increases from Q2 2010 through Q4 2012.

**Table A**

Renewal Month	Incurral/Earned Month											
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
Jan	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040
Feb	1.169	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040
Mar	1.169	1.169	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040	1.040
Apr	1.126	1.126	1.126	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010
May	1.126	1.126	1.126	1.126	1.010	1.010	1.010	1.010	1.010	1.010	1.010	1.010
Jun	1.126	1.126	1.126	1.126	1.126	1.010	1.010	1.010	1.010	1.010	1.010	1.010
Jul	1.104	1.104	1.104	1.104	1.104	1.104	1.018	1.018	1.018	1.018	1.018	1.018
Aug	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.018	1.018	1.018	1.018	1.018
Sep	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.018	1.018	1.018	1.018
Oct	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	0.994	0.994	0.994
Nov	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	0.994	0.994
Dec	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	1.104	0.994

**Table B**

<u>Quarter</u>	<u>Quarterly Premium Increase</u>
Q2 2010	1.038
Q3 2010	1.020
Q4 2010	1.000
Q1 2011	1.061
Q2 2011	1.030
Q3 2011	0.992
Q4 2011	1.024
Q1 2012	0.937
Q2 2012	1.020
Q3 2012	1.020
Q4 2012	1.020

Per the instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

**A. Base Period Data**

Start Period: 07/01/2011 End Period: 06/30/2012

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	533,579	\$ 37,435,880.42	\$ 34,893,976.19	\$ 2,541,904.23	\$ 4.76	\$ 65.40	\$ 70.16
Outpatient	533,579	\$ 28,028,501.06	\$ 22,022,105.99	\$ 6,006,395.07	\$ 11.26	\$ 41.27	\$ 52.53
Professional	533,579	\$ 58,841,292.31	\$ 44,050,987.67	\$ 14,790,304.63	\$ 27.72	\$ 82.56	\$ 110.28
Prescription Drugs	533,579	\$ 31,156,469.09	\$ 21,371,227.16	\$ 9,785,241.93	\$ 18.34	\$ 40.05	\$ 58.39
Other	533,579	\$ 1,750,972.41	\$ 1,750,972.41	\$ 0.00	\$ 0.00	\$ 3.28	\$ 3.28
Capitation	533,579	\$ 3,398,288.09	\$ 3,398,288.09	\$ 0.00	\$ 0.00	\$ 6.37	\$ 6.37
<b>Total</b>	<b>533,579</b>	<b>\$ 160,611,403.38</b>	<b>\$ 127,487,557.51</b>	<b>\$ 33,123,845.87</b>	<b>\$ 62.08</b>	<b>\$ 238.93</b>	<b>\$ 301.01</b>

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: 07/01/2012 End Period: 06/30/2013

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.0999	\$ 77.17	\$ 72.40	0.0617
Outpatient	1.0999	\$ 57.78	\$ 46.52	0.1948
Professional	1.0999	\$ 121.29	\$ 93.57	0.2285
Prescription Drugs	1.0151	\$ 59.27	\$ 40.93	0.3094
Other	0.9971	\$ 3.27	\$ 0.0000	0.0000
Capitation	0.9635	\$ 6.14	\$ 6.14	0.0000
<b>Total</b>		<b>\$ 324.92</b>	<b>\$ 262.84</b>	<b>0.19</b>

**B2. Claims Projection for Future Rate**

Start Period: 07/01/2013 End Period: 06/30/2014

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.0862	\$ 83.82	\$ 79.06	0.0568
Outpatient	1.0862	\$ 62.76	\$ 51.50	0.1794
Professional	1.0862	\$ 131.75	\$ 104.03	0.2104
Prescription Drugs	1.0068	\$ 59.67	\$ 41.34	0.3073
Other	0.9971	\$ 3.26	\$ 3.26	0.0000
Capitation	0.9635	\$ 5.91	\$ 5.91	0.0000
<b>Total</b>		<b>\$ 347.18</b>	<b>\$ 285.10</b>	<b>0.18</b>

**B3. Medical Trend Breakout**

Factor	Impact
Utilization	24.1654%
Unit Cost	57.9511%
Other Factors	17.8835%

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 285.10	84.62%	\$ 259.82	85.80%	\$ 25.28	74.17%
2. Administrative Costs	\$ 43.22	12.83%	\$ 43.00	14.20%	\$ 0.22	0.64%
3. Underwriting Gain/Loss	\$ 8.59	2.55%	\$ 0.00	0.00%	\$ 8.59	25.19%
4. Total Rate	\$ 336.91	100.00%	\$ 302.83	100.00%	\$ 34.08	100.00%
5. Overall Rate Increase		11.26%				

**D. Components of Rate Increase**

Claims Components	Impact on Rate	Percent
1. Inpatient	\$ 6.24	24.70%
2. Outpatient	\$ 4.01	15.87%
3. Professional	\$ 8.07	31.92%
4. Prescription Drugs	\$ 0.28	1.10%
5. Other	\$ (0.01)	-0.04%
6. Capitation	\$ (0.22)	-0.89%
7. Cost Share	\$ 3.90	15.41%
8. Correction of Prior Net Claims Estimate	\$ 3.01	11.93%
9. Total	\$ 25.28	100.00%

Claims Restatement for Current Rate Period

8.a. Prior Net Claims Estimate for Current Rate Period	\$ 259.82
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 262.84

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	New Form	Requested	Implemented
2012	N	15.2364%	15.2364%
2011	N	11.7768%	11.1520%
2010	N	9.9013%	9.9013%

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	14,811	Threshold Rate Increase	16.4992%
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Range of Rate Increase	
Minimum % Increase	1.3998%
Maximum % Increase	18.3874%

Per the instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

**A. Base Period Data**

Start Period: 07/01/2011 End Period: 06/30/2012

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	97,885	\$ 10,418,576.55	\$ 10,287,447.61	\$ 131,128.93	1.34	105.10	106.44
Outpatient	97,885	\$ 6,830,733.20	\$ 6,325,436.99	\$ 505,296.22	5.16	64.62	69.78
Professional	97,885	\$ 14,339,880.00	\$ 12,641,701.08	\$ 1,698,178.92	17.35	129.15	146.50
Prescription Drugs	97,885	\$ 10,547,679.55	\$ 8,388,588.72	\$ 2,159,090.84	22.06	85.70	107.76
Other	97,885	\$ 1,436,873.43	\$ 1,436,873.43	\$ 0.00	0.00	14.68	14.68
Capitation	97,885	\$ 1,407,889.52	\$ 1,407,889.52	\$ 0.00	0.00	14.38	14.38
<b>Total</b>	97,885	\$ 44,981,632.25	\$ 40,487,937.35	\$ 4,493,694.90	45.91	413.63	459.54

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: 07/01/2012 End Period: 06/30/2013

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.1001	\$ 117.09	\$ 115.75	0.0114
Outpatient	1.1001	\$ 76.77	\$ 71.61	0.0672
Professional	1.1001	\$ 161.16	\$ 143.81	0.1076
Prescription Drugs	0.9814	\$ 105.75	\$ 83.69	0.2086
Other	0.9905	\$ 14.54	\$ 14.54	0.0000
Capitation	0.9635	\$ 13.86	\$ 13.86	0.0000
<b>Total</b>		\$ 489.17	\$ 443.26	0.09

**B2. Claims Projection for Future Rate**

Start Period: 07/01/2013 End Period: 06/30/2014

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.0862	\$ 127.19	\$ 125.85	0.0105
Outpatient	1.0862	\$ 83.39	\$ 78.23	0.0619
Professional	1.0862	\$ 175.06	\$ 157.71	0.0991
Prescription Drugs	1.0068	\$ 106.47	\$ 84.42	0.2072
Other	0.9905	\$ 14.40	\$ 14.40	0.0000
Capitation	0.9635	\$ 13.35	\$ 13.35	0.0000
<b>Total</b>		\$ 519.86	\$ 473.95	0.09

**B3. Medical Trend Breakout**

Factor	Impact
Utilization	23.4757%
Unit Cost	61.7606%
Other Factors	14.7637%

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 473.95	85.16%	\$ 402.96	86.74%	\$ 70.99	77.16%
2. Administrative Costs	\$ 40.39	7.26%	\$ 42.55	9.16%	\$ (2.16)	-2.35%
3. Underwriting Gain/Loss	\$ 42.23	7.59%	\$ 19.06	4.10%	\$ 23.17	25.19%
4. Total Rate	\$ 556.57	100.00%	\$ 464.58	100.00%	\$ 91.99	100.00%
5. Overall Rate Increase		19.80%				

**D. Components of Rate Increase**

Claims Components	Impact on Rate	Percent
1. Inpatient	\$ 9.98	14.06%
2. Outpatient	\$ 6.17	8.70%
3. Professional	\$ 12.40	17.47%
4. Prescription Drugs	\$ 0.57	0.80%
5. Other	\$ (0.51)	-0.19%
6. Capitation	\$ (0.51)	-0.71%
7. Cost Share	\$ 2.21	3.11%
8. Correction of Prior Net Claims Estimate	\$ 40.30	56.77%
9. Total	\$ 70.99	100.00%
<b>Claims Restatement for Current Rate Period</b>		
8.a. Prior Net Claims Estimate for Current Rate Period	\$ 402.96	
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 443.26	

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	New Form	Requested	Implemented
2012	N	15.5586%	15.5586%
2011	N	17.6033%	16.4395%
2010	N	10.8464%	10.8464%

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	1,818	Threshold Rate Increase	18.9802%
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Range of Rate Increase	
Minimum % Increase	-7.5573%
Maximum % Increase	20.9698%

Per the instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

**A. Base Period Data**

Start Period: 07/01/2011 End Period: 06/30/2012

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	16,111	\$ 2,656,367.36	\$ 2,635,502.19	\$ 20,865.17	\$ 1.30	\$ 163.58	\$ 164.88
Outpatient	16,111	\$ 2,208,304.61	\$ 2,193,825.31	\$ 14,479.31	\$ 0.90	\$ 136.17	\$ 137.07
Professional	16,111	\$ 7,822,353.93	\$ 7,315,410.13	\$ 506,943.80	\$ 31.47	\$ 454.06	\$ 485.53
Prescription Drugs	16,111	\$ 818,031.99	\$ 750,641.30	\$ 67,390.69	\$ 4.18	\$ 46.59	\$ 50.77
Other	16,111	\$ 99,278.02	\$ 99,278.02	\$ 0.00	\$ 0.00	\$ 6.16	\$ 6.16
Capitation	16,111	\$ 122,198.08	\$ 122,198.08	\$ 0.00	\$ 0.00	\$ 7.58	\$ 7.58
<b>Total</b>	16,111	\$ 13,726,533.98	\$ 13,116,855.02	\$ 609,678.96	\$ 37.84	\$ 814.16	\$ 852.00

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period: 07/01/2012 End Period: 06/30/2013

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.0863	\$ 179.10	\$ 177.81	0.0072
Outpatient	1.0863	\$ 148.89	\$ 148.00	0.0060
Professional	1.0863	\$ 527.42	\$ 495.95	0.0597
Prescription Drugs	0.9928	\$ 50.41	\$ 46.23	0.0830
Other	1.0307	\$ 6.35	\$ 6.35	0.0000
Capitation	0.9635	\$ 7.31	\$ 7.31	0.0000
<b>Total</b>		\$ 919.48	\$ 881.64	0.04

**B2. Claims Projection for Future Rate**

Start Period: 07/01/2013 End Period: 06/30/2014

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient	1.0702	\$ 191.67	\$ 190.38	0.0068
Outpatient	1.0702	\$ 159.34	\$ 158.44	0.0056
Professional	1.0702	\$ 564.43	\$ 532.96	0.0557
Prescription Drugs	0.9919	\$ 50.00	\$ 45.82	0.0837
Other	1.0307	\$ 6.55	\$ 6.55	0.0000
Capitation	0.9635	\$ 7.04	\$ 7.04	0.0000
<b>Total</b>		\$ 979.03	\$ 941.19	0.04

**B3. Medical Trend Breakout**

Factor	Impact
Utilization	35.7741%
Unit Cost	65.8668%
Other Factors	-1.6409%

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	\$ 941.19	91.63%	\$ 950.73	87.39%	\$ (9.54)	15.69%
2. Administrative Costs	\$ 40.39	3.93%	\$ 42.55	3.91%	\$ (2.16)	3.56%
3. Underwriting Gain/Loss	\$ 45.56	4.44%	\$ 94.66	8.70%	\$ (49.10)	80.75%
4. Total Rate	\$ 1,027.14	100.00%	\$ 1,087.95	100.00%	\$ (60.81)	100.00%
5. Overall Rate Increase		-5.59%				

**D. Components of Rate Increase**

Claims Components	Impact on Rate	Percent
1. Inpatient	\$ 12.48	-130.74%
2. Outpatient	\$ 10.39	-108.82%
3. Professional	\$ 34.80	-364.67%
4. Prescription Drugs	\$ (0.37)	3.90%
5. Other	\$ 0.19	-2.04%
6. Capitation	\$ (0.27)	2.80%
7. Cost Share	\$ 2.33	-24.40%
8. Correction of Prior Net Claims Estimate	\$ (69.09)	723.96%
9. Total	\$ (9.54)	100.00%
<b>Claims Restatement for Current Rate Period</b>		
8.a. Prior Net Claims Estimate for Current Rate Period	\$ 950.73	
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	\$ 881.64	

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	New Form	Requested	Implemented
2012	N	17.2185%	17.2185%
2011	N	13.7816%	13.7816%
2010	N	15.2693%	15.2693%

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	217	Threshold Rate Increase	0.0000%
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Range of Rate Increase	
Minimum % Increase	-16.8203%
Maximum % Increase	10.1014%